

CTMUHB Audit & Risk Committee

Wed 19 April 2023, 11:30 - 14:00

Virtually via Microsoft Teams

Agenda

11:30 - 11:35
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information

Patsy Roseblade, Committee Chair

1.2. Apologies for Absence

Information

Patsy Roseblade, Committee Chair

1.3. Declarations of Interest

Information

Patsy Roseblade, Committee Chair

11:35 - 11:40
5 min

2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the meeting held on 13 February 2023

Decision

Patsy Roseblade, Committee Chair

 2.1.1 Unconfirmed Minutes CTMUHB ARC 13 February 2023 Final ARC 19 April 2023.pdf (11 pages)

2.1.2. Unconfirmed Minutes of the In Committee meeting held on 13 February 2023

Decision

Patsy Roseblade, Committee Chair

 2.1.2 Unconfirmed Minutes In Committee CTMUHB ARC 13 February 2023 Final ARC 19 April 2023.pdf (2 pages)

2.1.3. Audit & Risk Committee Terms of Reference

Decision

Cally Hamblyn, Assistant Director of Governance & Risk

 2.1.3a Audit & Risk Committee Terms of Reference ARC 19 April 2023.pdf (2 pages)

 2.1.3b GC01 Standing Orders - Schedule 3.1 - Audit & Risk Committee ToR ARC 19 April 2023.pdf (11 pages)

2.2. FOR NOTING

2.2.1. Audit & Risk Committee Annual Cycle of Business for 2023

Information

Cally Hamblyn, Assistant Director of Governance & Risk

 2.2.1a Audit & Risk Committee Cycle of Business - Cover Paper ARC 19 April 2023.pdf (2 pages)

 2.2.1b Audit Risk Committee Cycle of Business ARC 19 April 2023.pdf (4 pages)

2.2.2. Audit & Risk Committee Forward Work Programme

Information

Cally Hamblyn, Assistant Director of Governance & Risk

 2.2.2 Audit & Risk Committee Forward Work Plan ARC 19 April 2023.pdf (2 pages)

2.2.3. Annual Report Timetable 2022 - 2023

Information Cally Hamblyn, Assistant Director of Governance & Risk

 2.2.3 Updated Timetable 22-23 ARC April 23 ARC 19 April 2023.pdf (3 pages)

2.2.4. CTMUHB ISO14001 Certification Progress Report - To follow

Information Gethin Hughes, Chief Operating Officer

2.2.5. Declarations of Interest and Gifts and Hospitality Report

Information Cally Hamblyn, Assistant Director of Governance & Risk

 2.2.5a Declarations of Interest and GHS Register - Cover Report ARC 19 April 2023.pdf (3 pages)

 2.2.5b Appendix 2 Board Member & Hard Copy Non Board Member DOI Spreadsheet 2022 2023.pdf (7 pages)

 2.2.5c Appendix 3 Register of Gifts Hospitality and Sponsorship 2022 2023.pdf (1 pages)

2.2.6. Cwm Taf Morgannwg University Health Board (CTMUHB) National Clinical Audit Programme Update 2022-2023

Information Dom Hurford, Medical Director

 2.2.6a National Clinical Audit Programme Update ARC 19 April 2023.pdf (6 pages)

 2.2.6b Appendix 1 National Clinical Audit Annual Plan 28022023 ARC 19 April 2023.pdf (12 pages)

2.2.7. Audit Wales Annual Audit Report

Information Sara Utley, Audit Wales

 2.2.7a Audit Wales -CTMUHB Annual Audit Report 2022 - Cover Report ARC 19 April 2023.pdf (2 pages)

 2.2.7b Appendix 1 - 3314A2023 CTMUHB Annual Audit Report 2022 ARC 19 April 2023.pdf (28 pages)

2.2.8. PCH Redevelopment Programme Integrated Audit Plan 2023/24

Information Paul Dalton, Head of Internal Audit

 2.2.8 PCH Audit Plan 2023 24 Draft ARC 19 April 2023.pdf (5 pages)

11:40 - 11:45
5 min

3. MAIN AGENDA

3.1. Audit & Risk Committee Action Log

Discussion Cally Hamblyn, Assistant Director of Governance & Risk

 3.1 Audit & Risk Committee Action Log ARC 19 April 2023.pdf (6 pages)

3.2. Matters Arising not Contained within the Action Log

Discussion Patsy Roseblade, Committee Chair

11:45 - 12:25
40 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

Discussion Matthew Evans, Local Counter Fraud Specialist

To include the following:

- Counter Fraud Annual Report
- Counter Fraud Annual Self Review
- Counter Fraud Draft Work Plan

 4.1a Local Counter Fraud Update Report ARC April 2023.pdf (3 pages)

-  4.1b Local Counter Fraud Update Report Apr 23 ARC 19 April 2023.pdf (4 pages)
-  4.1c Appendix 1 CTMUHB Counter Fraud Work Plan 2023-24 ARC 19 April 2023.pdf (9 pages)
-  4.1d Appendix 2 CTMUHB Counter Fraud Annual Report 2022-23 ARC 19 April 2023.pdf (22 pages)
-  4.1e Appendix 3 CTMUHB Annual Self Review - Functional Standard Return ARC 19 April 2023.pdf (21 pages)
-  4.1f Appendix 4 Counter Fraud Investigations Update ARC 19 April 2023.pdf (12 pages)

4.2. Procurement and Scheme of Delegation Report

Discussion Sally May, Director of Finance

-  4.2a Scheme of Delegation Report ARC 19 April 2023.pdf (7 pages)
-  4.2b FP17 Patients Property, Income & Allowances ARC 19 April 2023.pdf (25 pages)

4.3. Post Payment Verification Annual Report

Discussion Post Payment Verification Manager

-  4.3a Post Payment Verification Report April22-March23 ARC 19 April 2023.pdf (4 pages)
-  4.3b CTMuHB Audit report Apr 2022-Mar 2023 Anonymised ARC 19 April 2023.pdf (6 pages)

12:25 - 13:50
85 min

5. IMPROVING CARE

5.1. Annual Review: Risk Management Framework

Discussion Cally Hamblyn, Assistant Director of Governance & Risk

-  5.1a Annual Review-Risk Management Framework.pdf (4 pages)
-  5.1b Appendix 1 - Risk Management Strategy - Review April 2023.pdf (27 pages)
-  5.1c Appendix 2 - Risk Appetite Statement - Approved 31.3.2022 - Review April 2023.pdf (2 pages)
-  5.1d Appendix 3 - Risk Domain & Scoring Matrix - Review March 2023.pdf (2 pages)

5.2. Organisational Risk Register

Discussion Cally Hamblyn, Assistant Director of Governance & Risk

-  5.2a Organisational Risk Register March 2023 ARC Cover Paper.pdf (5 pages)
-  5.2b Appendix 1 Master Organisational Risk Register Final March 2023.pdf (14 pages)

5.3. Audit Recommendations Tracker

Discussion Emma Walters, Corporate Governance Manager

-  5.3a Audit Recommendations Tracker Update Report ARC 19 April 2023 - CH.pdf (6 pages)
-  5.3b Appendix 1 Internal Audit Recommendations Tracker ARC 19 April 2023.pdf (26 pages)
-  5.3c Appendix 2 External Audit Recommendations Tracker ARC 19 April 2023.pdf (5 pages)

5.3.1. Consultant Job Planning - Progress Report

Discussion Dom Hurford, Medical Director

-  5.3.1 Consultant Job Planning Progress Report ARC 19 April 2023.pdf (4 pages)

5.3.2. Medical Rostering - Progress Report

Discussion Dom Hurford, Medical Director

-  5.3.2 Medical Rostering Progress Report ARC 19 April 2023.pdf (4 pages)

5.4. AUDIT WALES

5.4.1. Audit Wales Audit & Risk Committee Update

Discussion Sara Utley, Audit Wales

-  5.4.1 AW CTMUHB April 2023 Audit Update ARC 19 April 2023.pdf (14 pages)

5.4.2. Audit Wales - Structured Assessment

Discussion Sara Utley, Audit Wales

-  5.4.2a Audit Wales - CTMUHB Structured Assessment Report 2022 ARC 19 April 2023.pdf (3 pages)
-  5.4.2b CTMUHB Structured Assessment Report 2022 ARC 19 April 2023.pdf (34 pages)
-  5.4.2c CTMUHB Structured Assessment 2022 - Organisational Response ARC 19 April 2023.pdf (9 pages)

5.4.3. Audit Wales Outline Audit Plan 2023

Discussion Sara Utley, Audit Wales

-  5.4.3 Audit Wales Outline 2023 CTMUHB Audit Plan ARC 19 April 2023.pdf (10 pages)

5.4.4. Audit Wales National and Local Report Orthopaedic Services

Discussion Sara Utley, Audit Wales

Management Response To follow

-  5.4.4a Orthopaedic_Services_in_Wales_Tackling_the_Waiting_List_Backlog (1) ARC 19 April 2023.pdf (43 pages)
-  5.4.4b AW ctm_orthopaedics ARC 19 April 2023.pdf (28 pages)

5.5. INTERNAL AUDIT

5.5.1. Internal Audit Progress Report

Discussion Paul Dalton, Head of Internal Audit

-  5.5.1 IA Progress report ARC 19 April 2023.pdf (9 pages)

5.5.2. Internal Audit Review - Board awareness of digital

Discussion Paul Dalton, Head of Internal Audit

-  5.5.2 IA Board Awareness of Digital final Report ARC 19 April 2023.pdf (12 pages)

5.5.3. Internal Audit Review - Reasonable offer

Discussion Internal Audit

-  5.5.3 IA Reasonable Offers-Final Internal Audit Report ARC 19 April 2023.pdf (19 pages)

5.5.4. Internal Audit Review - Bridgend transfer of IT – Follow up

Discussion Internal Audit

-  5.5.4 IA Bridgend informatics tf - follow up - Final report ARC 19 April 2023.pdf (12 pages)

5.5.5. Internal Audit Review - Board Assurance Framework

Discussion Internal Audit

-  5.5.5 CTMUHB22.23-14 Board Assurance Framework - Final Internal Audit Report.pdf (14 pages)

5.5.6. Internal Audit Annual Audit Plan 2023/2024

Discussion Paul Dalton, Head of Internal Audit

-  5.5.6 IA CTMUHB 2023-24 Internal Audit Plan for AC approval ARC 19 April 2023.pdf (28 pages)

13:50 - 13:55
5 min

6. ANY OTHER BUSINESS

Information Patsy Roseblade, Committee Chair

13:55 - 13:55
0 min

7. COMMITTEE HIGHLIGHT REPORT TO BOARD

Discussion

Patsy Roseblade, Committee Chair

13:55 - 14:00
5 min

8. HOW DID WE DO IN THIS MEETING

Discussion

Patsy Roseblade, Committee Chair

14:00 - 14:00
0 min

9. DATE AND TIME OF NEXT MEETING - WEDNESDAY 21 JUNE

**Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)
Audit & Risk Committee held on the 13 February 2023 as a Virtual
Meeting via Microsoft Teams**

Members Present:

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

In Attendance:

Sara Utlej	Audit Wales
Mark Jones	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Eifion Jones	NWSSP – Internal Audit & Assurance (In Part)
Sally May	Executive Director of Finance (In part)
Mark Thomas	Deputy Director of Finance (In part)
Cally Hamblyn	Assistant Director of Governance & Risk
Owen James	Head of Corporate Finance
Matthew Evans	Head of Local Counter Fraud
Richard Hughes	Deputy Director of Nursing
Emma Walters	Corporate Governance Manager (Secretariat)

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

P Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members **noted** that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members **noted** that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.

The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.

1.2 Apologies for Absence

S May advised that she would need to leave the meeting earlier and added that M Thomas, Deputy Director of Finance would be joining the meeting from around 3.15pm.

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the In Committee Meeting held on the 12 December 2022

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

2.1.2 Audit & Risk Committee Annual Cycle of Business for 2023

M Jones made reference to the timetable for the Audit of Financial Accounts and the Annual Report for 2022-2023 and advised that it was highly likely that this would now need to be undertaken during July and not June as stated within the Annual Cycle of Business. C Hamblyn advised that a note had been included in the Annual Report Timetable 2022-2023 at agenda item 2.2.2 that the timetable may be subject to change.

M Jones advised that in previous years, the Committee had also met in May to receive the draft financial statements, which would need to be reflected in the annual cycle of business.

S May advised that the whole timetable would need to be reviewed as a result of the significant movement in the date for the accounts to be finalised, which would impact on the work undertaken by teams as focus would need to be placed on the previous year for a longer period.

Resolution: The Annual Cycle of Business was **APPROVED**.

Action: Annual Cycle of Business to be amended to reflect the comments made regarding discussion of the draft accounts and approval of the final accounts.

2.2 FOR NOTING

2.2.1 Audit & Risk Committee Forward Work Programme

Resolution: The Forward Work Programme was **NOTED**.

2.2.2 Annual Report Timetable 2022-2023

Resolution: The report was **NOTED**.

3.0.0 MAIN AGENDA

GOVERNANCE

3.1 Unconfirmed Minutes of the meeting held on 12 December 2022

P Roseblade advised Members that the minutes had been included on the main agenda as it was felt that the paragraph highlighted on page 3 of the minutes, which related to referral rates of Counter Fraud items being reviewed pragmatically, required further explanation. Members were assured that case closures were taken through a thorough review process prior to being closed.

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

3.2 Audit & Risk Committee Action Log

C Hamblyn presented Members with the action log. I Wells expressed concern in relation to action log reference 18/099 which related to the JAG Accreditation Closure Report. I Wells expressed concerns on the continuing delay in receiving an update. S May advised that this matter was heavily dependent on the development of a Business Case for the Decontamination Unit at Princess of Wales Hospital which was due to be presented to the last meeting of the Executive Capital Management Group, but had now been deferred to the March meeting. P Roseblade suggested that a realistic completion date be sought which could be reflected in the action log. C Hamblyn agreed to discuss further with the Chief Operating Officer outside the meeting.

S Utley confirmed that she had now met with the Director of Digital to discuss the closure of the Clinical Coding recommendations and advised that an update would be included in the next iteration of the Audit Recommendations Tracker.

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

Action: Discussion to be held with the Chief Operating Officer outside the meeting to identify and agree a more realistic completion date for the JAG Accreditation closure report.

3.3 Matters Arising not contained within the Action Log

There were no further items identified.

4.0.0 SUSTAINING OUR FUTURE

4.1 Local Counter Fraud Report

M Evans presented the report and highlighted the key matters for Members attention.

A discussion was held in relation to the work being undertaken in relation to the offering of free Health Sector Conferences/working events to NHS Staff. Members noted that these conferences had been circulating for some time and tended to have Terms and Conditions associated with them, which sometimes

resulted in the attendee being invoiced if they were no longer able to attend the conference. J Sadgrove expressed concerns on this matter and was assured that review is being undertaken.

J Sadgrove welcomed the report and the progress being made in case closures and advised that she was pleased to see that at this point in the year, the way in which the days were being used was tracking much better. J Sadgrove also noted the improvement in the presentation of the performance graphs where it was clearly identified that there had been an increase in the number of people who were willing to raise potential areas of fraud.

P Roseblade made reference to case number INV/21/00041 which related to an overpayment of salary and queried whether this case was subject to a police check issue or a different issue. M Evans advised that this related to the inability to submit the Police National Computer Check into the Crown Prosecution Service which had been an ongoing issue since late last year. Members noted that in this case, the bank had queried the signature provided which did not match the signature they had on file. Steps had now been taken to ask the Finance payment team to prove that payments had been made.

Resolution: The report was **NOTED**.

4.2 **Losses and Special Payments Report**

O James presented the report and advised that the main risk being highlighted was in relation to the timely submission of Learning From Events reports (LFER), with a number of blank reports being submitted.

R Hughes provided members with an update on the steps being taken to improve the process in relation to the completion and submission of (LFER) forms, which was an area of priority. Members noted that the revised Quality Governance operating model should help to alleviate some of the issues being experienced and noted that a five week implementation plan had now been initiated to finalise the Patient Safety and Quality elements of the structure. Members noted that the position was being reviewed weekly at the Executive Director led patient safety meetings.

In response to a query raised by C Donoghue as to the reasons why blank forms were being submitted, R Hughes advised that a blank form was being submitted when the initial deadline date was being reached, which then allowed a further 6 months to review. Members noted that completed forms were being submitted following the 6 month extension and noted that some escalation points had been put into place to limit the submission of blank forms, with any blank forms now requiring approval by the Deputy Director of Nursing prior to submission.

P Roseblade made reference to paragraph 2.13 which stated that there were a further 42 Red/Amber deferred case that were due to hit the 6 month deadline and sought clarity as to whether this deadline was imminent or whether these

related to the need to submit a blank form to obtain a further 6 month extension. R Hughes advised that he would need to review the position outside the meeting.

S May advised that the submission of the blank LFER forms had been done so in agreement with the Welsh Risk Pool with their full knowledge and acceptance. S May added that this piece of work should hopefully help staff to have much greater focus in relation to the embedding of learning and added that it would be important to have the Care Group Medical and Nurse Directors working alongside R Hughes to make the process more meaningful.

P Roseblade sought clarity as to whether the £1.1m accrual in the accounts for the Welsh Risk Pool overspend was a prediction or the actual figure of what the Cwm Taf Morgannwg share of the overspend would be. O James advised that this was the projected share of the overspend and added that he was unsure if this figure had been confirmed.

Resolution: The report was **NOTED**.

Action: Review to be undertaken outside the meeting in relation to the 42 Red/Amber deferred cases that were due to hit the six month deadline to determine whether the deadline was imminent or whether these related to the need to submit a blank LFER in order to obtain a further six month extension.

4.3 Procurements and Scheme of Delegation Report

S May presented Members with the report.

J Sadgrove made reference to the Single Tender action which related to the provision of 4x4 vehicles and questioned whether this was related to snow. S May advised that this was in relation to the anticipation of snow and added that each year, as part of the Health Board's winter plan, the provision of these vehicles had been put into place. Members noted that the Assistant Director of Facilities had been asked to undertake a review of the overall process in relation to Car and Leasing arrangements.

C Donoghue advised that she was pleased to see the improvement in performance of payment of non NHS invoices but disappointed to see that performance was not as strong in relation to payment of NHS invoices. S May advised that it had been identified that there were some service areas within the Health Board who were less effective in paying invoices on time compared to others. O James advised that there had now been an improvement in the payment of nurse agency invoices, which had been highlighted as an area of concern previously. Members noted that NHS invoices were exempt from the No Purchase Order, No Pay rule which made it more difficult for invoices to be followed up without a purchase order included.

Resolution: The report was **NOTED**.

5.0.0 IMPROVING CARE

5.1 Organisational Risk Register

C Hamblyn presented the report and provided an update against the key matters for Members attention. Members noted that the report had also been presented to the Quality & Safety and People & Culture Committees where a number of updates were being addressed following discussions held.

I Wells made reference to Risk 5276, which related to the Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025, and sought clarity as to whether there was an outcome of the discussions held with the configuration supplier on the 10 January 2023. C Hamblyn advised that she would obtain an update outside the meeting and advised that a Board Briefing session would be held on the 16 February in relation to the LINC programme.

I Wells made reference to Risk 5267 which related to the risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses, and noted that the risk score had increased to 20 in January and queried whether this was as a result of winter pressures or whether this risk was a permanent risk. C Hamblyn agreed to obtain a response outside the meeting and added that there were a large number of workforce risks on the register which are being reviewed. R Hughes advised that he had also planned to undertake a robust review of this risk.

C Donoghue advised that there were some risks on the register that had not been reviewed since September and October and noted that the mortuary risk had been an issue since 2018 but had only recently been added to the risk register. C Hamblyn advised that this risk had now been de-escalated and will be removed from the Organisational Risk Register.

In relation to Risk 4103 - Sustainability of a safe and effective Ophthalmology service, C Donoghue welcomed the positive action that was being taken in this area.

C Donoghue made reference to Risk 3008 - Risk of injury due to unavailability of opportunities to train and maintain compliance with Manual handling training and Risk 4780 Patient Handling Training and advised that these risks appeared to be the same and questioned whether they could be aligned. C Hamblyn advised that consideration was being given to these risks as part of the review.

In response to a query raised by P Roseblade as to whether a discussion had been held with Executive colleagues regarding the consistency of approach to the scoring of risks, C Hamblyn confirmed that a discussion was held and steps would be taken to ensure calibration and moderation of risk scoring across the Health Board.

In response to a comment made by P Roseblade in relation to the LINC programme and the references being made to an extension of the current contract which she thought was not possible, C Hamblyn advised that the contract could be extended, but by three months only. P Roseblade sought clarity as to what was meant by the term sequential deployment and what this meant for the Health Board. C Hamblyn agreed to confirm the position outside the meeting.

P Roseblade made reference to Risk 2721 - Capacity to deliver Point of Care Testing (POCT) training to Health Board Nursing Staff, which made reference to a post that had been agreed through Covid-19 funding which is only available until March 2023. P Roseblade sought clarity as to what the plans were in terms of funding this post if the recruitment was ongoing. C Hamblyn agreed to obtain a response outside the meeting.

P Roseblade made reference to Risk 4253 - Ligature Points - Inpatient Services which had been proposed for closure and sought clarity as to whether all of the schemes connected to this had been completed in all areas. C Hamblyn advised that she would seek assurance outside the meeting and agreed to keep this risk on the register until assurance had been provided.

Resolution: The report was **REVIEWED**.

Action: Response to be provided outside the meeting in relation to a number of queries raised by Independent Members regarding risks contained within the risk register.

5.2 Audit Recommendations Tracker

C Hamblyn presented the report and highlighted the key matters for the attention of the Committee.

P Roseblade made reference to the following recommendations contained within the audit trackers:

- Concerns recommendations – Realistic timeframes to be identified against these recommendations as deadlines were being extended by one month at a time;
- Princess of Wales Theatres – The update provided seemed to be generic for all recommendations and did not seem to address the specific recommendation made;
- Digital recommendations – Revised implementation dates needed to be identified for these recommendations

Resolution: The report was **NOTED**.

Action: Discussions to be held with lead officers in relation to the points highlighted.

5.3 INTERNAL AUDIT

5.3.1 Internal Audit Review Progress Report

P Dalton presented the report and advised that discussions were ongoing in relation to the programme of work for 2023/2024, which would be presented to the April meeting of the Committee.

In response to a comment made by J Sadgrove in relation to the drop in the turnaround times for management responses, P Dalton advised that this was possibly a reflection of the pressures being felt by all staff at present, particularly during the winter period.

Resolution: The report was **NOTED**.

5.3.2. Internal Audit Review – Wellbeing

P Dalton presented the report which had undergone further review following discussions held at the December meeting. Members noted that the adjustments made had resulted in an improvement in the overall opinion of the report, which had now been allocated a substantial assurance rating.

Resolution The report was **NOTED**.

5.3.3 Internal Audit Follow Up Review – Fire Safety

E Jones presented the report and advised that the report had now been given a reasonable assurance rating following a marked improvement in the completion of recommendations.

In response to a query raised by P Roseblade as to whether the draft report had been presented to the February Health, Safety & Fire Sub Committee, Members noted that the February meeting was stood down and the meeting had been rescheduled to take place on 7 March 2023. Members noted that this report would be presented to that meeting.

Resolution The report was **NOTED**.

5.3.4 Internal Audit Review – Medical Variable Pay

E Samways presented the report which had been allocated a Limited Assurance rating. Members noted that the review highlighted that procedures and policies were not always being followed despite Standard Operating Procedures and Financial Control Procedures (FCP) being in place, lack of approvals in place to use agency and lack of evidence in place to support the higher payments higher than the Welsh Government cap. Members noted that assurance was provided that the Medical Director was approving the pay caps but there was no evidence in place to support these approvals.

In response to a question raised by I Wells as to the potential reasons why staff were not adhering to the correct approval process, and whether this was down to lack of knowledge in relation to the process or whether staff were worried that their request would not be approved if it went through the correct process, E Samways advised that the majority of staff did not know there was a process in place and were not aware of the Standard Operating Procedure. S May advised that the opportunity to use a different agency may get lost in this process, and advised that it appeared that staff were working on a presumption that the request would always be approved so why follow process. Members noted that work was being undertaken as part of the value and effectiveness programme on how to tighten controls in relation to medical variable pay.

C Donoghue made reference to the statement made within the report that reports which summarised the rates that had been agreed above Welsh Government cap had stopped being presented to the Committee and questioned whether these reports needed to be reinstated. E Samways advised that the Financial Control Procedure does set out that these reports need to be presented to the Committee.

C Donoghue advised that whilst she found the management response to be very helpful, she felt that there was a significant amount of work to undertake and questioned whether the assigned timescales were realistic. E Samways advised that the Team had commenced a review of the FCP prior to the audit being undertaken. C Donoghue added that the procedural elements would take time to address and the education of staff would be a significant challenge.

P Roseblade advised that she found the report to be concerning and advised that she did recall reports previously being presented to the Committee in relation to agency spend above Welsh Government cap and advised that this would need to be revisited. P Roseblade added that she took some comfort that the agreed management actions were very comprehensive and there was full acceptance that improvements were required.

Resolution: The report was **NOTED**.

Action: Reports outlining the rates that had been agreed above cap to be reinstated and presented to future meetings of the Audit & Risk Committee.

5.4 **AUDIT WALES**

5.4.1 **Audit Wales Audit & Risk Committee Update**

S Utley presented the report and advised that the Structured Assessment Review would be issued this week and added that interviews would shortly be commencing in relation to the Joint Follow Up Review into Quality Governance arrangements.

Resolution: The report was **NOTED**.

5.4.2 Audit Wales Review – Ysbyty Cwm Cynon Minor Injuries Unit

S Utley presented the report and advised that four recommendations had been made which had been accepted by management.

R Hughes advised that at least 50% of the recommendations had now been completed, with all recommendations expected to be completed in full by May 2023. C Hamblyn advised members that an update would be presented to the March 2023 Quality & Safety Committee in relation to the quality aspects and lessons learned.

J Sadgrove fully supported the need for closure on this matter and advised that she had asked for a review to be undertaken of all issues that had been presented to Quality & Safety Committee over the last few years to ensure closure reports had been received and that lessons had been learnt.

I Wells made reference to recommendation 3 which related to staff within the Minor Injuries Unit not having up to date performance appraisals and stated that this was a similar issue across the Health Board. I Wells added that the management response provided did not seem to respond to the issue from a Health Board perspective. R Hughes advised that he would be happy to review this element of the response outside the meeting and added that a bespoke plan had been put into place to address overall compliance.

P Roseblade also raised a query in relation to recommendation 3 and questioned whether the recommendation was completed as she couldn't see a completion date identified. R Hughes advised that the action associated with the People & Culture Committee was completed last week and the second element of the action was due to be completed March 2023. S Utley advised that the report was the final report and not in draft as highlighted in the report.

Resolution: The report was **NOTED**.

Action: Review to be undertaken of the response provided against recommendation 3 to ensure it covered the Health Board position and not just the position related to Ysbyty Cwm Cynon.

5.4.3 Audit Wales - Review of Commissioning and Contracting Arrangements (CTM & Swansea Bay)

S Utley presented the report which now included the agreed management response.

Resolution: The report was **NOTED**.

6.0.0 ANY OTHER BUSINESS

There was no other business to report

7.0.0 COMMITTEE HIGHLIGHT REPORT

8.0.0 How Did We Do?

The Committee Chair advised that she would welcome feedback from Members outside the meeting as to how they felt the meeting went.

9.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Wednesday 19 April 2023.

8.0.0 CLOSE

**Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)
Audit & Risk In Committee held on the 12 December 2022 as a Virtual
Meeting via Microsoft Teams**

Members Present:

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

In Attendance:

Mark Jones	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Mark Thomas	Deputy Director of Finance
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Corporate Governance Manager (Secretariat)

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

P Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted.

1.2 Apologies for Absence

Apologies for absence were received from:

- Sally May, Director of Finance

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 MAIN AGENDA

2.1 Organisational Risk Register – Cyber Risks

C Hamblyn presented Members with the report which outlined the Cyber Security Risks that had been included within the risk register. She advised that agenda item 2.1 and 2.2 were being considered in private session due to the sensitivities of discussing any vulnerabilities in relation to cyber security in the public domain.

Resolution: The report was **NOTED**.

2.2 Audit Recommendations Tracker – Cyber Security

C Hamblyn presented the report which highlighted progress made against the recommendations highlighted within the Internal Audit Review undertaken into Cyber Security.

Resolution: The report was **NOTED**.

3.0.0 ANY OTHER BUSINESS

There was no other business to report

4.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Wednesday 19 April 2023 at 12.30pm.

5.0.0 CLOSE



AGENDA ITEM

2.1.3

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE TERMS OF REFERENCE

Date of meeting	19/04/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Emma Walters, Corporate Governance Manager

Presented by	Cally Hamblyn, Assistant Director of Governance & Risk

Approving Executive Sponsor	Chief Executive

Report purpose	ENDORSE FOR BOARD APPROVAL

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

Committee/Group/Individuals	Date	Outcome

ACRONYMS

SO's	Standing Orders

1. SITUATION/BACKGROUND

- 1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.
- 1.2 The SO's require each Board Committee to establish Terms of Reference & Operating Arrangements that are reviewed on a regular basis and which form Schedule 3 of the Standing Orders document.

- 1.3 A review of all Terms of Reference has been undertaken to ensure consistency across all Committees as appropriate.

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

- 2.1 Audit & Risk Committee Terms of Reference (ToR)– Appendix 1
- The Terms of Reference are included at Appendix 1.
- 2.2 Any changes made to the Terms of Reference have been highlighted in red.

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

- 3.1 The Committee are asked to consider and ratify the Terms of Reference which will be submitted to the Board for formal approval.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outlined 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 Goals	Improving Care

5. RECOMMENDATION

- 5.1 The Audit & Risk Committee are being asked to **ENDORSE FOR BOARD APPROVAL** the Terms of Reference attached at Appendix 1.

Schedule 3.1

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in
the University Health Board Standing Orders

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

ARC - Review April 2023

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that “The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board’s behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board’s commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees”.

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Audit and Risk Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

CONSTITUTION AND PURPOSE

The Committee will function in accordance with the NHS Audit Committee Handbook as appropriate.

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services Committee, the Emergency Ambulance Services Committee **and the National Imaging Academy for Wales**. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

SCOPE AND DUTIES

Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurance, prior to endorsement by the Board;
- the structures, processes and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation;
- the Health Board's Organisational Risk Register and the adequacy of the scrutiny of strategic risks by assigned Committees;
- the Board Assurance Framework;
- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements.
- the operational effectiveness of policies and procedures
- the effectiveness of risk identification, management, escalation and monitoring
- the policies and procedures for all work related to fraud and corruption as set out in the National Assembly for Wales Directions and as required by NHS Protect and the Counter Fraud and Security Management Service.
- proposed changes to the Standing Orders, Scheme of Delegation, Standing Financial Instructions and Financial Control Procedures.
- the circumstances associated with each occasion where Standing Orders or Standing Financial Instructions are waived.
- matters relating to counter fraud work.

The Committee will also:

- Receive and determine action in response to the declaration of Board member and other officers interests in accordance with advice received from the Director of Governance / Board Secretary;
- Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers;
- Review all losses and special payments;
- Retrospectively assure any purchase / expenditure above the delegated financial limit of the Chief Executive.

Internal Audit

The Committee shall:

- consider the proposals for accessing internal audit services via a shared services arrangement (where appropriate), the audit fee and any questions of resignation and dismissal;
- review the internal audit programme, consider the major findings of internal audit investigations, ensure co-ordination between the Internal and External Auditors and ensure all management responses to recommendations are appropriate and timely;
- ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organization;
- assure itself that IA complies with the requirements of the public sector internal audit standards.
- Monitor the timely implementation by management of agreed audit recommendations.

Clinical Audit

- Ensure where appropriate and in line with the Audit Committee Handbook that the CTMUHB has a Clinical Audit Programme in place and the outcomes of Clinical Audit provide internal assurance to the Board.

External Audit

The Committee shall consider the work carried out by key sources of external assurance, in particular but not limited to the Health Board external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity.

The Committee will:

- from time to time, consider and make any necessary representations to the Auditor General for Wales on his appointment of an engagement partner;
- discuss with the External Auditor, in line with the agreed audit plan, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health economy and with Internal Audit;
- review External Audit reports, including value for money reports and annual audit letters, together with the management response;

- Monitor the timely implementation by management of agreed audit recommendations;
- Receive a report from the Auditor General for Wales / Wales Audit Office on the results of his audit of the annual accounts before recommending adoption of those accounts to the Accountable Officer and the Health Board.

Financial Reporting

The Committee shall review the annual financial statements before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;
- major judgemental areas;
- significant adjustments resulting from the audit;
- compliance with legal requirements;
- review any material mis-statements identified during the Audit.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Audit & Risk Committee has a key role in assisting the Board to fulfil its oversight responsibilities in areas such as the Health Board's financial reporting, internal control systems, risk management systems and the internal and external audit functions.

AUTHORITY

The Committee is authorised by the Board to:

- investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It may seek relevant information from any:
 - Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
 - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;
- by giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.
- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

ACCESS

The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit & Risk Committee at any time, and the Chair of the Audit & Risk Committee will seek to gain reciprocal access as necessary.

The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

The Chair of Audit & Risk Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:

A minimum of **(4)** members, comprising

Chair Independent Member of the Board

Vice Chair Independent Member of the Board

Members Two Independent Members of the Board (one of which should be a member of the Quality & Safety Committee).

The Chair of the Health Board shall not be a member of the Audit & Risk Committee.

Attendees:

- Executive Director of Finance & Procurement
 - Director of Corporate Governance / Board Secretary (Executive Lead for Risk)
 - Head of Internal Audit
 - Local Counter Fraud Specialist
 - Representative of the Auditor General for Wales
-
- The Chief Executive and Chair shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.
 - The Director of Finance for WHSSC and Committee Secretary will normally attend the **Hosted Bodies** meetings of the **Audit & Risk** Committee. The Director of Specialised and Tertiary Services and the Chair of the Welsh Health Specialised Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.
 - The Emergency Ambulance Services Commissioner **will normally attend meetings of the Hosted Bodies Audit & Risk Committee** and the Chair of the Emergency Ambulance Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.
 - **The Academy Director for the National Imaging Academy for Wales will normally attend the Hosted Bodies meetings of the Audit & Risk Committee on at least a six monthly basis.**
 - **The CTMUHB Director of Finance and Head of Corporate Finance will also attend the Hosted Bodies meetings of the Audit & Risk Committee.**
 - Other Directors may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

By Invitation:

- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.
- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the CTMUHB Chair – taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

The Independent Member who is the nominated Audit Lead for WHSSC and EASC must be a member of the Audit Committee.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of **Workforce & Organisational Development for People**

COMMITTEE MEETINGS

Quorum

A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, the Vice Chair or an Independent Member who will be nominated to Chair the Committee.

Frequency of Meetings

Meetings shall be held not less than four times a year, and otherwise as the Chair of the Committee deems necessary. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of Individuals in Attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers

The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the CTMUHB Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall



responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Audit & Risk Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board.



AGENDA ITEM

2.1.2

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE CYCLE OF BUSINESS

Date of meeting

19/04/2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Emma Walters, Corporate Governance Manager

Presented by

Cally Hamblyn, Assistant Director of Governance & Risk

Approving Executive Sponsor

Chief Executive

Report purpose

FOR NOTING

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

Committee/Group/Individuals

Date

Outcome

ACRONYMS

1. SITUATION/BACKGROUND

- 1.1 The Audit & Risk Committee should, on annual basis, receive a Cycle of Business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.



1.2 The Cycle of Business covers the period 1 January 2023 to 31 December 2023.

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

2.1 The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and Committee business.

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

3.1 Please refer to **Appendix 1** – Audit & Risk Committee Cycle of Business for further detail.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the Committee Cycle of Business.

Audit & Risk Committee

Cycle of Business (1st January 2023 – 31st December 2023)

The Audit & Risk Committee should, on annual basis, receive a cycle of business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Audit & Risk Committee is effectively carrying out its role.

The Cycle of Business covers the period 1st January 2023 to 31st December 2023.

The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business.

The principal role of the Committee is set out in the Standing Orders – Schedule 3.1.

The Committee is an independent member committee of the Board and has no executive powers, other than those specifically delegated in the Terms of Reference. The Committee will function in accordance with the NHS Audit Committee Handbook.

The Committee will also consider issues in respect of the roles and responsibilities of organisations hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services Committee, the Emergency Ambulance Services Committee and the National Imaging Academy. The meeting will be split into two parts with Cwm Taf Morgannwg University Health Board business and hosted organisations business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

Audit & Risk Committee Cycle of Business (1st January 2023 – 31st December 2023)

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Consent Agenda														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Cycle of Business	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Committee Forward Work Programme	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Audit & Risk Committee Annual Report	Director of Corporate Governance	Annually								✓				
Audit & Risk Committee Annual Self-Assessment	Director of Corporate Governance	Annually												✓
Audit & Risk Committee Terms of Reference	Director of Corporate Governance	Annually				✓ Amends required								
Declarations of Interest and Gifts & Hospitality Report	Director of Corporate Governance	Quarterly				✓				✓				✓
Clinical Audit Annual Plan	Medical Director	Annually				✓								
Clinical Audit Annual Report	Medical Director	Annually												✓
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Annual Financial Accounts	Director of Finance	Annually						✓ Extra ordinary meeting (draft accounts)	✓ Extra ordinary meeting					
Accountability Report (Including the Governance Statement)	Director of Corporate Governance	Annually						✓ Extra ordinary meeting (draft report)	✓ Extra ordinary meeting					
Annual Review of the Risk Management Strategy / Board Assurance Framework	Director of Corporate Governance	Annually				✓								
Sustaining our Future														
Losses & Special Payments Report	Director of Finance	Quarterly		✓				✓		✓				✓



Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		✓		✓		✓		✓		✓		✓
Local Counter Fraud Report	Director of Finance	All Regular Meetings		✓		✓		✓		✓		✓		✓
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				✓								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				✓								
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				✓								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										✓		
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Organisational Risk Register	Director of Corporate Governance	All regular meetings		✓		✓		✓		✓		✓		✓
Consultant Job Planning	Medical Director	Bi-Annually				✓						✓		
Medical Rostering	Medical Director	Bi-Annually				✓						✓		
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		✓		✓		✓		✓		✓		✓
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				✓								
Internal Audit Reviews	Head of Internal Audit	All regular meetings		✓		✓		✓		✓		✓		✓
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually							✓ Extra ordinary meeting					
Audit & Risk Committee Update	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings		✓		✓		✓		✓		✓		✓

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Audit Wales Annual Audit Report	Audit Wales	Annually				✓								
Audit Wales Audit Plan 2022	Audit Wales	Annually				✓								
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually							✓ Extra ordinary meeting					
Structured Assessment	Audit Wales	Annually				✓								
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually								✓				
Hosted Bodies														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings		✓		✓		✓		✓		✓		✓
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually							✓ Extra ordinary meeting					
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings		✓		✓			✓ Extra ordinary meeting	✓		✓		✓
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually							✓ Extra ordinary meeting					
WHSSC & EASC Annual Accounts	WHSSC/EASC	Annually							✓ Extra ordinary meeting					
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually							✓ Extra ordinary meeting					
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually		✓		✓				✓				



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University Health Board

Agenda Item 2.2.2

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN				
Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	13 February 2023 – Deferred to 19 April 2023 as per action log update. Deferred to July 2023 as per action log update.
Advised at the meeting held on 12 December 2022 that this report would be presented to the June 2023 meeting	Additional Item	National Fraud Initiative progress and outcomes.	Local Counter Fraud Specialist	21 June 2023
Email request received from the Facilities Governance & Compliance Manager on 3 February 2023	Additional Item	CTMUHB ISO14001 Certification Progress Report	Chief Operating Officer	19 April 2023 – On agenda
Email request from the	Additional Item	Annual Report Timetable 2022-2023	Assistant Director of	Completed – Received at the February 2023 Committee meeting



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University Health Board

Agenda Item 2.2.2

Assistant Director of Governance & Risk			Governance & Risk	



AGENDA ITEM

2.2.3

AUDIT & RISK COMMITTEE

REVISED ANNUAL REPORT TIMETABLE 2022-2023

Date of meeting	19/04/2023
FOI Status	Open
If closed please indicate reason	Not applicable – Public Meeting
Prepared by	Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
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
ELG	30.01.23	Noted
ELG updated schedule of dates	10.3.23	Noted

ACRONYMS

ELG	Executive Leadership Group
EQIA	Equality Impact Assessment

1. SITUATION/BACKGROUND

- 1.1 In recent weeks the final iteration of the Manual for Accounts has been received confirming the deadlines for submission of documents to Welsh Government and Audit Wales. The Annual Report encompassing the required reporting elements set out in the Manual for Accounts will be presented at the Health Board's Annual General Meeting on 28th September 2023. As in previous years, the suite of Annual Report documents will be presented electronically at the Annual General Meeting along with a video looking back on achievements from the year being reported and looking ahead into 2023/24 and beyond.

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

- 2.1 There is a timetable enclosed at **Appendix 1**, supporting the development of the Annual Report led by the Assistant Director of Governance & Risk and Head of Corporate Governance & Board Business. The timetable highlights the final deadline dates to deliver the Annual Report and Financial Statements for the year 2022/23.
- 2.2 The majority of submissions have now been received from Executive Directors during March 2023 and the content is being worked through. Those which are outstanding are being followed up in order that we are able to complete the complex task of drafting the Annual Report element and these are being processed for the initial review by ELG.
- 2.3 Audit Wales and Internal Audit colleagues have received a copy of the timetable and concur that they will be able to meet the scheduled dates.

2 KEY RISKS/MATTERS FOR ESCALATION TO THE COMMITTEE

- 3.1 As is the case each year, the production of these annual reporting documents takes place alongside the delivery of normal business. This task is therefore a significant challenge for all those involved.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality impact assessment (EQIA) completed	No (Include further detail below)
	EQIA 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	Provide high quality, evidence based, and accessible care.

5. RECOMMENDATION

- 5.1 The Audit & Risk Committee is asked to **NOTE** the final timescales in place in respect of the delivery of the Annual Report process for 2022-2023.

APPENDIX 1

CTMUHB Annual Report & Financial Statements 22/23 Timetable for Submissions					
	May	June	July	August	September
Accounts	5th May Draft to WG & AW	Draft to go to the existing ARC meeting - 21st June.	Extra Ordinary Meeting of ARC to Endorse Board Approval on 26th July Existing Board Meeting on 27th July for approval. Submission to AW for Auditor General to sign and send to WG by 31st July	-	AGM 28 th September 2023
Accountability, Performance and Remuneration Report	12th May Draft to WG & AW	Draft to go to the existing ARC meeting - 21st June.	Extra Ordinary Meeting of ARC to Endorse Board Approval 26th July Existing Board Meeting 27th July for approval. Submission to AW 28th July for Auditor General to sign and send to WG by 31st July	Translation	AGM 28 th September 2023



AGENDA ITEM

2.2.5

AUDIT & RISK COMMITTEE

**DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY
& HONORARIA**

Date of meeting

19/04/2023

FOI Status

Open/Public

**If closed please indicate
reason**

Not Applicable - Public Report

Prepared by

Emma Walters, Corporate Governance
Manager

Presented by

Cally Hamblyn, Assistant Director of
Governance & Risk

Approving Executive Sponsor

Chief Executive

Report purpose

FOR NOTING

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

Committee/Group/Individuals

Date

Outcome

Executive Leadership Group

Reviewed

ACRONYMS

DOI

Declarations of Interest

1. SITUATION/BACKGROUND

- 1.1 In accordance with the requirements of the Health Board's Standing Orders and Standards of behaviour Framework Policy, a report is required to be received by the Audit & Risk Committee as a standing agenda item which will detail the Declarations of Interest, Gifts, Hospitality and Sponsorship etc. activities approved within each Health Board. A similar report will also be considered by the Strategic Leadership Group.



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

- 2.1 The form in the Standards of Behaviour Framework policy or online via SharePoint should be used to declare interests and/or seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is submitted to the Corporate Governance Team.
- 2.2 In early May 2022 an email to all Board Members requesting their annual Declarations of Interest was sent. As at July 2022, all returns had been returned and approved. Board Members compliance – 100%. Since the last report, in year amendments have been received by Board Members which have been reflected in red in Appendix 1. This exercise will be repeated in May 2023 for the 2023-2024 reporting period.
- 2.3 An email was issued in May to 547 members of staff (included all Consultants, Very Senior Managers, Board Members and Staff at Band 8d and Band 9). To date we have received 208 returns equalling a 38.1% return rate. It should be noted that some of the returns received in this period may have been received from individuals that did not receive the targeted email as there is an onus on all employees to declare interests. This exercise will be repeated in May 2023 for the 2023-2024 reporting period.
- 2.4 In summary there have been:
- 13 new declarations of interest received and entered on the Declarations of Interest Register for the period 1 December 2022 – 31 March 2023.
 - 3 new entries on the Gifts, Hospitality and Sponsorship Register.
- 2.5 The appendices to this report include the new entries received up to the 31 March 2023 as follows:
- Appendix 1 – Declarations of Interest received 1 December 2022 – 31 March 2023.
 - Appendix 2 – Gifts, Hospitality and Sponsorship Declarations received 1 December 2022 – 31 March 2023.



- 2.6 The Declaration of Interest Register and Gift Hospitality and Sponsorship Register for the financial year 2022-2023 is available upon request.
- 2.7 The advice from the Interim Head of Information Governance is any information published on the register, which is then published in the public domain, excludes first and last names and includes job titles only. This has been actioned in terms of the appendices to this report.

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

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

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The Register and Declaration of Interests is the method by which the Health Board safeguards against conflict or potential conflict of interest where private interests and public duties of members of staff do not concur. The Health Board must be impartial and honest in the conduct of its business and must ensure that employees remain beyond suspicion at all times.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If no, please provide reasons why an EIA was not considered required in the box below.
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

Targeted DOI Request Sent	Received	Full Name	Designation	Declarations	Period of Involvement	Financial Benefits/In Kind	In Year Amendments
Completed Online	Online Completion 27.4.2022	Lauren Edwards	Executive Director of Therapies & Health Sciences	Nil declarations of interest.	Not applicable	Not applicable	
3.5.2022 - Email sent from CH.	Hard copy received 1.7.2022	Emrys Elias	Chair	1. Director, Trustee National MIND. 2. Chair, MIND Governance Board (Pwyllgor) Wales. 3. Spouse (Elizabeth Jayne Elias) Clinical Director Health Inspectorate Wales	1. 2016 to date 2. 2016 to date 3. February 2020 - December 2021	1 & 2 - Nil 3. Salaried NHS Role	
3.5.2022 - Email sent from CH.	Online Completion approved by EE 1.7.2022	Jayne Sadgrove	Vice Chair	1) Senior Professional Fellow, Cardiff University. 2) Director, Cardiff Union Services Ltd. 3) Trustee, Cardiff University Students Union. 4) Trustee, The Escape Route. 5) Spouse: Director Home Study Courses Ltd.,	1) 2019 ongoing. 2) 2019 ongoing. 3) 2019 ongoing. 4) 2015 ongoing. 5) 1995 ongoing.	1 - 5 Nil 5 - Salaried	
3.5.2022 - Email sent from CH.	Hard Copy for received and signed 27.6.2022	James Hehir	Independent Member	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. 8) Interim Chair of the WHSSC All Wales IFPR Panel	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. 8) 27/07/2022 for 6 months to 27/01/2023. Extended until March 2023.	Nil for all entries.	As at 30.9.2022 - James Hehir advised that there will be some potential links between his roles with Llandarcy Park Ltd and NPTG in terms of opportunities for NHS Wales Commissioning. James Hehir receives no financial or any other benefit for these roles. Also noted Chair of the WHSSC IFPR Panel. 21.11.2022 - Confirmed the Chair of the WHSSC All Wales IFPR Panel will be extended until March 2023. James Hehir advised by Sian Lewis, Managing Director, WHSSC that she saw no conflict of interest involving role as interim chair of IPFR panel and role at Llandarcy Park Ltd.
3.5.2022 - Email sent from CH.	5.5.2022 (Hard Copy)	Dilys Jouvenat	Independent Member	1. South East Wales Citizens Advice 2. Chair of RCT Citizens Advice 3. Trustee Newport Citizens Advice	1. From May 2022 2. June 2015 to Date 3. March 2020 to date	1. Nil 2. Nil 3. Nil	
3.5.2022 - Email sent from CH.	10.5.2022 (Hard Copy)	Mel Jehu	Independent Member	1. Independent Member (Vice Chair) South Wales Police Crime Panel. 2. Chair (Standards Committee) Rhondda Cynon Taff Council. 3. Trustee, Safe Merthyr Limited. 4. Independent Member - Merthyr Tydfil County Borough Council Standards Committee. 5. Independent Member - Audit & Governance Committee - RCTCBC 6. Deputy Lord Lieutenant for Mid Glamorgan. 7. Spouse is employed in CTMUHB in a part time role as a Lymphedema Nurse since 2012 and prior to that Breast Care Specialist Nurse.	1. 2012 to date 2. 2012 to date 3. 2008 to date 4. 24.2.2022 to date 5. 7.3.2022 to date 6. September 2021 to date 7. 2012 to date	1. Attendance Fee 2. Attendance Fee 3. Voluntary no financial gain 4. Attendance Fee 5. Attendance Fee 6. No remuneration or benefits in kind. 7. Salaried position.	
3.5.2022 - Email sent from CH.	5.5.2022 (Hard Copy)	Nicola Milligan	Independent Member	1. Board Member Royal College of Nursing in Wales 2. Vice Chair Royal College of Nursing in Wales	1) January 2021 - December 2024. 2) 1 January 2021 to 31 December 2022.	1. Nil 2. Nil	
3.5.2022 - Email sent from CH.	Received 21.06.2022 - Hard Copy Form	Ian Wells	Independent Member	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.	1. 3 days per week from 1/2/20 to date.	1. Nil financial transactions or benefits in kind.	In year amendment received from Ian Wells declaring a nil return as he is no longer a Director for the Wales Institute of Digital Information
3.5.2022 - Email sent from CH.	Received 1.7.2022 - Hard Copy Form	Patsy Roseblade	Independent Member	1. NED Tennis Wales	1. April 2020 to present.	1. Nil - Voluntary.	
3.5.2022 - Email sent from CH.	10.05.2022 (and 24.10.22 - amendment confirmed by CD as correct)	Carolyn Donoghue	Independent Member	1. Lay Governor - University West of England 2. Chair - Welsh Wound Innovation Centre	1. Since March 2021 2. Chair since July 2020	1. Nil 2. One off payment for each Board Meeting.	Carolyn emailed on 24.10.22 to confirm her son Edward Donoghue works for Hillrom a medical supply company. Whilst she was not aware of any conflict she was aware that they had been working with RGH and PoWH recently. DOI form amended and sent to Chair - approval received from Chair on 25.10.22.

3.5.2022 - Email sent from CH.	Received in Hard Copy form 6.7.2022	Lynda Thomas	Independent Member	1) Chief Executive Macmillan Cancer Support. 2) Member of Cicely Saunders Institute Advisory Board. 3) Member of the Richmond Group of Charities. 4) Member of the NHS England National Cancer Board. 5) Member of NHS Assembly. 6) Chair of NHS Cancer Programme Cancer Charity Forum.	1.2001 to date 2. 2015 to date 3. 2017 to date 4. 2018 to date 5. 2019 to date 6. 2019 to date	1. Salaried Role. 2-6- Nil	In Year Amendments: Chair role at Norfolk Community Health and Care NHS Trust - February 2023. Discuss the position with WG and there are no issues of concern to note. There are no contractual links with the NHS organisation or any performance issues within the organisation that that were of major concern. Regular communication with the Chair of CTMUHB to ensure that the demands of the new role are not impacting IM role at CTMUHB.
3.5.2022 - Email sent from CH.	Received 3.7.2022 - Hard Copy Form.	Geraint Hopkins	Independent Member	1. Llanharan Community Development Project Limited. 2. Elected Member, Rhondda Cynon Taf County Borough Council	1. Over 10 Years. 2. 18 years - ongoing.	1. Nil 2. Nil	No changes required
3.5.2022 - Email sent from CH.	Received 3.7.2022 - Electronic Form.	Paul Mears	Chief Executive	1. Director Drake Consultancy Services LTD (Dormant Company).	1. May 2018-present	1. Nil	No changes required
3.5.2022 - Email sent from CH.	Received 23.6.2022 - Hard Copy form	Gethin Hughes	Chief Operating Officer	School Governor and Trustee Ditcham Park School	7 Years	Nil	
3.5.2022 - Email sent from CH.	Received 17.6.2022 - Hard Copy Form	Sally May	Executive Director of Finance	1. Cousin is Director of DECIPHER; Professor in Social Interventions and Health, Cardiff University Ongoing Salaried position Cousin is Regional Sales Manager South West Arthrex Ltd	1. Ongoing	1. Salaried Role.	In year amendment received from Sally May to advise that her daughter is employed as a Respiratory Physiologist and Cardiff & Vale UHB since June 2020 and her cousin is a partner in Knight Frank Ltd which is ongoing
3.5.2022 - Email sent from CH.	Online Completion 5.5.2022	Dom Hurford	Executive Medical Director	Nil Interests Declared	N/A	N/A	
3.5.2022 - Email sent from CH.	17.06.2022 - Hard Copy Form	Greg Dix	Executive Nurse Director	1. Trustee Royal Colleague of Nursing Foundation 2. Board Director - Welsh Wound Innovation Centre 3. Visiting Professor, University of South Wales 4. Associate Professor, University of Plymouth	1. September 2021 - Ongoing 2. January 2022 - Ongoing 3. 2020 to date. 4. 2015 to date.	1. Voluntary role, travel / accommodation paid for by the Charity. 2. No financial or benefits in kind. 3. 2020 to date. Nil financial or benefits in kind. 4. 2015 to date. Nil financial or benefits in kind.	
3.5.2022 - Email sent from CH.	17.06.2022 - Hard Copy Form	Hywel Daniel	Executive Director for People	Nil interests declared.	N/A	N/A	
3.5.2022 - Email sent from CH.	Online Completion 5.5.2022	Kelechi Nnoaham	Executive Director Public Health	1. Honorary Professorship Cardiff University 2. Honorary Professorship Plymouth University 3. Spouse works in Blood Sciences Laboratory in the Royal Glamorgan Hospital	1. From 2015 to date 2. From 2021 to date 3. From 2017 to date	1. Nil 2. Nil 3. Yes -Salaried Position	Kelechi Nnoaham departure from CTMUHB with effect from 30.11.2022. Checked accuracy of DOI on departure via email 21.11.2022 and confirmed no change.
3.5.2022 - Email sent from CH.	Online Completion 5.5.2022	Linda Prosser	Executive Director of Strategy & Transformation	1. Director, Altyn Tep Ltd 2. Niall Prosser - son Deputy COO RUH Bath	November 2019 April 2021 to Present	Yes Yes -Salaried Position	
3.5.2022 - Email sent from CH.	17.5.2022 - Hard Copy Form	George Galletly	Director of Governance	1. BROTHER - Consulting Practice Lead for M365, Microsoft Industry Solutions (UK, France, Middle East, Africa)	1. Since October 2021	1. Salaried Role.	George Galletly departure from CTMUHB with effect from 14.11.2022 - Secondment to WG. Checked accuracy of DOI on departure via email 21.11.2022 and confirmed no change.

3.5.2022 - Email sent from CH.	5.5.2022 - Hard Copy Form	Stuart Morris	Director of Digital	Chair of Governors for Penyfai School, Bridgend.	2017 to date	Nil	
3.5.2022 - Email sent from CH.	5.5.2022 - Hard Copy Form	Lisa Curtis Jones	Associate Member	Statutory Director of Social Services in Merthyr Tydfil	April 2016 - ongoing	Member of the Regional Partnership Board (RPB) - RIF Funding to Local Authorities through the RPB.	
3.5.2022 - Email sent from CH.	10.5.2022 - Hard Copy Form	Sharon Richards	Associate Member	1. Chief Officer at Voluntary Action Merthyr Tydfil	1. 01.10.2020 - ongoing	1. Full time employed.	
3.5.2022 - Email sent from CH.	Online Completion - 9.5.2022	Anna Lewis	Associate Member	Nil interests declared.	N/A	N/A	
6.7.2022 - Email Sent from CH	Hard Copy Form received 14.07.2022	Anne Morris	Associate Member (SRG)	1. Deputy Chief Executive - Interlink RCT	1. 13 Years	1. Salaried	

Request for Changes March 2023	Annual Eligibility Form and Indemnity Check - next due March 23.
No changes requested	Completed - no issues to highlight
Request made to remove spouse from the Declaration of Interest Form as now retired from the role as Clinical Director Healthcare Inspectorate Wales in December 2021.	Completed - no issues to highlight
Request made to add personal & spouse - Director of Keyford Properties Ltd, 2023	Completed - no issues to highlight
No changes requested. Further email sent to James asking him to confirm the date he became Trustee of Neath Port Talbot Contact Centre. Confirmation received from James that he became Trustee in 2005 and not 2007 as stated on his Declaration of Interest form	Completed - no issues to highlight
Request made to add additional Trusteeship - Trustee of South East Wales Citizens Advice and Trustee of INTERLINK	Completed - no issues to highlight
Request made for changes - No longer a member of RCTCBC Standards Committee	Completed - no issues to highlight
No longer vice chair of RCN Wales	Completed - no issues to highlight
No further changes requested following the in year amendment received	
No changes requested	Completed - no issues to highlight
Son is Business Development Manager for Seating Matters. The company supplies specialist seating to Healthcare settings which may involve him with some seating supplies to CTMUEB. Not personally involved in any way	Completed - no issues to highlight

1. No longer Chief Executive of Macmillan Cancer Support. 2. No longer a member of the NHS England National Cancer Board. 3. No longer a member of the NHS Assembly. 4. No longer a Member of the Richmond Group of Charities. 5. No longer a Member of the Cicely Saunders Institute Advisory Board. 6. Appointed as Chair of the Norfolk Community Health and Care NHS Trust from 1 February 2023. This is a paid role remunerated at 42k per annum. 7. Now Trustee of Age Up	Completed - L Thomas Highlighted that role as Chair in Norfolk in NHS England had commenced. This is paid employment.
No changes requested	Completed. 1. Term of Directorship for first declaration queried and G Hopkins confirmed that he has been Director since 2017 which aligns with Companies House records.
No changes requested	Completed - no issues to highlight
No changes requested	Completed -no issues to highlight
No changes requested	Completed - no issues to highlight
No changes requested	Completed - no issues to highlight
No changes requested	Completed - no issues to highlight
No changes requested	Completed - no issues to highlight
No changes requested	Completed - no issues to highlight

No changes required	Completed - No issues to highlight
No changes requested	Completed - no issues to highlight
N/A No longer an Associate Member	N/A No Longer an Associate Member
N/A No longer an Associate Member	N/A No Longer an Associate Member
No changes requested	Completed - no issues to highlight

Received	Designation	Declarations	Period of Involvement	Financial Benefits/In Kind	In Year Amendments
6.2.2023	Assistant Director of Quality Improvement	Co-creator and host of The Aural Apothecary Podcast – a podcast about medicines and the people behind them. These are undertaken in my own time. No CoI as the topic is based on broad professional issues rather than anything specifically relating to employment. As a pharmacist I am also bound by my professional code of ethics.	Since January 2021	Expenses, accommodation and fee's for conferences. Possibility of future sponsorship but nothing as of yet.	
9.3.2023	Consultant Child Learning Disability Psychiatrist	1. Director of own company A Hassan Ltd. Undertake private sessions and consultations. 2. Spouse is a partner in the above company	1. Since May 2022	1. Financial	
28.3.2023	Superintendent Radiographer	1. Spire Healthcare - Consultant Sonographer 2. Nuffield Healthcare. 3. Darcy Health	1. Since 2007 2. Since 2010 3. March 2023	2. Fee per patient	
13.1.2023	Interim Deputy Director Public Health / Acting Director Public Health	Nil Interests Declared	N/A	N/A	
2.3.2023	Midwife	Nil Interests Declared	N/A	N/A	
2.3.2023	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
6.3.2023	Head of Strategic Planning & Commissioning	Nil Interests Declared	N/A	N/A	
21.3.2023	Healthcare Support Worker Supervisor	Nil Interests Declared	N/A	N/A	
23.3.2023	Radiographer	Nil Interests Declared	N/A	N/A	
24.3.2023	Healthcare Support Worker	Nil Interests Declared	N/A	N/A	
28.3.2023	Assistant Director of Policy, Governance & Compliance	Nil Interests Declared	N/A	N/A	
28.3.2023	Ward Manager	Nil Interests Declared	N/A	N/A	
29.3.2023	Mammography Superintendent Radiographer	Nil Interests Declared	N/A	N/A	

Register of Gifts, Hospitality Sponsorship - April 2023

Date Received by Corporate Governance	Designation / Department	Provided by / From	Date Received	Details	Gift/Hospitality and or Sponsorship	Accepted or Declined
1.3.2023	Advanced Practitioner Radiographer	Online CPD Courses	February/March 2023	1. Speakers fees for online CPD Courses - CT Head Reporting Lectures	Speakers fees	Accepted
3.3.2023	Highly Specialist Clinical Pharmacist Cardiology	AstraZeneca, Pharmacosmos	Occasional work since 2019	1. Joint Working Project (Apr 23 - Apr 24) 2. Speakers Fees 3. Sponsorship to attend National/International Congress Consultancy Fees.	Sponsorship	Accepted
9.3.2023	Consultant Cardiologist and General Physician	Bayer Public Limited Company	17.4.2023 - 18.4.2023	Invited to attend a Cardiology, Diabetes and Nephrology at the Limits 2023 Conference, Royal College of Physicians, London. 17/18 April 2023. Registration Fees, travel and accommodation sponsored by Pharmaceutical Company to the value of £500.00	Hospitality	Accepted. Supported by Line Manager 8.3.2023



AGENDA ITEM

2.2.6

AUDIT & RISK COMMITTEE

**CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB)
NATIONAL CLINICAL AUDIT PROGRAMME UPDATE 2022-2023**

Date of meeting	19/04/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Townsend – Head of CA&QI, Natalie Morgan - Thomas Deputy Head of CA&QI & Lead Nurse for Clinical Effectiveness & Lauren Dyton – Clinical Audit Manager
Presented by	Dr Dom Hurford – Executive Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

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

Committee/Group/Individuals	Date	Outcome
Quality & Safety Committee	16/03/2023	NOTED

ACRONYMS

CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
NHFD	National Hip Fracture Database
CA&QI	Clinical Audit & Quality Informatics Department
NACEL	National Audit for Care at the End of Life
NAIF	National Audit of Inpatient Falls
NJR	National Joint Registry



PoWH	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
NEIAA	National Early Inflammatory Arthritis Audit
NICE	National Institute of Clinical Excellence
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
COPD	Chronic Obstructive Pulmonary Disease
PEDW	Patient Episode Dataset for Wales
HQIP	Healthcare Quality Improvement Partnership

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is to provide an update for the Audit & Risk Committee on progress against the CTMUHB Clinical Audit Forward Plan 2022-2023 aligned to the National Clinical Audit and Outcome Review Plan for 2022/23, which is also available via the Welsh Government website: <https://gov.wales/national-clinical-audit-and-outcome-review-plan-2022-2023>, published June 2022.
- 1.2 **29** out of 35 national audits and 9 clinical outcome reviews (tier 1) are green fully compliant and **5** amber where the audits are delayed, a backlog exists but a plan is in place to comply with the national audit deadline. **1** clinical outcome review audit is red because the deadlines has passed, and we were only able to achieve limited participation (NCEPOD Epilepsy Study).
- 1.3 The DNACPR Tier 2 organisation priority audit has been completed, but all other planned tier 2 audits have been delayed due to a lack of available clinical audit resources diverted to underpin the prioritised COVID Mortality Review cases. The postponed tier 2 audits are currently under review for completion in 2023/24.
- 1.4 The AMaT ward and area module continues to develop with work in progress to include, the mental health unit and operating theatre department audits.

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

2.1 Clinical Audit Forward Plan 2022-2023 Current Position

The Royal College of Physicians acknowledged the HB data collection and entry performance for the national COPD audit, with 82% case ascertainment an improvement from 59% pre-Covid (% between number



of cases submitted compared to those reported to PEDW). Based on the organisation's significant achievement in improving case ascertainment compliance a case study has been submitted for inclusion in the Royal College of Physicians good practice repository, to share the learning across England and Wales, so that hospitals can use the steps taken to make improvements in their services.

Following release of the preliminary findings from the NACEL audit a potential outlier alert status was received, following a review of the identified data quality issues this has now been revised prior to publication of the report noting the organisation is no longer an outlier and therefore has no case to answer.

A clinical lead remains outstanding for the COPD National audit for PCH and a Health Board lead for the National Audit of Dementia (Round 5).

The NHFD amber compliance position for quarter 2, 2022/23 has been revised to green following considerable efforts from staff with overtime and the filling of a staff vacancy.

NJR is compliant for RGH and PCH, but amber compliance position reported for the PoWH due to clinical pressures and concerns that the end of February 2023 submission deadline would not be met, by the directorate. Therefore, the clinical audit department has agreed to commission overtime to maintain the HB Quality Data Provider status for this national audit activity put in place to provide a UK wide implantable medical device registry. The directorate is now looking at support arrangements to ensure full compliance for 2023. For PoWH this audit remains amber.

The NEIAA (Arthritis) audit is amber, but good progress is being made to achieve compliance. The current focus for the audit team in quarter 3 and 4, 2022-2023 is to recover the NAIF, TARN and Heart Failure non-compliance positions.

The following actions are being taken:

- Out to interview for Senior Clinical Audit Facilitator with responsibility for TARN, NHFD and NAIF.
- Commissioning overtime for staff to reduce backlogs, funding permitting.

Noting the above exceptions the clinical audit team are working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2022-2023, by the end of March 2023.

2.2 Key clinical audit publications, findings and actions

National Early Inflammatory Arthritis Audit (NEIAA) Year 4 annual report



Based on data from 11,722 patients seen in England and Wales between 1 April 2021 and 31 March 2022.

The latest NEIAA annual report provides information on national and regional performance against seven key metrics of care and on outcomes. It found the first review by a specialist was achieved within three weeks of referral for 42% of patients (vs 48% in year two). Other key findings include:

- Conventional disease modifying anti-rheumatic drug (cDMARD) treatment delays remain stable with initiation within six weeks of referral in 65% of patients (vs 64% in year two).
- Early arthritis clinics were available in 76% of departments (vs 77% in year two).
- That disease remission was achieved in 34% of patients by three months after diagnosis (vs 37% in year two).

CTM Update – Findings from the report and NEIAA dashboards are being reviewed by the Rheumatology multidisciplinary team. Where required, a local improvement action plan will be developed.

Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care Report 2022

The Maternal, Newborn and Infant Clinical Outcome Review Programme has published its ninth MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity, which includes surveillance data on 536 women who died during or up to one year after pregnancy between 2018 and 2020 in the UK. It also includes Confidential Enquiries into the care of women who died between 2018 and 2020 in the UK and Ireland from cardiovascular causes, hypertensive disorders, early pregnancy disorders and accidents and the care of women who died from mental-health related causes in 2020, and a Morbidity Confidential Enquiry into the care of 61 women with diabetic ketoacidosis in pregnancy.

CTM Update – The Clinical Audit Department is engaging with Maternity services to review the report findings and facilitate local action planning activity.

2.3 Clinical Audit Training

Bespoke clinical audit and effectiveness training was delivered to Pharmacy trainees and technicians from across the HB, designed to meet the needs of the staff and provide practical advice and resources to support good quality clinical audits.

Clinical Audit and AMaT training was also delivered to trainee doctors as part of the post graduate teaching programme. Feedback from the session was positive with attendees rating the overall standard of the session either 'good' or 'excellent'.



2.4 **Clinical Audit & NICE Monitoring System (AMaT) Implementation**

With the implementation of AMaT the organisation is now able to monitor the CTMUHB Clinical Audit Forward Plan in real-time and compliance with NICE guidelines, standards and focus at present is on the ward and area audit module rollout.

The AMaT ward and area module rollout is progressing well with a health board wide focus on Mental Health and Theatre departments. Due to increasing service demands for support and rollout of this module work is ongoing to ensure suitable resources are in place for the long term management and support of this module.

2.5 **NICE Compliance Programme of work**

The CTMUHB NICE Reference Group (NRG) established in September 2021 and the centralised monitoring has currently been on hold whilst the team are focussing on other high priority areas.

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB will now remain with directorates and individual clinical leads.

A review of the Clinical Audit policy and Strategy is being undertaken to reflect this.

2.6 **CTMUHB Clinical Audit Forward Plan 2023-24**

Welsh Health Circular and NHS Wales National Clinical Audit and Outcome Review Plan is due to be published in June 2023. The CTMUHB Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by Welsh Government (WG) in June 2023. The CTMUHB Clinical Audit Forward Plan 2023-24 has been attached at Appendix 1.

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

- 3.1 Identifying appropriate colleagues to be involved in National tier 1 Audits has been challenging due to other commitments and availability of teams. SPA allocated time is being addressed in the recently approved Consultant SPA paper.
- 3.2 A lack of early detection of 'outlier status' or assurance around the monitoring of NICE clinical guidance and standards and risk of failure to comply with national audit programme tier 1 targets.



4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Effective Care
	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.
Legal implications / impact	Not required
	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	
	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

- 5.1 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB.



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University Health Board

Knowing How Well
We Are Doing

Clinical Audit Forward Plan 2023-24



Standard 3.1:
Safe and Clinically Effective Care
Effective Care

Version 1.0, 24 February 2023



NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

A Welsh Health Circular and Annual Plan is due to be published in June 2023 to clarify the mandatory audit list. The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by WG.

Compliance Key

RED	Cause for concern. Full compliance not achieved by audit deadline.
AMBER	Tier 1: National audit delayed, backlog exists but plan in place to comply with national audit deadline. Tier 2: Organisation priority audit delayed by one quarter, but plan in place to comply with revised audit deadline.
GREEN	Audit on track at 31/03/2023 or completed, evidence of audit compliance documented on AMaT system.
BLUE	Audit and action plan completed by clinical audit leads and signed off on AMaT system.

Due to COVID submission deadlines and planned report release deadlines are constantly changing and in most cases being delayed.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
Acute						
National Joint Registry (NJR)	operates continuous data capture	N/A	September 2023	Trauma and Orthopaedics	Fully compliant RGH and PCH, PoWH compliance affected by clinical pressures, work ongoing to ensure full compliance	AMBER
National Emergency Laparotomy Audit (NELA)	operates continuous data capture	N/A	November 2024	Surgery / Anaesthetics	Organisation wide compliance	GREEN
Case Mix Programme (CMP) ICNARC	operates continuous data capture	Monthly	March 2024	Anaesthetics	Organisation wide compliance	GREEN
Major Trauma Audit # (TARN)	operates continuous data capture	Quarterly in line with dashboard publication	Quarterly Dashboards From Apr 2023	Emergency Medicine	Support arrangements under review to ensure compliance by end of March 2023	AMBER
Long Term Conditions						
National Diabetes Audit *	operates continuous data capture	N/A	June 2023	Therapies	Organisation wide compliance	GREEN
Note this covers the following areas : National Diabetes Foot Care Audit (NDFCA)						

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
• National Diabetes Inpatient Audit (NaDia)	WG decided not to participate in year one of the harms collection	TBC		General medicine	Bedside audit discontinued / Harms audit England only	N/A
• National Pregnancy in Diabetes Audit (NPID)	operates continuous data capture	N/A	October 2023	Obstetrics and Gynaecology	Organisation wide compliance	GREEN
• National Core Diabetes Audit (NCDA)	Data capture from Primary Care at specific intervals	N/A	July 2023	Primary Care	Organisation wide compliance	GREEN
• National Diabetes Transition Audit (NCDA)	N/A	Data will be collated from existing submissions		Primary / Secondary Care	Organisation wide compliance	GREEN
National Diabetes Paediatric Audit (NPDA) * #	01/04/2022 – 31/03/2023	N/A	July 2023	Paediatrics	Organisation wide compliance	GREEN
National Asthma and COPD Audit Programme (NACAP) * # Note this covers the following areas: Adult Asthma	operates continuous data capture	N/A	March 2024	General medicine	Organisation wide compliance	GREEN
COPD	operates continuous data capture	N/A	March 2024	General medicine	Organisation wide compliance	GREEN
Children and Young People Asthma	operates continuous data capture	N/A	March 2024	Paediatrics	Organisation wide compliance	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
Pulmonary Rehabilitation	N/A	N/A	TBC	General medicine / Therapies	Service not operational	N/A
National Early Inflammatory Arthritis Audit * # (NEIRT)	N/A	N/A	October 2023	Rheumatology	Action being taken to improve compliance	AMBER
All Wales Audiology Audit #	operates continuous data capture	N/A	TBC	Ears, Nose and Throat	Organisation wide compliance	GREEN
Older People						
Sentinel Stroke National Audit Programme (SSNAP) (SSNAP) *	operates continuous data capture	N/A	April 2023	General medicine / Therapies	Organisation wide compliance	GREEN
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls * (NIFA)	operates continuous data capture	N/A	November 2023	General Medicine / Trauma & Orthopaedics	Support arrangements under review to ensure compliance by end of March 2023	AMBER
• National Hip Fracture Database (NHFD)	operates continuous data capture	N/A	November 2023	General Medicine / Trauma & Orthopaedics	Organisation wide compliance	GREEN
National Dementia Audit * (NDA)	April – July 2023	July 2023	June 2023	Mental Health / Care of the Elderly	Organisation wide compliance	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
End of Life						
National Audit for Care at the End of Life (NACEL) *	N/A	N/A	July 2023 (Round 4)	Palliative Care / Medicine	Organisation wide compliance	GREEN
Heart						
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * (NHFA)	operates continuous data capture	June 2023	June 2023	Cardiology	Action being taken to improve compliance	AMBER
• Cardiac Rhythm Management * (CRM)	operates continuous data capture	N/A	TBC	Cardiology	Organisation wide compliance. (excludes Bridgend)	GREEN
• Myocardial Ischaemia National Audit Project (MINAP)*	operates continuous data capture	June 2023	June 2023	Cardiology	Action being taken to improve compliance	AMBER
Cardiac Rehabilitation Audit (CRA)	operates continuous data capture	N/A	TBC	Cardiology	Organisation wide compliance	GREEN
Cancer						
National Bowel Cancer Audit * (NOGCA)	operates continuous data capture	N/A	January 2024	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
National Oesophago-Gastric Cancer Audit * (NOGCA)	operates continuous data capture	N/A	August 2024	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Audit of Breast Cancer in Older People (NABCOP)	operates continuous data capture	N/A	May 2023	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Lung Cancer Audit * (NLCA)	operates continuous data capture	N/A	TBC	Respiratory Medicine	Organisation wide compliance. Managed through cancer services.	GREEN
National Prostate Cancer Audit * (NPCA)	operates continuous data capture	N/A	January 2024	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
Women's and Children's Health						
National Neonatal Audit Programme Audit * # (NNAPA)	operates continuous data capture	N/A	November 2023	Paediatrics	Organisation wide compliance.	GREEN
National Maternity and Perinatal Audit * # (NMPA)	operates continuous data capture	N/A	June 2023	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
National Perinatal Mortality Review Tool	operates continuous data capture	N/A	October 2023	Obstetrics / Midwifery	Organisation wide compliance.	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
Other						
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *# (NASECYP)	Series of data collection cohorts within the audit	Various deadlines for cohorts	July 2023	Paediatrics	Organisation wide compliance.	GREEN
National Clinical Audit of Psychosis * (NCAP) EIP Audit	TBC	N/A	TBC	Mental Health	Organisation wide compliance.	GREEN

(* denotes NCAPOP Audits)

(# denotes reports likely to include information on children and / or maternity services)

National Vascular Registry Audit (includes Carotid Endarterectomy Audit) * ([NVRA](#)) no longer included on the annual rolling programme due to vascular services moved to tertiary centre, combined outcomes now reported under Cardiff & Vale UHB.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

Clinical Outcomes Review Programme (2022/23)

The Clinical Outcome Review Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2022/23	RAG Status 2022/23
National Confidential Inquiry into Suicide and Safety in Mental Health	operates continuous data capture	N/A	April 2023	Mental Health Programme	Organisation wide compliance.	GREEN
NCEPOD – Transition from Child to Adult Services	01/04/2022 – 30/06/2022	March 2023	June 2023	Child Health Clinical Outcome Review Programme	Organisation wide compliance.	In progress at the time of publication
NCEPOD – Crohn's Disease	2022	March 2023	TBC	Medical & Surgical programme	Organisation wide compliance.	In progress at the time of publication
NCEPOD – Epilepsy	01/02/2022 – 30/06/2022	June 2022	December 2022	Medical & Surgical programme	Incomplete	RED
NCEPOD – Testicular Torsion	2022	March 2023	February 2024	Medical & Surgical programme	Organisation wide compliance.	In progress at the time of publication
NCEPOD – Community Acquired Pneumonia	2022	March 2023	TBC	Medical & Surgical programme	Organisation wide compliance.	In progress at the time of publication
NCEPOD - Endometriosis	2022/23	February 2024	April 2023	Medical & Surgical programme	N/A (new for 2023/24)	N/A

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2022/23	RAG Status 2022/23
End of Life	2023/24	TBC	TBC	Medical & Surgical programme	N/A (new for 2023/24)	N/A
Rehabilitation after Critical Illness	2023/24	TBC	TBC	Medical & Surgical programme	N/A (new for 2023/24)	N/A
Juvenile Idiopathic Arthritis	2023/24	TBC	TBC	Child Health Clinical Outcome Review Programme	N/A (new for 2023/24)	N/A
MBRRACE – Perinatal Mortality Surveillance	operates continuous data capture	TBC	October 2023	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	GREEN
MBRRACE – Saving Lives Improving Mothers Care	operates continuous data capture	TBC	November 2023	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	GREEN

Cwm Taf Morgannwg University Health Board Organisation (Tier 2) Priority Annual Audit Programme 2023/24

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/2023
Case Note Documentation Audits: - Acute Hospital Documentation Audit - Community Hospital Documentation Audit - A&E Documentation Audit	Revised methodology TBC	TBC	TBC	Acute inpatient activity Community hospital inpatient activity Emergency Medicine	All tier 2 audits affected by requirement to divert resources to underpin priority COVID Mortality Review cases	
					Compliance significantly affected by closure of department and demands on clinical audit staff December 2021 / February 2022	AMBER
					Compliance significantly affected by closure of department and demands on clinical audit staff December 2021 / February 2022	AMBER
					Organisation wide compliance.	GREEN
Consent to Treat Audit	Revised methodology TBC	TBC	TBC	Surgery	N/A	N/A
Do Not Attempt Cardiopulmonary Resuscitation Audit	Autumn / Winter 2022	March 2023	March 2023	Critical Care	Organisation wide compliance.	GREEN
National Ophthalmology Audit (Adult Cataract surgery) * (NOD)	Under Review	TBC	TBC	Ophthalmology	CTM agreed as an organisation priority audit, Bridgend inclusion delayed	AMBER

Cwm Taf Morgannwg University Health Board Organisation (Tier 2) Priority Annual Audit Programme 2023/24

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/2023
Appendectomy Audit	Prospective audit methodology TBC	TBC	TBC	Surgery	Organisation wide compliance.	GREEN
Tracheostomy Care Audit	TBC	TBC	TBC	Surgery	Limited Clinical Audit resources focused on national audit compliance so audit rolled over to 2022/23	RED



AGENDA ITEM

2.2.7

AUDIT & RISK COMMITTEE

AUDIT WALES – CTMUHB ANNUAL AUDIT REPORT 2022

Date of meeting

19th April 2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Cally Hamblyn, Assistant Director of Governance & Risk

Presented by

Sara Utley, Audit Wales

Darren Griffiths, Audit Wales

Approving Executive Sponsor

Paul Mears, Chief Executive

Report purpose

FOR NOTING

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

Committee/Group/Individuals

Date

Outcome

Executive Leadership Group

13th March
2023

ENDORSE IN TERMS OF
FACTUAL ACCURACY, TONE
AND BALANCE

Health Board Meeting

30th March
2023

NOTED

ACRONYMS

CTMUHB | Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

- 1.1 This report summarises the findings from the 2022 audit work at CTMUHB, undertaken to fulfil the Auditor General's responsibilities under the Public Audit (Wales) Act 2004. The report was considered and noted by the Board at its meeting on the 30th March 2023.

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

- 2.1 The overall findings of the report are captured under the following headings:
- Audit of accounts
 - Arrangements for securing economy, efficiency, and effectiveness in the use of resource

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

- 3.1 Please refer to the full report at Appendix 1. The 'Key Messages' are captured on pages 5 and 6 of the report.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below) Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Health Board can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below. Not required.
Legal implications / impact	No
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

- 5.1 The Committee are asked to **NOTE** CTMUHB's Annual Audit Report 2022.

Annual Audit Report 2022 – Cwm Taf Morgannwg University Health Board

Audit year: 2021-22

Date issued: March 2023

Document reference: 3314A2023

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

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

- 1 This report summarises the findings from my 2022 audit work at Cwm Taf Morgannwg University (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:
 - examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
 - satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
 - satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.
- 2 I report my overall findings under the following headings:
 - Audit of accounts
 - Arrangements for securing economy, efficiency, and effectiveness in the use of resources
- 3 This year's audit work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services.
- 4 I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.
- 5 As was the case in the previous two years, the delivery of my audit of accounts work has continued mostly remotely. The success in delivering it reflects a great collective effort by both my staff and the Health Board's officers.
- 6 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. I have commented on how NHS Wales is tackling the backlog of patients waiting for planned care. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

- 7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.
- 8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2022 Audit Plan.
- 9 **Appendix 3** sets out the audit of accounts risks set out in my 2022 Audit Plan and how they were addressed through the audit.
- 10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Board on 30 March 2023, and the Audit and Risk Committee will consider it on 19 April 2023. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the [Audit Wales website](#) after the Audit and Risk Committee have considered it.
- 11 I would like to thank the Health Board staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

- 12 I concluded that the Health Board's 2021-22 accounts¹ were properly prepared and materially accurate and I therefore issued an unqualified true-and-fair opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).
- 13 However, I qualified my regularity opinion because the accounts include an accounting provision (and corresponding expenditure) of £943,000, which I deem to be irregular. The amount relates to the Health Board's estimated liability arising from a Ministerial Direction in 2019 to the Permanent Secretary of the Welsh Government. This matter also affected other Welsh health boards.
- 14 I found no other regularity matters of a material adverse nature. In terms of financial performance, the Health Board achieved financial balance for the three-year period ending 31 March 2022, against both its revenue and capital resource limits.
- 15 I reported 14 audit issues, together with my audit recommendations, to officers and the Health Board's Audit and Risk Committee. Officers formally accepted 13 of the 14 recommendations and agreed management actions and dates of

¹ I audit and certify the Health Board's Performance Report, Accountability Report and Financial Statements. 'Accounts' is a generic term.

implementation. I will review the Health Board's progress with the actions as part of my 2022-23 audit.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- Despite the additional investment in waiting list recovery, the significant growth in the numbers of people waiting is likely to mean that waiting lists will not return to pre-pandemic levels for many years.
- The Cwm Taf Morgannwg Regional Partnership Board's Transformation Leadership Programme Board is well-placed to develop stronger regional working building on the productive relationships over the past 18 months. However, it needs to ensure its planning is more integrated and longer term, strengthen aspects of its governance arrangements, and be more ambitious in using its combined core resources to have a greater impact on the Cwm Taf Morgannwg region.
- Contract arrangements following the health board boundary change in 2019² are sound and supported by good operational oversight and project management. However, there has been no clear programme for disaggregation of services until recently, and the lack of commissioning capacity and programme management, alongside the impact of COVID-19, has meant that the original timetable has not been met. Oversight and scrutiny of the programme at Board and committee level within both Health Boards also need to be improved, as well as the management of risk.
- The temporary closure of the Minor Injuries Unit in Ysbyty Cwm Cynon could have been avoided if action had been taken sooner to strengthen managerial oversight of the unit as well as to address the concerns raised in 2018/19 around staff training and qualifications.
- While corporate governance arrangements continue to develop and improve, the Health Board needs to strengthen its arrangements for addressing the significant performance and financial challenges it faces.

17 These findings are considered further in the following sections.

² On 1 April 2019, Welsh Government introduced changes to the boundaries of Abertawe Bro Morgannwg University Health Board (ABMUHB) and Cwm Taf University Health Board. Neath Port Talbot, Singleton and Morriston Hospitals, and services relating to the Swansea and Neath Port Talbot population became part of the new Swansea Bay University Health Board (UHB). The Princess of Wales Hospital, formerly part of ABMUHB, became part of the new Cwm Taf Morgannwg University Health Board (CTMUHB). Commissioning responsibility for the health needs of the Bridgend population transferred to CTMUHB.

Detailed report

Audit of accounts

- 18
- Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation’s financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use (‘regularity’) of public monies.
- 19
- My 2022 Audit Plan set out the key risks for audit of the accounts for 2021-22 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.
- 20
- My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2021-22 accounts

- 21
- I concluded that the Health Board’s accounts were properly prepared and materially accurate (true and fair) and I issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board’s internal controls (as relevant to my financial audit).
- 22
- I reported 14 audit issues, together with my audit recommendations, to the officers and the Health Board’s Audit and Risk Committee. Officers formally accepted 13 of the 14 recommendations and agreed management actions and dates of implementation.
- 23
- I must report issues arising from my work to those charged with governance (the Members of Board), for their consideration before I issue my audit opinion on the accounts. My audit team reported these issues to the Board on 14 June 2022. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Board

Issue	Auditors’ comments
Uncorrected misstatements	There were two areas of uncorrected misstatements. The first area relates to the value of the Health Board’s buildings, with their disclosed value as at 31 March 2022 being understated by £8.110 million. Three associated disclosures were also misstated by amounts of £5.619 million, £2.194 million, and £327,588.

Issue	Auditors' comments
	The second area related to an overstatement of £815,212, in respect of an invalid current-liability relating to general medical services' costs. I judge these misstatements not to be material to my audit opinions on the 2021-22 accounts.
Corrected misstatements	I reported the four most significant areas of corrected misstatements. They related mainly to accounting classifications and disclosures.
Other significant issues	I reported 14 recommendations for improvement, with management's formal responses. The Health Board's Audit and Risk Committee considered them on 22 August 2022.

- 24 I undertook a review of the Health Board's Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2022 and the return was prepared in accordance with the Treasury's instructions.
- 25 I audited the 2021-22 charitable funds' financial statements, which I certified with an unqualified opinion on 27 January 2023. The Charity Commission's annual deadline is 31 January.

Regularity of financial transactions

- 26 I qualified my regularity opinion because the 2021-22 accounts include an accounting provision (and corresponding expenditure) of £943,000, which I deem to be irregular. The amount relates to the Health Board's estimated liability arising from a Ministerial Direction in 2019 to the Permanent Secretary of the Welsh Government. This matter also affected other Welsh health boards.
- 27 The Ministerial Direction covered the need for interim remedial action to address the impact of HM Treasury's changes to the tax arrangements on senior clinicians' pension contributions. I placed an explanatory narrative report alongside my audit report on the accounts.
- 28 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are

no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

- 29 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. **Exhibits 2 and 3** show that the Health Board met both its revenue and capital resource allocations.
- 30 Except for the £943,000, I found no material financial transactions that were not in accordance with authorities nor used for the purposes intended. In terms of financial performance, the Health Board achieved financial balance for the three-year period ending 31 March 2022

Exhibit 2: financial performance against the revenue resource allocation

	2019-20 £'000	2020-21 £'000	2021-22 £'000	Total £'000
Operating expenses	1,066,192	1,234,552	1,278,665	3,579,409
Revenue resource allocation	1,067,075	1,234,640	1,278,837	3,580,552
Under (over) spend against allocation	883	88	172	1,143

Exhibit 3: financial performance against the capital resource allocation

	2019-20 £'000	2020-21 £'000	2021-22 £'000	Total £'000
Capital charges	38,328	52,231	79,154	169,713
Capital resource allocation	38,332	52,278	79,196	169,826
Under (over) spend against allocation	24	47	42	113

Source: audited 2021-22 accounts

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

- 31 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health

Board over the last 12 months to help me discharge that responsibility. This work has involved:

- undertaking a high-level review of how NHS Wales is tackling the planned care backlog.
- undertaking a baseline governance review of Cwm Taf Morgannwg Regional Partnership Board's Transformation Leadership Programme Board.
- undertaking a joint review at both Swansea Bay and Cwm Taf Morgannwg University Health Boards of the arrangements for overseeing and managing the contractual agreements established following the realignment of Health Board boundaries.
- undertaking a high-level review to examine the issues surrounding the temporary closure of the Minor Injuries Unit in Ysbyty Cwm Cynon.
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

32 My conclusions based on this work are set out below.

Tackling the planned care backlog in Wales

- 33 In May 2022, I published a report that set out the extent of the planned care backlog in NHS Wales, and the key actions the system needs to take to start to tackle the backlog. My report highlighted the continued growth of the overall waiting list numbers month on month, whilst noting the rate of growth was slowing. It also noted that the inevitable drop in referrals seen during the pandemic would likely result in this latent demand eventually coming back into the system. Taking these and other factors into account my work estimated that it could as much as seven years before overall waiting list numbers in Wales returned to pre-pandemic levels.
- 34 The Welsh Government has produced a national recovery plan for planned care with key milestones for health boards to achieve, including an initial focus on those patients facing very long waits. However, those milestones are already proving difficult to achieve.
- 35 In line with the key actions I set out in my report, the Health Board, along with others in Wales, will need to both build and protect capacity for planned care, and continue to maintain a focus on efficiency and productivity.
- 36 The Health Board will also need to ensure that it actively manages the clinical risks to patients that are facing long waits for treatment, and enhance its systems for communicating with patients to help them manage their condition whilst they are waiting and inform them of what to do if their condition deteriorates.

Transformational Leadership Programme Board - Baseline Governance Review

- 37 My work considered whether the governance arrangements of the Cwm Taf Morgannwg Regional Partnership Board's Transformation Leadership Programme Board (TLPB) are supporting the four statutory partners³ to develop effective and sustainable approaches to regional working.
- 38 In terms of the TLPB's planning arrangements, my work found that planning was moving from a short-term basis to a more medium-term basis with an increased focus on a 5-year planning period. However, strategic plans require a more integrated approach to developing a longer-term perspective, which is supportive of partners' plans and will deliver a stronger regional identity. The TLPB also needs to ensure that its planning is driven by the population's needs, rather than the funding regime. There are also opportunities to improve the TLPB internal engagement arrangements, especially in relation to increasing the voices of non-statutory partners.
- 39 In terms of the TLPB's governance arrangements, my work found that chairing of the TLPB meetings was effective, and we saw strong synergy between the meetings we observed. However, we found some variation in the quality of meeting papers, and limited evidence of scrutiny and challenge. Further work is needed in respect of key performance metrics and milestones, with the new outcomes and performance dashboard yet to be implemented. The Finance Sub-group was well structured, with constructive discussions and there was detailed financial reporting. However, the Cross-Cutting Programme Board was not yet operational, despite this being a key part of the governance architecture designed to oversee the development and delivery of regional cross-cutting services. In addition, risk management is an area that needs to be strengthened with the need for better articulation of shared risks, prioritisation, and mitigating actions.
- 40 In terms of TLPB resources, my work found that the TLPB was still developing its approach to the new Health and Social Care Regional Integrated Funding regime. Whilst there are examples of pooled funding and shared resources, these are limited, and the statutory partners need to consider how they can use their combined core resources more effectively to deliver the TLPB's plans and address the significant health and social care challenges in the region. The statutory partners have developed stronger relationships during the pandemic and need to build on these to do this. Like many areas in the public sector, there are significant workforce challenges in the region and there needs to be a regional and strategic approach to addressing these.

³ The four statutory partners are: Cwm Taf Morgannwg University Health Board, Rhondda Cynon Taf County Borough Council, Merthyr Tydfil County Borough Council, and Bridgend County Borough Council.

Commissioning and contracting arrangements post Bridgend boundary change

- 41 My work considered the robustness of the arrangements for overseeing and managing the contractual agreements established following the realignment of health board boundaries in 2019, which saw commissioning responsibility for the health needs of the Bridgend population transferred to Cwm Taf Morgannwg University Health Board. We also considered the programme for service disaggregation (for relevant services), and whether the arrangements support future regional service models being explored by Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board.
- 42 My work found that the contract arrangements are sound and supported by good operational oversight and project management. However, there has been no clear programme for disaggregation of services until recently, and the lack of commissioning capacity and programme management, alongside the impact of COVID-19, has meant that the original timetable has not been met. Oversight and scrutiny of the programme at Board and committee level within both health boards also need to be improved, as well as the management of risk.
- 43 My work found that there are comprehensive programme arrangements in place to provide operational oversight of the Bridgend commissioning arrangements. The current operational governance arrangements work well, with clear leadership and involvement from all relevant corporate functions. Agendas for meetings are well managed. However, operational, and clinical staff are not always involved in meetings, which means that clinical and operational issues and implications are being missed.
- 44 Arrangements for monitoring the contracts are sound, and regular information is provided to the operational groups to ensure scrutiny. Changes to any contracts are managed well, although there is scope to ensure that any impacts from service changes are appropriately assessed. A joint risk register is in place, which captures the risks appropriately. However, there is no clear process for escalation of these risks to the relevant health board risk register.
- 45 Although there has been recent progress in disaggregating services, the anticipated time to disaggregate all contracts was underestimated. As a result, there has been no clear disaggregation plan in place up until recently. The capacity of the commissioning teams has not been sufficient to enable effective programme management and, compounded with the impact of COVID-19, has affected the ability to disaggregate services at the expected rate. While a plan is now in place, the ability to disaggregate remaining contracts will be hindered without additional capacity. Opportunities to look more broadly at regional working may also be missed as a result.

Review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit

- 46 My work considered the issues surrounding the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit (MIU) between September 2021 and May 2022. This is a service led by Emergency Nurse Practitioners (ENPs).
- 47 My work found that the MIU temporarily closed at short notice largely due to shortcomings in the managerial oversight arrangements of the MIU, which led to:
- the unit operating with staff whose competence to work autonomously had not been adequately assessed, despite concerns over staff training and supervision being raised as far back as 2018/19;
 - a fragile unit that was operating sub-optimally due a lack of investment in support staff to enable ENPs to manage workload demands efficiently;
 - staff not having up-to-date performance appraisals; however, this situation is not unique to the MIU.
- 48 We found that the temporary closure of the MIU led to reduced service options available to residents and increased the number of individuals attending the Emergency Department at Prince Charles Hospital (PCH), which was already operating under significant pressure.
- 49 The Health Board formally reported the decision to temporarily close the MIU to the Quality and Safety Committee. Although the Health Board determined that the risk of harm to patients of being seen at the Ysbyty Cwm Cynon MIU was minimal, that this was not formally reported to the Quality and Safety Committee, thus limiting opportunities to enable full scrutiny and provide assurance. Furthermore, we found that the Health Board has not assessed or reported on the impact on the patient experience, or the quality of the care provided to residents required to attend the Emergency Department at PCH following the closure of the MIU.
- 50 More positively, we found that the Health Board's arrangements for communicating the temporary closure to patients, the Quality and Safety Committee, and other key stakeholders as well as its arrangements for redeploying MIU staff were effective.

Structured assessment

- 51 My 2022 structured assessment work took place at a time when NHS bodies were not only continuing to tackle the challenges presented by COVID-19 but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health.
- 52 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. Auditors also paid attention to progress made to address previous recommendations.

Governance arrangements

- 53 My work considered the Health Board's governance arrangements, with a particular focus on:
- Board and committee effectiveness;
 - the extent to which organisational design support supports good governance; and
 - key systems of assurance.
- 54 My work found that **the Health Board's governance and leadership arrangements are improving, and organisational structures are being refreshed to support further improvements. However, the Health Board needs to further strengthen its systems of assurance to fully address the performance challenges facing the organisation.**
- 55 My work found that the Health Board's governance arrangements support the effective conduct of Board and committee business. The Board is committed to conducting its business in an open manner; however, opportunities exist to improve the Health Board's administrative arrangements for ensuring public transparency of Board business. The Health Board has a stable, skilled, and experienced cadre of Independent Members that provide a good balance of challenge and support. The Health Board has a stable committee structure, which is well embedded, and the papers prepared for Board and committee meetings provide sufficient detail to enable scrutiny and decision making. The Board demonstrates a good commitment to hearing from staff and patients, and has effective arrangements for self-review and improvement.
- 56 We found that the Health Board has taken positive steps to strengthen and stabilise its Executive Team as well as to ensure that Executive Directors have clear responsibilities and balanced and equitable portfolios of work. The Corporate Governance Team provides good support to the Board and its committees, despite not having a full complement of staff. The Health Board has made a number of positive changes to the role of the Director of Corporate Governance, which should allow the postholder to focus exclusively on the Health Board's governance arrangements. The Board has approved the creation of a new operating model with the aim of supporting post-pandemic recovery, improving service quality, streamlining management arrangements, and facilitating joint-working across the Health Board. Although the Board has maintained good oversight of the development and implementation of the new operating model, it will take time for the new structures to embed and deliver the intended benefits and improvements.
- 57 We found that the Health Board's risk management arrangements continue to evolve. The Health Board has made positive progress in developing a Board Assurance Framework, which it must now use to actively shape and inform Board and committee business. Although the Health Board has effective arrangements for reporting performance to the Board, its performance remains the worst in Wales in a number of areas which has led it to be escalated from routine arrangements to

enhanced monitoring for performance under Welsh Government's Escalation and Intervention Arrangements⁴. The Health Board, therefore, needs to ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales. The Health Board has appropriate arrangements for overseeing information governance at a committee-level, but some operational arrangements require improvement. The Health Board has taken a number of positive steps to improve its arrangements for tracking internal and external recommendations, but further enhancements are required.

Strategic planning arrangements

- 58 My work considered the Health Board's strategic planning arrangements, with a particular focus on the organisation's:
- vision and strategic objectives;
 - Integrated Medium-term Plan;
 - planning arrangements; and
 - arrangements for implementing and monitoring the delivery of corporate strategies and plans.
- 59 My work found that **the Health Board's strategic planning arrangements continue to improve, and positive progress has been made in developing a clear long-term vision and strategy for the organisation. Preparing a Clinical Strategy and an approvable IMTP, and enhancing reporting arrangements, must remain key priorities for the Health Board.**
- 60 My work found that the Health Board has made good progress in developing its long-term strategy for the organisation, CTM 2030. The strategy provides a clear vision for the Health Board and sets out four strategic goals, which each have four clear priorities for action. The Board formally adopted the vision, strategic goals, and priorities in March 2022 following extensive engagement with staff, residents, partners, and other stakeholders. The Health Board is currently developing a Clinical Strategy for the organisation in the context of CTM 2030.
- 61 The Health Board has been unable to produce a financially balanced and Welsh Government approved Integrated Medium Term Plan for 2022-25 due to its challenging financial position. Instead, it produced an Annual Plan for 2022-23. As a result, the Health Board has been escalated from routine arrangements to enhanced monitoring for planning and finance under Welsh Government's Escalation and Intervention Arrangements.
- 62 We found that the Board has maintained effective oversight of the organisation's arrangements for developing corporate strategies and plans, particularly CTM

⁴ There are four escalation levels: routine arrangements, enhanced monitoring, targeted intervention, and special measures.

2030. The Board has actively been involved in shaping the long-term vision, strategic goals, and priorities for CTM 2030 through workshops, development sessions, and regular discussions in public Board meetings. The Health Board also has a positive approach to stakeholder engagement. It has demonstrated strong engagement with a diverse range of the stakeholders in developing CTM 2030, using a range of approaches to engage residents, staff, and external partners.

- 63 Whilst CTM 2030 sets a clear direction of travel for the Health Board, we found that it currently lacks clear and measurable outcomes. The CTM 2030 Steering Group and Strategy Groups are currently developing outcomes for each strategic priority, setting out what success would look like, and identifying how to measure and report progress. However, there is scope to accelerate the pace of this work. The 2022-23 Annual Plan includes a range of different actions / deliverables, timescales, and measures, some of which relate to the strategic goals and priorities set out in CTM 2030. However, they not summarised or presented in a way that allows progress to be monitored and reported effectively on a quarterly basis, and there is lack of detail on which Executive Directors are responsible for ensuring delivery. The Health Board provides routine updates on the delivery of corporate strategies and plans to the Planning, Performance, and Finance Committee. However, the reports are very high-level in nature and do not provide sufficient information to enable full scrutiny, challenge, and assurance.

Managing financial resources

- 64 My work considered the Health Board's arrangements for managing its financial resources, with a particular focus on the organisation's:
- arrangements for meeting key financial objectives;
 - financial controls; and
 - arrangements for reporting and monitoring financial performance.
- 65 My work found that **the Health Board has clear arrangements for financial planning, and its finances are well scrutinised. Whilst the Health Board met its financial duties for 2021-22, it faces several risks to achieving financial balance and sustainability in the short- and medium-term.**
- 66 At the end of 2021-22, the Health Board met both its financial duty to operate within its annual revenue resource limit and within its cumulative resource limit for the three-year rolling period 2019-20 to 2021-22. The Health Board also met its 2021-22 financial duty to break-even against its annual and three-year rolling capital resource limit. However, as it failed to meet its 2021-22 savings target by £11.1m, it started the 2022-23 financial year with an accumulated underlying deficit of £44.5m.
- 67 The Health Board's financial plan is clearly set out in the 2022-23 Annual Plan. The Health Board is seeking to manage its financial challenges by improving forecasts, identifying remedial actions, and delivering cost savings. However, these arrangements do not appear to be sufficiently robust. In Month 9 2022-23, the

Health Board was reporting a shortfall of £7.2m in recurrent savings, and overspends of £5.8m and £11m in Primary Care Prescribing and Planned Care Groups / Directorates respectively. At the time of my work the Health Board was not on course to meet all its financial duties in 2022-23. At month 9 2022-23, the Health Board reported a £21.3m year-to-date deficit against its core revenue plan, which was £1.4m worse than plan. However, the Health Board was forecasting that the core plan deficit would remain at £26.5m as per the core plan submitted to Welsh Government. The Health Board is on course to remain within its capital resource limit for 2022-23.

- 68 We found that the Health Board has adequate arrangements to ensure compliance with its with Standing Financial Instructions and Scheme of Reservation and Delegation. We did not identify any significant control weaknesses from our review of the Health Board's 2021-22 financial statements. However, as noted earlier in this report, we made fourteen recommendations for improvement, which included a need for the Health Board to seek timely approval for any senior officer appointment that would exceed the relevant pay band authorised by Welsh Government. The Audit and Risk Committee maintains effective oversight of the Health Board's arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud. Whilst the Health Board's Financial Control Procedures are generally effective, we identified opportunities to strengthen controls further by setting a clear delegated upper financial limit for the Chief Executive, and ensuring there is a clear process in place for the Board to review and approve capital programmes and projects.
- 69 We found that the Health Board has effective arrangements for reporting financial performance to the Board and the Planning, Performance, and Finance Committee. Reports provide timely and good quality information, and contain a good mixture of text and exhibits to convey key messages. However, opportunities exist to enhance the reports by providing greater assurances that mitigating actions are in place to address key financial risks, and reporting on the performance of the new Care Groups. We have observed good scrutiny and challenge around the organisation's financial position at both Board and Planning, Performance, and Finance Committee meetings.

Managing the workforce, digital resources, the estate, and other physical assets

- 70 My work considered the Health Board's arrangements for managing its wider resources, with a particular focus on the organisation's:
- arrangements for supporting staff wellbeing;
 - arrangements for managing its digital resources; and
 - arrangements for managing its estate and other physical assets.
- 71 My work found that **staff well-being remains a clear priority for the Health Board. However, capacity and funding challenges need to be addressed to**

enable the Health Board to maximise the benefits of digital, and Board-level oversight of matters relating to the estate require strengthening.

- 72 We found that the Health Board has effective arrangements for seeking staff views about their well-being needs and using staff feedback to shape its well-being offer. The Health Board routinely provides updates on its well-being activities and performance against workforce metrics to the People and Culture Committee. Whilst reports provide a good overview of activity, they do not provide sufficient assurance that well-being interventions are having a positive impact on staff well-being.
- 73 The Health Board's strategic digital intentions are clearly set out in its Digital Strategy, which it will review as part of its arrangements for developing the organisation's Clinical Strategy. However, there is limited capacity and capital funding within the Health Board to fully deliver the digital transformation agenda. Whilst these risks are appropriately reflected in the BAF, the Health Board should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.
- 74 The Health Board does not currently have an Estates Strategy, but is aiming to develop one during 2023. The Health Board's arrangements for ensuring appropriate Board-level oversight of the condition of the estate and other physical assets require strengthening. Whilst the Health Board's Capital and Estates Governance Board maintains operational oversight, it does not provide assurance reports to the Planning, Performance, and Finance Committee. The Health Board, therefore, needs to ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee. It also needs to update the committee's Terms of Reference to reflect these responsibilities, and establish a clear process for ensuring appropriate cross-referral of issues with the Quality and Safety Committee, which oversees health and safety matters.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2022.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2022
Opinion on the Financial Statements	June 2022
Audit of Financial Statements Report Addendum	August 2022
Charitable Funds (2020-21 Accounts)	January 2022
Charitable Funds (2021-22 Accounts)	January 2023
Performance audit reports	
Tackling the Planned Care Backlog in Wales	May 2022
Transformational Leadership Programme Board - Baseline Governance Review	May 2022
Commissioning and Contracting Arrangements Post Bridgend Boundary Change – Swansea Bay and Cwm Taf Morgannwg University Health Boards	November 2022

Report	Date
Review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit	February 2023
Structured Assessment 2022	March 2023
Cwm Taf Morgannwg University Health Board – Tackling the Orthopaedic Services' Waiting List Backlog	March 2023
Other	
2022 Audit Plan	April 2022

My wider programme of national value for money studies in 2022 included reviews that focused 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. Reports are available on the [Audit Wales website](#).

Exhibit 3: performance audit work still underway

There are a number of performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Unscheduled care – patient flow out of hospital	April 2023
Joint Review Follow up – Quality Governance	June 2023
Follow-up Review of Primary Care Services	June 2023
Unscheduled care – access to unscheduled care services	July 2023

Appendix 2

Audit fee

My 2022 Audit Plan set out my fee estimate of £416,770 (excluding VAT, which is not chargeable). I also set a fee estimate of £25,000 in the 2022 Audit Plan for my audit of the charitable funds' financial statements. I can confirm that there is a rebate of £12,996 in respect of the £416,770 relating to my audit of accounts work; and an additional charge of £1,832 in respect of my charitable funds audit work.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2022 Audit Plan set out the risks for the audit of the Health Board’s 2021-22 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • any additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	I reviewed numerous accounting estimates and a sample of transactions that included journal entries. I undertook an extended review of the Health Board’s current liabilities. While my audit findings were materially satisfactory, I found an old and invalid liability of £815,212, which officers should have identified and corrected, prior to the audit. As reported at Exhibit 1, officers did not correct this misstatement.
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. Health boards instead moved to a rolling three-year	I will continue to monitor the Health Board’s financial position for 2021-22 and the cumulative three-year position to 31 March 2022. This review will also consider the impact of	As set out in this report, my audit confirmed that the Health Board met its three-year resource allocations for both revenue and capital.

Audit risk	Proposed audit response	Work done and outcome
resource limit for both revenue and capital. The first three-year period ran to 31 March 2017. For 2021-22 and the three years to 31 March 2022, Health Board forecasts⁵ to operate within its revenue and capital resource limits, subject to anticipated 2021-22 COVID-19 funding of £19.8 million from the Welsh Government. If the Health Board receives the anticipated funding, and maintains its forecast position, it would support an unqualified regularity opinion. Your current financial pressures do, however, increase the risk that management's judgements and estimates could be biased in an effort to achieve the financial duty.	any relevant uncorrected misstatements over the three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2021-22 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.	
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for	I will review the evidence one year on around the take-up of the scheme and the need for a provision, and the	As set out in this report, for 2021-22 the Health Board provided for an estimated liability and costs of £943,000 and, as

⁵ Based on the Month 11 year-end forecast, which the Health Board has reported to the Welsh Government.

Audit risk	Proposed audit response	Work done and outcome
clinical staff is ongoing. Last year we included an 'emphasis of matter' paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, I would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	consequential impact on the regularity opinion.	advised in the 2022 Audit Plan, I qualified my regularity opinion accordingly.
While COVID-19 restrictions are due to be removed in Wales on 28 March 2022, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit, and publication of the financial statements. There is a risk that the quality of the accounts and supporting working papers may be compromised, leading to an increased incidence of errors.	I will continue to discuss your closedown process and quality monitoring arrangements with the relevant officers.	I continued my discussions with officers and monitored the arrangements in place and I am pleased to report that no significant problems arose.
There continues to be increased funding streams and	I will identify the key issues and associated risks and plan my work	I reviewed transactions and balances relating to

Audit risk	Proposed audit response	Work done and outcome
expenditure in 2021-22 to deal with the COVID-19 pandemic. They could have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include: fraud, error, and regularity risks of additional spend; valuation (including obsolescence) of year-end inventory, including PPE; and the estimation of year-end annual leave balances.	to obtain the assurance needed for my audit.	COVID-19, and tested them where appropriate. My audit findings were satisfactory.
I audit some of the disclosures in the remuneration report to a far lower level of materiality, such as the remuneration of senior officers and independent members. The disclosures are therefore inherently more prone to material misstatement. In past audits I have identified material misstatements in the draft remuneration report submitted for my audit, which the Health Board had to correct. I therefore judge the 2021-2022 disclosures to be at risk of misstatement.	I will examine all entries in the remuneration report to verify that it is materially accurate, and that remuneration is at the appropriately approved levels.	I examined all entries and misstatements were corrected where necessary. I established that the Health Board had continued to remunerate some senior officers above the Welsh Government's pay bands and then, after the appointments, seek the Welsh Government's approval retrospectively. The Welsh Government raised its concerns with the Health Board in January 2022, and I again reported my concerns to the Health Board's Audit and Risk Committee in August 2022.

Audit risk	Proposed audit response	Work done and outcome
There is also the risk, as reported last year, that the Health Board remunerates senior officers above the Welsh Government's pay bands, but without the Welsh Government's formal approval to do so.		
I also audit the disclosure of related party transactions and balances to a far lower level of materiality. Last year I identified a number of material disclosures that had been omitted and had to be added.	I will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations also include other means of testing, such as my review of Companies House records using data analytics.	For 2021-22, a high number of corrections were again required, as result of my audit, which I reported to the Audit and Risk Committee in June and August 2022.
Between May 2020 and June 2021, I undertook a significant level of additional audit testing of the Health Board's old current-liabilities. As a result of this work, and as reported last year, the Health Board wrote-off and removed a material value of its old liabilities. The Health Board's remedial work has continued into 2021-22.	I will be reviewing the new accounting principles and processes adopted, analysing the age profile of the year-end current liabilities, and testing the balances disclosed as at 31 March 2022.	I continued my review of the Health Board's current liabilities. My audit findings were materially satisfactory.



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telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

PCH Redevelopment Programme Integrated Audit Plan 2023/24

April 2023

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1. Background

NHS Wales Infrastructure Investment Guidance (updated guidance issued by **Welsh Government** in October 2018) requires an Integrated Assurance and Approval Plan (IAAP), that sets out assurance and approval points for each stage of the Business Case process. Accordingly, the organisation is required to outline the various formalised assurance mechanisms proposed (e.g. internal audit, Gateway reviews, functional reviews etc.) and the timing of each.

The updated IAAP seeks to address a common misconception that Gateway reviews and Internal Audit Reviews provide the same level of assurance; it requires that Health Boards/ Trusts separately identify both.

The UHB made a provision for the Audit fee within the Phase 2 Business Case – accordingly, this document provides clarity on the potential coverage for 2023/24.

2. Methodology

This paper sets out the risk based audit plan for 2023/24 – subsequent year's requirements will be risk assessed and agreed with management. The proposal has been drafted in compliance with the Public Sector Internal Audit Standards.

For the purposes of this plan, key source information has been utilised as provided during the recent 2022/23 audits. The current programme anticipates:

- **Phase 1a:** Construction complete.
- **Phase 1b:** Construction complete.
- **Phase 2:** Construction ongoing and due to complete in June 2026.
- **Programme Business Case:** Submitted in April 2019.

The requirement has been developed based on our audit resourcing model and our experience of major project audits.

Applying our standard governance-based audit assessment methodology, the PCH Redevelopment Programme is identified as a high priority due to its significant cost, corporate importance and political materiality. As such, the audit plan has been developed to reflect this assessment.

The proposal includes a combination of programme-level, functional and consultancy assurance that, when combined, provide a balanced programme for the client to achieve the desired level of assurance.

The integrated audit plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

3. Outputs

The plan at **Appendix A** outlines that a number of audit reports will be targeted in the year. These will be reported to the Lead Executive (SRO) and Audit & Risk Committee.

This will be further supplemented with output(s) from the Non-Opinion Assurance elements that will be shared with management for consideration/ implementation, as appropriate.

4. Recommendation

The overall audit plan was included within the Full Business Case for Phase 2 and, accordingly, the funding of the associated fee has been agreed with Welsh Government.

This paper has been developed after consultation with management and the Responsible Officer. The proposed coverage aligns with the assumptions of the initial plan, with costs adjusted for inflation. This has been agreed by the Director of Finance/ Senior Responsible Officer.

The Audit & Risk Committee is asked to approve the attached audit plan for 2023/24.

Appendix A: Audit Plan 2023/24

Assurance/Approval	Outline Scope	2023/24												
		A	M	J	J	A	S	O	N	D	J	F	M	Total
Programme/Project Milestones														
	Phase 2: Construction Phase	Construction Period												
General Programme-Level Assurance														
Validation of Management Action	Assurance of Timely/ Appropriate Management Action													
Delivery of Key Project Objectives	Time Cost Quality													
Governance	Defined Arrangements Effectiveness of Operation Adequacy of Management and Control Arrangements Approvals Readiness to Proceed Adequacy and effectiveness of work streams													
Functional Assurance														
Financial	e.g. Approvals Budget setting Financial Monitoring/Management Use of Project Bank Accounts Cost Control Risk Management (and associated costs) Ongoing Cost Monitoring													
Technical	e.g. Programme Management Determination of Target Cost Tender Evaluation Validation of costs to date Calculation of Pain/Gain Adequacy of site surveys incl. Construction Environmental Management Plan, Green Information Management System, EPS Licence arrangements etc. Compliance with Framework Conditions Utilities Management Compliance with third party agreements Agreement of the Final Account													
Change Control	e.g. Change Management Arrangements Delegated Authority Case for Change													

Assurance/Approval	Outline Scope	2023/24												Total
		A	M	J	J	A	S	O	N	D	J	F	M	
	Approvals													
	Change - Cost control													
Advisers	e.g.													
	Appointments													
	Contractual arrangements													
	Fee Management													
	Monitoring/Reporting													
	Performance													
Quality	e.g.													
	Site Supervisor role													
	Planning Conditions													
	Design Review & Approval													
	BREEAM													
	Performance Management													
Information	e.g. Information Management Systems													
Stakeholders	e.g. Stakeholder engagement Fire Service engagement													
Non- Opinion Assurance														
Attendance at Key Meetings														
SRO/Deputy SRO Support														
General Advisory Support														
Audit Committee Prep & Attendance														
														£ 53,798.38



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ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers where circulated)
18/099	8/10/2018	Endoscopy JAG Accreditation Closure report to be presented to a future meeting.	Chief Operating Officer	January 2019 Revised to: October 2020 Ongoing - Action being led by Director of Operations. This matter is linked to JAG accreditation and updates will be provided to the Committee through the action log at each meeting Now October 2021 Now February 2023 Now April 2023 Now July 2023	In progress Review of each site is progressing. Capacity of operational team has been redirected to Planned Care Recovery activity and therefore pace of progress has been impacted. Timeframe readjusted and review date now set for July 2023.
5.4.5	22/08/2022	Internal Audit Review Medical & Dental Rostering - Discussion to be held with the Medical Director outside the meeting in relation to the concerns raised by Members regarding the management response provided.	Director for People/ Medical Director	October 2022 Now July 2023	In progress Due to unforeseen circumstances the meeting between the Medical Director, Executive Director for People, Head of workforce productivity and e-systems had to be rearranged and is in the process of being rescheduled. The Medical



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					Director has suggested a review date of July 2023
5.2	24/10/2022	Audit Recommendations Tracker - Director of Corporate Governance to liaise with Audit Wales on the closure of the recommendations captured in the Clinical Coding Follow Up Review 03 audit.	Director of Corporate Governance	December 2022 Now April 2023	In Progress Meeting held between Audit Wales and the Director of Digital. Further update on progress to be included in the next iteration of the audit recommendations tracker.
4.6	12/12/2022	Medical Rostering - Discussion to be held with the Medical Director outside the meeting in relation to when and who made the decision to not use the Health Roster System within Anaesthetics and the Emergency Department. Discussion also required as to whether the system had been tested within these areas.	Director for People/ Medical Director	April 2023 Now July 2023	In progress Due to unforeseen circumstances the meeting between the Medical Director, Executive Director for People, Head of workforce productivity and e-systems had to be rearranged and is in the process of being rescheduled. The Medical Director has suggested a review date of July 2023
5.3.4	13/02/2023	Internal Audit Review – Medical Variable Pay - Reports outlining the rates that had been agreed above cap to be reinstated and presented to future meetings of the Audit & Risk Committee.	Medical Director	August 2023	In progress Due to unforeseen circumstances the meeting between the Medical Director, Executive Director for People, Head of workforce productivity and e-systems had to be rearranged and is in the



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					process of being rescheduled. The Medical Director has suggested a review date of July 2023
completed Actions					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers were circulated)
5.3.5	12/12/2022	Internal Audit Review – Wellbeing - Further discussion to take place outside the meeting in relation to the outcome of the review. Verbal update to be provided to the February Audit & Risk Committee regarding the outcome of the discussions held.	Head of Internal Audit/Director of Finance	February 2023	Completed Revised report and management response presented to the February Audit & Risk Committee meeting.
2.1.2	13/02/2023	Annual Cycle of Business for 2023 - Annual Cycle of Business to be amended to reflect the comments made regarding discussion of the draft accounts and approval of the final accounts.	Corporate Governance Manager	April 2023	Completed Annual Cycle of Business has been updated.
4.2	13/02/2023	Losses & Special Payments Report - Review to be undertaken outside the	Deputy Director of Nursing	April 2023	Completed/Ongoing The process to address the backlog (pre 6 April 2023)



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		meeting in relation to the 42 Red/Amber deferred cases that were due to hit the six month deadline to determine whether the deadline was imminent or whether these related to the need to submit a blank LFER in order to obtain a further six month extension.			and current (post 6 April 2023) has now been agreed and a report has been presented to the Executive Leadership Group. A workshop with Heads of Quality took place on 4 April 2023 to ensure alignment to Care Group activity. Weekly performance will be reported through the Executive patient safety weekly meeting. Assistant Director for Concerns/Compliance to work with the corporate Head of Finance on reporting mechanisms for potential financial risks consequences.
5.1	13/02/2023	Organisational Risk Register - Response to be provided outside the meeting in relation to a number of queries raised by Independent Members regarding risks contained within the risk register.	Assistant Director of Governance & Risk	April 2023	Completed Risk updates have been added to the March iteration of the Organisational Risk Register to respond to the



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					feedback raised at the ARC in February 2023
5.2	13/02/2023	Audit Recommendations Tracker - Discussions to be held with lead officers in relation to the points highlighted below: - Concerns recommendations – Realistic timeframes to be identified against these recommendations as deadline is being extended by one month at a time; - Princess of Wales Theatres – The update provided seemed to be generic for all recommendations and did not seem to address the specific recommendation made; - Digital recommendations – Revised implementation dates needed to be identified for these recommendations	Corporate Governance Manager	April 2023	Completed Email circulated to Lead Officers who have taken steps to address the points highlighted at the February meeting.



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5.4.2	13/02/2023	Audit Wales Review – Ysbyty Cwm Cynon Minor Injuries Unit - Review to be undertaken of the response provided against recommendation 3 to ensure it covered the Health Board position and not just the position related to Ysbyty Cwm Cynon.	Deputy Director of Nursing	April 2023	Completed The MIU/ENP team were declared as compliant against the audit recommendation. Recommendation by Deputy Executive Director of Nursing for closure of action to be considered with the broader CTM-wide elements of compliance being considered through care group performance mechanism as well as through committees such as People and Culture.



AGENDA ITEM

4.1

AUDIT & RISK COMMITTEE

LOCAL COUNTER FRAUD UPDATE REPORT

Date of meeting

19 April 2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Matthew Evans, Head of Local Counter Fraud Services

Presented by

Matthew Evans, Head of Local Counter Fraud Services

Approving Executive Sponsor

Executive Director of Finance & Procurement

Report purpose

FOR DISCUSSION / REVIEW

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

Committee/Group/Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

ACRONYMS

CFS
Wales

Counter Fraud Service Wales

FI

Financial Investigator

LCFS

Local Counter Fraud Specialist

LPE

Local Proactive Exercise

NHS
CFA

NHS Counter Fraud Authority

1. SITUATION/BACKGROUND

- 1.1 The Health Board is required to comply with NHS Counter Fraud Standards. A counter fraud work plan has been agreed for the year setting out work to meet these standards based around four strategic areas. This report presents the Counter Fraud Work Plan 2023/24 alongside the Counter Fraud Annual Report 2022/23 and the draft annual Functional Standard Return in compliance with standards requirements.

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



5. RECOMMENDATION

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



Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 19 April 2023

Counter Fraud Progress Report

Matthew Evans
Head of Local Counter Fraud Services

1. INTRODUCTION

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

2. BACKGROUND

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

3. RESOURCE UTILISATION

AREA OF WORK	Planned Days	Days to Date
Strategic Governance		
Ensuring that anti-crime measures are embedded at all levels across the organisation	45	52
Inform and Involve		
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.	125	97
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	125	149
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	321	318
TOTAL	616	616

4. STRATEGIC GOVERNANCE

A Counter Fraud Work Plan (Appendix 1) setting out intended activity for 2023/24 has been developed and is presented alongside the Counter Fraud Annual Report 2022/23 (Appendix 2) and draft Functional Standard Return 2022/23 (Appendix 3) for the Committee to review.

5. INFORM AND INVOLVE

The Health Board's programme of awareness for 2022/23 has concluded with an

increase in attendees at a counter fraud awareness training session of over 140% when compared with 2021/22 attendance figures. This is a movement in the right direction but still only represents 1.5% of total staff headcount reached with training and this is below All Wales average. This remains an area to drive forward into 2023/24.

Alongside this contact to the Counter Fraud Team has increased in 2022/23, which may be indicative of increased awareness borne from the other communication mechanisms deployed by the Counter Fraud Team.

Further analysis of the Health Board's awareness levels will be undertaken in 2023/24 with a view to developing informative KPIs beyond attendance at training sessions. Capture of contact and engagement information is being undertaken by the Team into the new year to support this.

6. PREVENT AND DETER

Work around the Health Board's National Fraud Initiative matched dataset has commenced and is proceeding. First assessments of data 210 records related to Payroll to Payroll matches have been completed. These matches are focussed on assessing dual working and working elsewhere whilst sick. Assessment involves accessing employment information for each match and querying any discrepancy and/or concern with the secondary employer. This is reversed where the Health Board is assessed as the secondary employer itself.

Focus will switch to first assessment of Payroll to Creditors and Payroll to Companies House data matches. These data sets look to match Health Board employees with entities with which the Health Board engages with for supply of goods and services. This can highlight potential procurement fraud and/or corruption or undeclared interests.

Review of these matches involves accessing employment records of each payroll match to assess role in line with the records of the procurement of goods/services the matched entity has provided.

A full report will be brought for the Committee's perusal in June 2023 in line with Audit Wales recommendation response.

7. HOLD TO ACCOUNT

The issue around lack of capability of Counter Fraud Services being able to access and carry out Police National Computer checks via NHS Counter Fraud Authority has been resolved. Cases are now able to progress to Crown Prosecution Service without hold awaiting checks to be undertaken on witnesses and suspects as is required.

The status of the LCFS investigative caseload is summarised in Appendix 4 to this report. A summary of basic investigation KPI data is presented.

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

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

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



Item 4.1

Counter Fraud Work Plan 2023/24

Matthew Evans
Head of Counter Fraud Services

19 April 2023

Introduction

Following introduction of new Government Functional Standards on Counter Fraud, which replaced NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)' from 2021/22, the Health Board's Counter Fraud Workplans have been aimed at ensuring compliance for the first enforcement year of the new standards in 2023/24.

Good progress has been made and this is reflected in continuing improvements to RAG ratings for each Standard in self assessed Functional Standard Returns throughout the last two financial years. There are two Standards Components that are still not Green rated however;

- Component 1B - Accountable individual - rated Red
- Component 3 - Fraud bribery and corruption risk assessment - rated Amber

Work Plan action number 30 sets out proposed activity to uplift Competent 1B and Work Plan action numbers 11 & 12 set out activity to uplift Component 3.

The Health Board contracts Swansea Bay UHB via Service Level Agreement for the provision of Counter Fraud Resource. This results in 2.6 FTE of accredited counter fraud specialist resource supplemented by 0.4 FTE admin support which translate to 616 days deliverable for counter fraud activity.

The Work Plan is set around proactive activity covering Inform & Involve, Prevent & Deter and Strategic Governance as well as reactive activity covered by Hold to Account. The planned days are split as proactive days – 296 and reactive days - 320 days. This is in line with delivery of previous years and takes in to account the commitments made within this Work Plan.

INFORM AND INVOLVE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture in line with GovS 013 component 11. Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	Throughout the Year
2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	Throughout the Year
3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	Q2 and Q4
4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	Throughout the Year
5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	Throughout the Year
6	Arrange for pay-slip messages to be utilised during the year as appropriate.	As Appropriate
7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other “beware” notices and relevant messages.	Q2 and Q4

COUNTER FRAUD WORK PLAN 2023/24



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INFORM AND INVOLVE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	Q2
9	In line with GovS 013 Components 4, 7 and 12 undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	Throughout the Year
10	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	Throughout the Year
TOTAL DAYS ALLOCATED		118

PREVENT AND DETER		
	TASK/OBJECTIVE	PROPOSED DELIVERY
10	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	As Appropriate
11	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate in line with GovS 013 component 3.	Throughout the Year
12	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud in line with GovS 013 component 2, GovS 013 component 3 and GovS 013 component 5.	Throughout the Year
13	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010 in line with GovS 013 component 12.	Q1
14	Review and update information sharing protocols currently in place. Review and refresh protocols with key partners of Internal Audit and Workforce & Organisational Development	Q4
15	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Throughout the Year
16	Record and respond to ad-hoc requests for assistance received.	Throughout the Year
17	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	As Appropriate

COUNTER FRAUD WORK PLAN 2023/24



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PREVENT AND DETER		
	TASK/OBJECTIVE	PROPOSED DELIVERY
18	Issue of fraud alerts to all appropriate staff.	As Appropriate
19	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Throughout the Year
20	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	Throughout the Year
21	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	As Required
22	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line with GovS 013 component 10.	Throughout the Year
23	Membership of Local Intelligence Network and attendance at meetings.	As Required
TOTAL DAYS ALLOCATED		130

HOLD TO ACCOUNT		
	TASK/OBJECTIVE	PROPOSED DELIVERY
24	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	As Required
25	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	As Required
26	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	As Required
27	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	As Required
28	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	As Required
29	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities in line with GovS 013 Component 9.	Q1
30	Explore Memorandum of Understanding between South Wales Police and the Health Board to cover matters of joint interest when undertaking investigation. This will look at joint approach too	
TOTAL DAYS ALLOCATED		320

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
29	Attendance at all Fraud Forum meetings held by CFS Wales.	As Required
30	Nominate a Fraud Champion for the Health Board in line with GovS 013 component 1.	Q3
31	Completion and agreement of the annual work plan with Director of Finance in line with GovS 013 component 2.	Q4
32	Completion and agreement of the annual report with Director of Finance	Q1
33	Regular meetings/liaison with Director and/or Assistant Director of Finance	Throughout the Year
34	Preparation for and attendance at Audit Committee meetings.	As Required
35	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Q4 and As Required
36	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	As Required
37	Continuing use of CLUE3 case management system, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise in line with GovS 013 component 8.	Throughout the Year
38	Provide regular reports and <i>ad hoc</i> information to NHS Counter Fraud Authority and Welsh Government as required	Throughout the Year
39	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards in line with GovS 013 component 4 and GovS 013 component 7.	Q2
TOTAL DAYS ALLOCATED		48

SUMMARY TOTALS

	STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
A	INFORM AND INVOLVE	118
B	PREVENT AND DETER	130
C	HOLD TO ACCOUNT	320
D	STRATEGIC GOVERNANCE	48
	TOTAL	616



Cwm Taf Morgannwg University Health Board

Counter Fraud Annual Report 2022/23

Matthew Evans

19 April 2023

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1. Introduction

This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Functional Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.

The Counter Fraud Work Plan for 2022/23 was approved by the Audit Committee in April 2022 and identified a total resource of 616 days for the year. The Counter Fraud Team delivered 616 days of counter fraud activity. The total cost for the provision of local counter fraud services for the year was £151,273.

For ease of reference and in line with the Work Plan, this report is structured under in line with Functional Standards Requirements of Counter Fraud activity. The annual report should be completed in enough detail to enable the responsible officers within the organisation to gain sufficient assurance that the counter fraud, bribery and corruption work undertaken is compliant with the Functional Standard Requirements and has been completed in line with organisations counter fraud workplan.

When the required work has not been completed against the counter fraud work plan or is not fully compliant with the Functional Standard Requirements details of the corrective actions to be undertaken should be reported.

2. Executive summary of organisational compliance

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2022/23 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic risk-based approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud activity. Flexibility contained in the work plan allowed high-risk work to be undertaken urgently and dynamically.

Progress against the plan has been monitored during meetings with the Director of Finance, with update reports produced and presented to the Audit Committee in line with its agreed work programme.

The Counter Fraud Team continue to attend meetings and forums organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter

Fraud Authority Training Delivery Leads to deliver key skills development sessions, refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. From 2021/22 NHS Wales adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. Counter Fraud work since that introduction has been focussed on building or maintaining compliance with the new standards. Since 2021/22 the Health Board has shown continual annual improvement in ratings against the Standards or maintained ratings.

There are two Standards Components that remain below Green rated however; Component 1B - Accountable individual - rated Red and Component 3 - Fraud bribery and corruption risk assessment - rated Amber.

Component 1B – Accountable Individual

This Standard is currently rated Red due to the Health Board currently holding a vacancy for the Fraud Champion role. The Health Board's Director of Corporate Governance was identified as the most suitable Senior Officer to meet the requirements of the Fraud Champion role and a nomination was subsequently completed. The Director in role left the Organisation in the review period thereby vacating the Fraud Champion at same time.

In the interim responsibilities of the Director of Corporate Governance role have been met by the Assistant Director of Governance and Risk. The Fraud Champion role has been picked up as part of this arrangement and support has been given around the implementation of fraud risk recording via DATIX, furthering counter fraud awareness at induction under Corporate Governance input, and supporting work around Standards of Behaviour Policy fraud proofing. The Counter Fraud Team are grateful for this ongoing support and there is a case to say the Fraud Champion role has been discharged in spirit.

Without a formal nomination however the rating for this Component is assessed as Red. All other elements of this Component are met and would be assessed as Green. A simple action plan of seeking nomination of the incoming Director of Corporate Governance upon appointment alongside maintaining current performance will uplift this rating to Green in 2023/24.

Component 3 - Fraud Bribery and Corruption Risk Assessment

This Component is currently rated as Amber due to the requirements for maturity of this area of work to enable demonstration of continuous monitoring of fraud risk at a senior level, evidence of subsequent risk mitigation and that review of resources has been undertaken to ensure levels are suitable for this purpose.

Since introduction of this Component the Counter Fraud Team have sought to establish the fraud risk assessment processes aligned to the Health Board's existing Risk Management procedures.

The Team have then created a core fraud risk profile developed from 129 NHS fraud risk descriptors. Alongside this further scanning has been undertaken to capture and manage emerging fraud risks such as arising from investigation, Fraud Prevention Notices, local intelligence, audit reports and findings, and NHS CFA IBURN releases. A tracker has been created to track and manage the actions around these known and emerging fraud risks.

LCFSs have subsequently sought to undertake comprehensive risk assessments in liaison with local risk owners to establish a core foundation of assessments to work from. Arrangements have been made to record those risks on the DATIX system which will be utilised from 2023/24 to manage, track and measure fraud risk within the Health Board.

Use of the DATIX system, alongside the local tracker, will allow evidence to be developed to meet the remaining elements outstanding to uplift this Component to Green.

3. Declaration of compliance against the Functional Standard Requirements at the end of March 2022

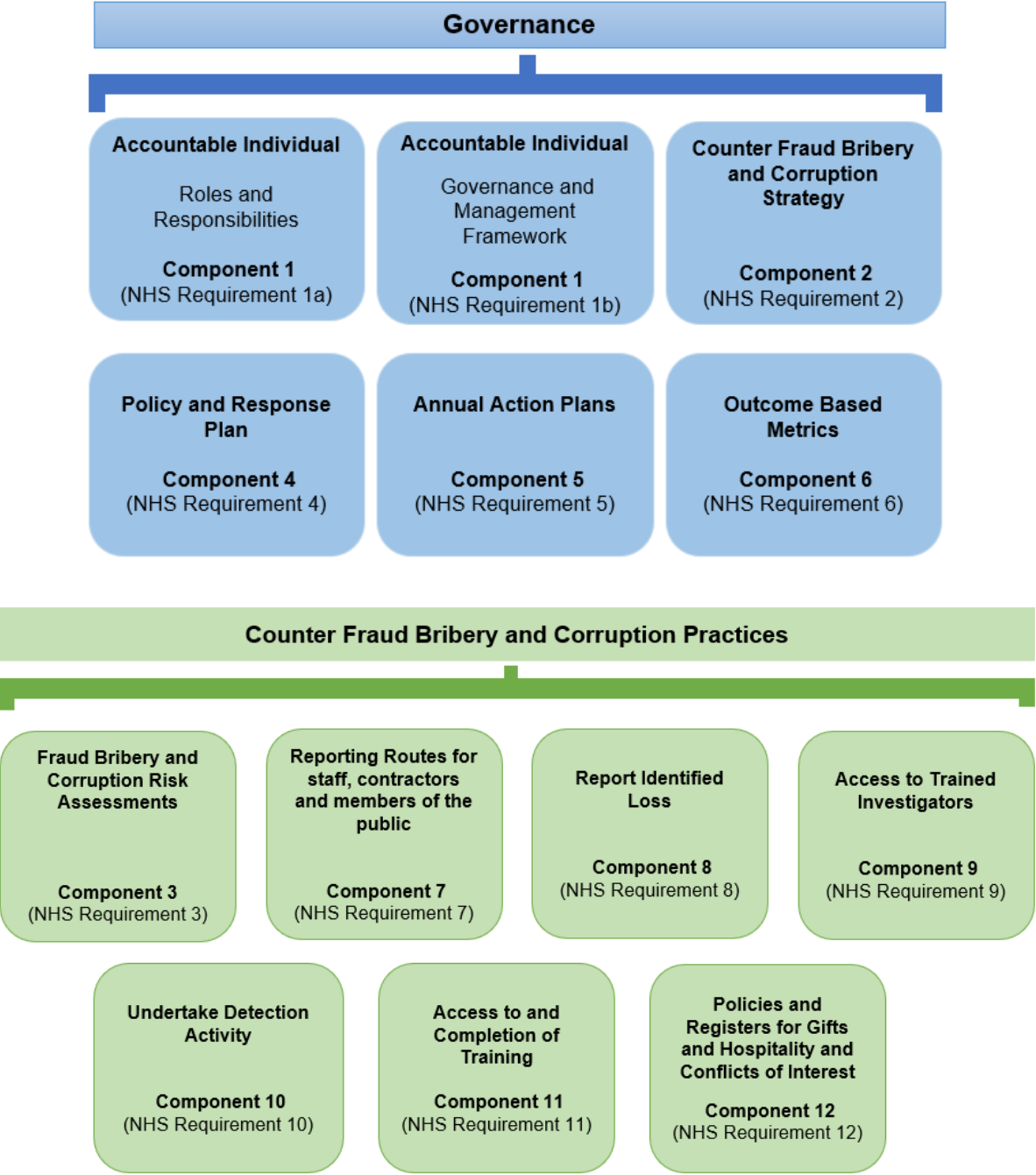
The annual report must contain one of the declarations listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2021-22 has been self-reviewed against the Functional Standard Requirements relating to fraud, bribery and corruption, and that the above rating has been achieved.

Organisation	Cwm Taf Morgannwg University Health Board
Accountable Board Member Signature	
Date	

4. Work carried out against the Functional Standard Requirements



Governance

This section of the annual report outlines how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption.

Work relating to each Governance Component of the Functional Standard is summarised and current and previous rating for each Requirement is set out below.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 1 Accountable individual	NHS Requirement 1A	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in gaining assurance and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.	GREEN	RED	NHSCFA proactive exercise reports have been presented to the Health Board's Audit Committee. A concluding report Quality & Assurance evaluation has also been presented to Audit Committee which highlighted work undertaken in response to findings. The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the template. This includes details of the Functional Standard Return for review. The Fraud Champion left employment with the Health Board in the review period. The Fraud Champion role has been delivered on an interim basis by the Health Board's Assistant Director of Governance and Risk. This includes supporting the implementation of fraud risk recording via DATIX, furthering counter fraud awareness at induction under Corporate Governance input, and supporting work around Standards of Behaviour Policy fraud proofing. The incoming Director of Corporate Governance will be approached for

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					nomination as the Health Board's Fraud Champion upon appointment.
Component 2 Counter fraud bribery and corruption strategy	NHS Requirement 2	This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is aligned to the objectives of the strategy and locally identified risks.	GREEN	GREEN	The Health Board's Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks The CFP&RP and work plan are agreed by Director of Finance and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 4 Policy and response plan	NHS Requirement 4	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. A full review was undertaken in March 2023. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy. Staff awareness of these key policy documents is measured using questionnaires and a survey issued in March 2022. Further surveys were undertaken on a targeted basis in November 2022.
Component 5 Annual Action Plan	NHS Requirement 5	This Component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.	GREEN	GREEN	A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is allocated in line with this within the context of 4 strategic areas of counter fraud activity; Inform and involve, prevent and deter, hold to account and strategic governance. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					and regular reporting to Audit Committee. Allocated resource is included as part of this regular reporting along with benchmarking of overall resource availability.
Component 6 Outcome based metrics	NHS Requirement 6	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	GREEN	GREEN	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism.

Counter Fraud Bribery and Corruption Practices

This section of the annual report outlines the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The organisation should report against each Counter Fraud Practice Component, under the Functional Standard and summarise the work completed to meet each Requirement. A high-level summary of each of the Counter Fraud Practice Components is set out below.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 3 Fraud bribery and corruption risk assessment	NHS Requirement 3	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	AMBER	AMBER	Comprehensive risk assessments are carried out in line with the GCFP methodology and recording aligns to the Health Board's Risk Management Policy. The annual counter fraud work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments, development of a fraud risk profile around core risk areas, implementation of managing fraud risk via DATIX, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments. Action plan to lift rating to Green is to utilise results of previous work to effectively

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					demonstrate monitoring of risk with measurable outcomes.
Component 7 Reporting routes for staff, contractors and members of the public	NHS Requirement 7	This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.	GREEN	GREEN	The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. Reporting routes are also highlighted within counter fraud awareness training, newsletters and communications, included on the Counter Fraud Intranet pages and highlighted in the Counter Fraud Information Booklet available for staff. Reporting routes include a central Counter Fraud email inbox, email and phone directly to LCFSSs, a Microsoft Forms Fraud Reporting form, the National Fraud and Corruption Reporting Line as well as alternative reporting routes to Director of Finance and whistleblowing charity Protect-Public Concern at Work. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					the commencement of 34 new investigations in 2022/23. Surveys have been undertaken in March and November 2022 to measure effectiveness.
Component 8 Report identified loss	NHS Requirement 8	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	GREEN	The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis.
Component 9 Access to trained investigators	NHS Requirement 9	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional	GREEN	GREEN	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS,

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
		development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.			who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2022/23 was 2.6 FTE.
Component 10 Undertake detection activity	NHS Requirement 10	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	GREEN	GREEN	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk assessments are considered as part of this work and completed where necessary. As a result of this information and intelligence review

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					process the Counter Fraud Team have registered 3 local proactive exercises on the case management system in 2022/23.
Component 11 Access to and completion of training	NHS Requirement 11	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations and e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts. The awareness programme is sufficient to achieve a Green rating but is an area highlighted for improvement. Work has been undertaken including risk based training resulting from proactive work, roll out of training to new areas such as GMS Contractors, targeting of high volume groups of staff following reintroduction of such meetings following Covid, refresh of existing communication methods such as the counter fraud intranet pages and introduction

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					of short form counter fraud awareness articles. Contact with the Counter Fraud Team has increased as a result but this remains an area to seek continued improvement despite Green rating.
Component 12 Policies and registers for gifts and hospitality and Conflicts of Interest	NHS Requirement 12	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations. Testing of staff awareness of the Policy has been included in surveys issued in March and November 2022.

5. Appendices

Appendix 1 – Counter Fraud Activity

This section of the annual report should detail the total counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Area of activity	Days used
Proactive work	298
Reactive work	318
Total days used	616

Appendix 2 – Counter Fraud Costs

This section of the annual report should detail the total costs of the counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Cost of Counter Fraud, Bribery and Corruption Work	Total Costs £
Proactive costs	£73180
Reactive costs	£78092
Total costs	£151273

Appendix 3 – Nominations Overview

This section of the annual report should detail the nominated officers at the organisation during the reporting period, including all supporting LCFS. If any of the nominations have changed during the year, the date of the change should be included.

The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B and 9.

Role	Name of Nominated Person
Accountable Board Member	Sally May
Audit Committee Chair	Patsy Roseblade
Fraud Champion	Vacant
Lead LCFS	Matthew Evans
Supporting LCFS	Beverley Jones
Supporting LCFS	Alison Williams

Appendix 4 – Investigation Information

This section of the annual report should detail all the activity recorded on the CLUE Case Management System. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6, 7 and 8.

Investigation Information	Number
Investigations carried forward from 2020/21	10
Investigations Opened during the period	34
Investigations Closed during period	31
Investigations Ongoing	13

Appendix 5 – Risk Based Exercises

This section of the annual report should detail all the Fraud Risk Assessments (FRAs), Local Proactive Exercises (LPEs) and System Weakness Reports (SWRs) undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the NHS Counter Functional Standard NHS Requirement 1B, 3, 5, 6, 8 and 10.

Fraud Risk Assessments	Number
Number of FRAs reviewed in line with the organisations risk management policy	4

Local Proactive Exercises	Number
Number of LPEs conducted during the year	3
Number of LPEs recorded on the NHS CFA Case management system as per component 8	3
Number of LPEs concluded during the year	2

System Weakness Reports	Number
Number of SWRs identified during the year	0
Number of SWRs concluded during the year on the NHS CFA Case management system as per component 8	0
Number of new processes adapted or introduced as a result of SWRs	0

Appendix 6 - Sanction & Redress Overview

This section of the annual report should detail of any sanctions and redress activity undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6 and 8.

Sanction Imposed	Number
Disciplinary	1
Civil	12
Criminal	0
Total Sanctions	13

Redress Imposed	Total Amount £
Fraud identified	£63070
Fraud Prevented	£134,257
Fraud Recovered	£63070

Counter Fraud Functional Standard Return (2022/2023)

**CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH
BOARD**

Your Overall Rating is:

Green

Submitted By:

Organisational information

Name of the organisation	CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD
Annual budget of the organisation	Over £ 1 billion
Staff headcount at the organisation including contracted employees	10,000 to 15,000
Organisation code	7A5
Organisation/provider type	Health Board
For which provider organisations are you the commissioner? Co-ordinating Commissioner for this provider	WALES Co-ordinating Commissioner for this provider
Region	Wales
NHS England region	Wales

Personnel information

Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management	Sally May
Name of the Local Counter Fraud Specialist	Matthew Evans
Email of the Local Counter Fraud Specialist	matthew.evans20@wales.nhs.uk
Name of the counter fraud provider organisation (including in-house)	Other Swansea Bay UHB
Counter fraud provider type	Wales
Name of the Chair of the Audit Committee / equivalent body	Patsy Roseblade
Email of the Chair of Audit Committee / equivalent body	patsy.roseblade@wales.nhs.uk
Name of the Counter Fraud Champion	Vacant
Email of the Counter Fraud Champion	Vacant@vacant.com

Costs and days information

Proactive days used (Maximum 3 digits)	298
Reactive days used (Maximum 3 digits)	318
Total days used for counter fraud work	616
Cost of counter fraud staffing per financial year - Proactive	73180.23
Cost of counter fraud staffing per financial year - Reactive	78092.77
Total costs for counter fraud work	151273

Reactive information

Number of incidents received during the most recent financial year	34
Number of investigations opened during the most recent financial year	34
Number of investigations closed during the most recent financial year	31
Number of investigations open as at 31/03/2023	13
Amount of fraud losses identified during the most recent financial year	63070.18
Amount of fraud losses recovered during the most recent financial year	63070.18
Amount of fraud losses prevented from reactive work during the most recent financial year	134257.00
Number of criminal sanctions applied during the year	0
Number of civil sanctions applied during the year	12
Number of disciplinary sanctions applied during the year	1

Proactive information

Number of proactive exercises conducted during the most recent financial year	3
Amount of fraud losses identified from proactive exercises during the most recent financial year	116500.00
Amount of fraud losses prevented from proactive exercises during the most recent financial year	116500.00
Amount of fraud losses recovered from proactive exercises during the most recent financial year	116500.00

1: Accountable individual

NHS Requirement 1A:

A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. N. B. ‘Equivalent body’ may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation

Your Rating is: Green

Comments:

The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.

NHS Requirement 1B:

The organisation’s non-executive directors, counter fraud champion or lay members and board /governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.

Your Rating is: Red

Comments:

NHSCFA proactive exercise reports have been presented to the Health Board's Audit Committee. A concluding report Quality & Assurance evaluation has also been presented to Audit Committee which highlighted work undertaken in response to findings. The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the template. This includes details of the Functional Standard Return for review. The Fraud Champion left employment with the Health Board in the review period. The Fraud Champion role has been delivered on an interim basis by the Health Board's Assistant Director of Governance and Risk. This includes supporting the implementation of fraud risk recording via DATIX, furthering counter fraud awareness at induction under Corporate Governance input, and supporting work around Standards of Behaviour Policy fraud proofing. The incoming Director of Corporate Governance will be approached for nomination as the Health Board's Fraud Champion upon appointment.

2: Counter fraud bribery and corruption strategy

NHS Requirement 2:

The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. (The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)

Your Rating is: Green

Comments:

The Health Board’s Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. The CFP&RP and work plan are agreed by Director of Finance and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.

3: Fraud bribery and corruption risk assessment

NHS Requirement 3:

The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation’s risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.

Your Rating is: Amber

Comments:

Comprehensive risk assessments are carried out in line with the GCFP methodology and recording aligns to the Health Board’s Risk Management Policy. The annual counter fraud work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments, development of a fraud risk profile around core risk areas, implementation of managing fraud risk via DATIX, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments. Action plan to lift rating to Green is to utilise results of previous work to effectively demonstrate monitoring of risk with measurable outcomes.

4: Policy and response plan

NHS Requirement 4:

The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA’s strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: Green

Comments:

The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. A full review was undertaken in March 2023. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy. Staff awareness of these key policy documents is measured using questionnaires and a survey issued in March 2022. Further surveys were undertaken on a targeted basis in November 2022.

5: Annual action plan

NHS Requirement 5:

The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).

Your Rating is: Green

Comments:

A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is allocated in line with this within the context of 4 strategic areas of counter fraud activity; Inform and involve, prevent and deter, hold to account and strategic governance. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance and regular reporting to Audit Committee. Allocated resource is included as part of this regular reporting along with benchmarking of overall resource availability.

6: Outcome-based metrics

NHS Requirement 6:

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.

Your Rating is: Green

Comments:

All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism.

7: Reporting routes for staff, contractors and members of the public

NHS Requirement 7:

The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA’s Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: Green

Comments:

The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. Reporting routes are also highlighted within counter fraud awareness training, newsletters and communications, included on the Counter Fraud Intranet pages and highlighted in the Counter Fraud Information Booklet available for staff. Reporting routes include a central Counter Fraud email inbox, email and phone directly to LCFSSs, a Microsoft Forms Fraud Reporting form, the National Fraud and Corruption Reporting Line as well as alternative reporting routes to Director of Finance and whistleblowing charity Protect-Public Concern at Work. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of 34 new investigations in 2022/23. Surveys have been undertaken in March and November 2022 to measure effectiveness.

8: Report identified loss

NHS Requirement 8:

The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises

Your Rating is: Green

Comments:

The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis.

9: Access to trained investigators

NHS Requirement 9:

The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.

Your Rating is: Green

Comments:

Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2022/23 was 2.6 FTE.

10: Undertake detection activity

NHS Requirement 10:

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.

Your Rating is: Green

Comments:

LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk assessments are considered as part of this work and completed where necessary. As a result of this information and intelligence review process the Counter Fraud Team have registered 3 local proactive exercises on the case management system in 2022/23.

11: Access to and completion of training

NHS Requirement 11:

The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA’s fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.

Your Rating is: Green

Comments:

The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations and e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts. The awareness programme is sufficient to achieve a Green rating but is an area highlighted for improvement. Work has been undertaken including risk based training resulting from proactive work, roll out of training to new areas such as GMS Contractors, targeting of high volume groups of staff following reintroduction of such meetings following Covid, refresh of existing communication methods such as the counter fraud intranet pages and introduction of short form counter fraud awareness articles. Contact with the Counter Fraud Team has increased as a result but this remains an area to seek continued improvement despite Green rating.

12: Policies and registers for gifts and hospitality and COI.

NHS Requirement 12:

The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested.

Your Rating is: Green

Comments:

The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations. Testing of staff awareness of the Policy has been included in surveys issued in March and November 2022.

ACC Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.As the Audit Committee Chair, and in line with the audit committee's responsibility for the strategic assurance and oversight of counter fraud work as described in section 5.6 of the NHS Audit Committee Handbook, I confirm that the information contained in this self review for RYA reflects the work reported and considered by the Audit Committee.

.....

DOF Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for PROVIDER anti-fraud, bribery and corruption. As the responsible member of the executive board or equivalent body I confirm that by ticking this authorisation box the information contained in this self review for RYA is correct and complete.

Declaration

Overall Rating

Please ensure that this Functional Standard Return has been fully completed. If your director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.



Item 4.1

Counter Fraud Investigations Update Report

19 April 2023

Summary

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

Cases being actively investigated by the Counter Fraud Team are listed in the [Open Cases](#) table.

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

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

Case Status

Cases Under Investigation

13

Cases Pending 3rd Party Outcome

0

Cases Closed 2022/23

31

Case Rates

Referrals Received 2022/23

34

Cases Under Investigation for Over 12 Months

2

Sanctions/Outcomes

Criminal Sanctions

0

Civil Sanctions (Inc. Financial Recovery)

12

Disciplinary Sanctions

1

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	A full committal file has been submitted to CPS for consideration for prosecution. Based on assessment of evidence charges are anticipated. A first review of prosecution file has been completed by CPS Prosecutor, an action plan was set and returned the same week. Further review has been undertaken by CPS and LCFS investigators have met with Prosecutors and charges have been decided. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are investigating potential criminal fraud offences committed against that organisation and assessing professional registration concerns.

Open Cases			
Reference Number	Date Opened	Allegation	Status
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. Subject has failed to attend interview. Subject has denied receiving payments and has given bank mandate authority for Financial Investigator to access account information to assess. This has caused issues however with Bank not releasing information. Transaction data will be gathered Health Board side. A case conference was held with CFS Wales in March 2023 to discuss prosecution file, an action plan was agreed and is being followed up on to finalise lines of enquiry.
INV/22/00707	21/06/2022	Leave Fraud	False information given in order to gain Special Leave. Investigation have established evidence corroborating allegation. This was shared with managers and parallel disciplinary and fraud investigations ongoing. An interview is being planned to gain account from subject. Given the low level of criminal fraud and the swift advancement of the disciplinary case that process was taking precedence. However processes have slowed due to health matters. That process will still take primacy given the circumstances.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/01138	18/08/2022	Non-completion of contracted hours and leave fraud	Evidence has been established of working patterns via digital and locally held records these are being assessed against timesheets and leave records. Approaches have been made to potential witnesses who have provided account. Further evidence was held by witness which will form part of investigation. Investigation proceeding with interview of subject considered for next actions.
INV/22/01233	06/09/2022	Overpayment of salary	Enquires have established that subject had a fixed term contract related to Covid recruitment. This should have ended and subject continued to work for Bank. Enquiries have established an overpayment with gross value of £7766.33. An interview has been undertaken and account gained from subject. Follow up enquiries have been undertaken and a second interview to cover findings has been arranged in April 2023.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/01512	18/10/2022	Falsification of qualifications amongst care home staff	Anonymous allegation received via the NHS fraud and corruption reporting line. Enquiries have established that the care home in allegation has closed down. Information has been sought from Health Board regarding potential impact on any NHS funded services. Information has also been shared with Rhondda Cynon Taf (RCT) Council for their consideration, RCT Council confirmed that the care home closed due to an HMRC winding up order. RCT subsequently had to step in to ensure continuation of service. Full details have been shared. Care Inspectorate Wales (CIW) have also been engaged. CIW had inspected this care home prior to closure and had knowledge of similar allegations as part of inspection. Inspection paperwork has been requested in order to review findings.
INV/22/01513	18/10/2022	Timesheet Fraud	Allegation that staff have been accessing their work rosters to add in additional hours. Enquiries have centred on the e-roster and full details of accesses and sign offs around the subject have been gained. The system has been found to allow alterations but not same person finalisation. System audit trails around alterations and finalisation are being examined.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/01535	21/10/2022	Timesheet Fraud	Allegation received via the NHS fraud and corruption reporting line. Staff member alleged to be taking more SPA time than other staff and using SPA time to avoid completing additional shifts. Enquiries have uncovered that the subject has a high SPA usage but this is relative based on their part time status. It was established that there is no guidance on SPA allocation for part time vs full time staff and this is being addressed by the Director of Nursing. Records of SPA activity for the subject are being sought to review as part of enquiries.
INV/23/00117	16/01/2023	Prescription Fraud	Patient presented falsified prescription for controlled drugs at a community pharmacy. Prescription found to be a genuine blank NHS script which was stolen from an independent prescriber at another pharmacy believed to have been handwritten by the person presenting. Police are investigating, LCFS is supporting via the drugs liaison officer and reviewing risk. Follow up on this suggests that the Police attended Pharmacy with intent to gain details to apprehend offender. Pharmacy advised that they only wanted a crime number and Police disengaged. This was raised with the Drugs Liaison Officer who advised to contact Officer in Case and explain that the NHS is the victim in this case and request investigation be reopened on that basis.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/00447	06/03/2023	Working Elsewhere Whilst Sick	Allegation highlighted via the National Fraud Initiative. NFI enquiries have established that a member of staff reporting sick to has worked 7 Bank shifts with another Health Board during the sickness absence. Enquiries are being undertaken to collate evidence around the sickness and bank shifts worked. An interview will be considered once information assessed.
INV/23/00498	23/03/2023	Non-disclosure of Criminal Conviction and Theft	Allegation received via Fraud and Corruption Reporting Line. Allegation states that subject is using drugs from the wards they work on, is often sleeping in car for hours whilst on shift, has been stealing ancillary products from wards, and has a previous conviction. Enquiries have established subject is a bank worker. Information has been shared with WOD colleagues and investigation is ongoing to corroborate allegation.
INV/23/00505	15/03/2023	Overpayment of Salary	A staff member who has now terminated their employment with CTM UHB has been overpaid salary relating to maternity pay for the period 16.02.22. to 16.12.22 Gross £29,636.31. Investigation has been allocated to CFS Wales Financial Investigator to work jointly with LCFS due to criteria for Financial Investigations. Financial investigations are underway and information will subsequently be assessed to inform next actions.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/00526	20/03/2023	Prescribing	Concerns over prescribing of Controlled Drugs, Shortec (Oxycodone). Patient representative presented two prescriptions for Shortec and stated to Pharmacist that their mother had told them not to take the two prescriptions to the same Pharmacy. The Prescriptions were dated the same day. A case conference was held with Medical Professional Standards, Pharmacy, Primary Care and Medicines Management colleagues. Information had also been reported to Police. Evidence at this stage suggested that these are genuine prescriptions. Action plan was agreed at this meeting for Professional Standards, Pharmacy, Primary Care to visit the prescribing practice to assess patient records. Any discrepancy found at that visit within records could be indicative of fraud and this would then be picked up for criminal investigation. No discrepancy would suggest professional prescribing issue and be dealt with under those processes. Police were in agreement with action plan.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
INV/22/00563	19/05/2022	Overpayment of Salary	The subject has been overpaid in error for an extensive period following their employment on a temporary contract on the CTM UHB Covid vaccination program. Information collated suggests 2 posts were being paid for the same role, 1 fixed term contract and 1 bank. An interview has been undertaken and account gained from subject. A case file was being prepared for CPS consideration however evidence was produced via the subject's solicitor of text messages between the Health Board manager and subject in which the manager accepted full responsibility for the situation and issuing apology. Additionally, the manager came forward and recalled a conversation with the subject in which they discussed the potential of an overpayment. The subject had maintained that they had made this disclosure during interview. Taken together this new evidence had the effect of undermining the prosecution and assisting the defence subsequently the investigation was discontinued as no realistic prospect of conviction was maintained. The matter was referred back for normal recovery processes to take effect.
INV/22/01137	18/08/2022	Patient selling prescribed medication	Originally reported by member of public known to subject. Information was shared with Police who initially sought to investigate. Intelligence was

			established that there is a long running dispute between the parties. Police concluded their enquiries with logging information as intelligence only. This case was discussed with the South Wales Police Drugs Liaison Officer during a recent meeting; they have stated intent to undertake a review of case and to reopen if findings suggest this is appropriate.
INV/22/01232	06/09/2022	Overpayment of salary	Enquiries have established an overpayment with gross value of £7628.47 following leaving Health Board employment. An interview has been undertaken to gain account from subject. The subject attended interview and gave full admission of having knowledge of payments and spending money when not entitled to. The subject has provided mitigation of conduct and bank account activity was reviewed which corroborated this. The case was assessed as not in the public interest to continue to prosecution in line with the Full Code Test. Matters that were considered in this assessment: The subject was assessed to be classed as a vulnerable adult; The subject utilised money for ordinary means including food, utilities in support of her children. No funds were found to have been spent on lavish lifestyle purchases; The subject had entered into an IVA for debts in efforts to address the extreme financial hardship they face for other debts;

			The subject fully engaged with the process and has made efforts alongside commitments to repay money. The normal recovery processes have commenced and the subject has engaged with this with initial payment plan proposed with commitments to increase payments once subject returns to work.



AGENDA ITEM

4.2

AUDIT & RISK COMMITTEE

PROCUREMENT & SCHEME OF DELEGATION REPORT

Date of meeting

19/04/2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Owen James, Head of Corporate Finance

Presented by

Sally May, Executive Director Finance & Procurement

Approving Executive Sponsor

Executive Director of Finance & Procurement

Report purpose

FOR APPROVAL

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

Committee/Group/Individuals

Date

Outcome

Choose an item.

ACRONYMS

OJEU

Official Journal of the European Union

FCPs

Financial Control Procedures

SoD

Scheme of Delegation

1. SITUATION/BACKGROUND

1.1 Procurement Matters

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

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

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

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

This report provides details of any such transactions within the period 01.01.23 to 31.03.23.

1.2 Purchase to Pay

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

1.3 Scheme of Delegation and Financial Control Procedures

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

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

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

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.01.23 to 31.03.23.



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

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

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Table A** below provides details of such actions during the period 01.01.23 to 31.03.23

Table A – Single Tender Actions 01.01.23 to 31.03.23

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1632	Revenue	Medicine CSG	Outsourcing of patients waiting for DEXA scan	University of South Wales	£43,000	c)	07/02/23
1644	Capital	Medicine	Ultrasound Tissue Characterisation	UTC Imaging BV	£38,000	c)	30/03/23
1647	Capital	Capital Estates	Ty Lidiard Ward Reconfiguration	ADJ Architects	£42,470	a)	16/03/23
1649	Capital	Multi Department	Pule Oximeters & Sedline Modules	Masimmo Ltd	£93,131	d)	08/03/23
1651	Revenue	Estates	Rental of Emergency Standby Generators at RGH	Power Electrics Bristol	£70,600	d)	24/03/23
1655	Revenue	ICT	2 databases of existing Audiology system between CTM and Bridgend	Auditdata	£26,750	c)	21/03/23



1657	Revenue	Pathology	AI software	IBEX	£30,400	a)	27/03/23

Reasons for approval:

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

b) Compatibility issue

c) Genuine 1 provider

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

STA 1649 Pule Oximeters & Sedline Modules

Capital Scheme E775-Theatres/Recovery/ICU RGH

The capital purchase is a one off. There is already a MASIMO pulse oximetry sensor/accessories agreement in place with CTM UHB for agreed prices/quantities for re-usable and disposable probes which multiple departments purchase. Massimino technology has been evaluated and agreed by Anaesthetists as preferred option. This equipment is compatible with existing equipment in the HB.

STA 1651 Rental Hire of Emergency Stand-by Generator at Royal Glamorgan Hospital

Investigations are still ongoing into the failure of the electrical switchboard and if there was to be another failure and the temporary generators removed from site, and in addition the power supply from outside of the site failed the hospital would be without electricity resulting in another major incident putting patients at risk. Due to the size of the generators required, and the shortage of availability, should the current generators on site be returned there would be issues in re-procuring replacements Therefore it is essential the generators remain in place until investigations into the original failures are completed.

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

None

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to 28th February 2023.

The Health Board has seen an improvement in the PSPP figures and has met its 95% target of paying non-NHS invoices within 30 days to Month 11 2022-23 achieving 95.1% (value 94.1%). This compares to 95.3% (value 93.8%) to Month 11 2021-22.

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-22	20,667	46,929,829	21,611	49,682,932	95.6	94.5
May-22	19,217	43,766,897	19,796	46,596,405	97.1	93.9
Jun-22	25,864	43,490,528	26,670	45,686,653	97.0	95.2
Jul-22	17,617	36,630,680	18,805	39,207,371	93.7	93.4
Aug-22	25,176	40,169,264	26,188	41,979,225	96.1	95.7
Sept-22	15,971	40,186,028	18,535	43,957,740	86.2	91.4
Oct-22	15,379	38,744,175	17,396	41,928,025	88.4	92.4
Nov-22	27,952	61,336,526	28,645	63,848,835	97.6	96.1
Dec-22	28,584	75,075,031	29,113	76,887,619	98.2	97.6
Jan-22	21,966	54,801,133	23,335	61,217,475	94.1	89.5
Feb-22	23,446	62,686,157	24,207	67,236,495	96.9	93.2
YTD	241,839	543,816,248	254,301	578,228,775	95.1	94.1

The NHS invoice position continues to be challenging and shows that 81.9% (number) and 96.5% (value) of invoices were paid within 30 days to month 11 2022-23. (79.6% (number) and 96.1% (value) for the same period in 2021-22).

Scheme of Delegation and Financial Control Procedures

Please see attached in Appendix 1, the updated Financial Control Procedure for FP17 - Patient's Property, Income and Allowances. This has been put onto the corporate policy template, so track changes have not been able to be followed. However, there is a record of all changes to the previous FCP available if required.

This has been shared with senior managers across the organisation for review and comment before submission for approval. The policy has been

reviewed and is consistent with the approach across NHS Wales / legislation.

An Equality Impact Assessment has been carried out and it is deemed that there is no equality issues arising from the review of the policy.

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

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

3.1 N/A

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outlined 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.	Yes If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below. Yes – available from Owen James – Head of Corporate Finance
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

The Audit & Risk Committee is asked to:

- a) **NOTE** the position on procurement matters for the period 01.01.23 to 31.03.23;
- b) **NOTE** the update regarding Purchase to Pay and achievement of PSPP target to 28.02.203;
- c) **APPROVE** the updated Financial Control Procedure for Patient's Property, Income & Allowances.

FINANCIAL CONTROL PROCEDURE:

PATIENT'S PROPERTY, INCOME AND ALLOWANCES

Document Type:	Non Clinical Organisational Wide Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk)
Author:	(Name and Title of Document Author)
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	Audit & Risk Committee
Approval / Effective Date:	19/04/2023
Review Date:	20/04/2026
Version:	

Target Audience:

People who need to know about this document in detail	Organisation wide audience
People who need to have a broad understanding of this document	(For example: Board Members, Management Board. Senior Leaders. Board Committees.)
People who need to know that this document exists	(For example: All staff involved in the development of Health Board Policies.)

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date:
	Outcome:
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.



Disclaimer:

Ref: FP 17

Policy Title: PATIENT'S PROPERTY, INCOME AND ALLOWANCES

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If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

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2. Scope of Policy
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APPENDICES

Ref: FP 17

Policy Title: PATIENT'S PROPERTY, INCOME AND ALLOWANCES

Page Number: 2

INTRODUCTION

1. POLICY STATEMENT

- 1.1 The Cwm Taf Morgannwg University Health Board (UHB) has a legal responsibility to safeguard any patient's monies and property that is handed over for safekeeping and to return it to the patient on discharge.
- 1.2 This procedure fulfils the following purposes:
- To ensure that the interests of the patient, the staff and the UHB are fully protected.
 - To guide in the procedures to be adopted for receiving, recording and disposing of property on behalf of the patient.

2. SCOPE OF POLICY

- 2.1. The procedure covers both short stay and long stay patients. A short stay patient will normally have a known discharge date, which in most cases will not be greater than 6 weeks. Long term patients are usually those in elderly care and mental health care whose length of stay is unknown.

3. AIMS AND OBJECTIVES

- 3.1. This procedure fulfils the following purposes:
- To ensure that the interests of the patient, the staff and the UHB are fully protected.
 - To guide in the procedures to be adopted for receiving, recording and disposing of property on behalf of the patient.

4. FORMS

- 4.1. The following forms are referred to within this Financial Procedure. They are either included as appendices or in the case of controlled stationery noted with the issuing source.

Appendix	Name of Form	To be used by:
1	Patient's Property – Disclaimer Form	Wards
2	Investment of Patients' Monies: Court of Protection	Finance
3	Application for cash withdrawal on behalf of patient.	Wards (Long stay Only)

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4	Authorisation Form for Patient's Purchases	Wards (Long stay Only)
5	Record of Transfer Form	Wards
6	Bank Transfer Form	Wards/General Office

Controlled stationery	Name of Form	Issued by:	To be used by:
CS 1	Ward Property Book (On Admission)	General Office	Wards
CS 2	Register of Patient's Property	Finance	General Office
CS 3	Patient's Ledger Sheet	Finance	General Office
CS 4	Request to Open Current Account	Finance	General Office/ Finance
CS 5	Summary of Patient's Private Monies paid from Petty Cash	Finance	General Office/ Finance
CS 6	Payment Request Form	Finance	General Office/ Finance
CS 7	Record of Private Property and Clothing retained on the ward	General Office	Wards (Long stay Only)
CS 8	Form of Indemnity	Finance	General Office/ Finance

Please note that the references CS 1 to CS 8 are to aid in the understanding of this Financial Procedure and are not included as a reference on the forms themselves.

5. WARD PROCEDURE: SHORT STAY PATIENTS

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5.1. **Planned Admissions**

- 5.1.1. Where admission to hospital is planned, the patient is advised in advance not to bring in any valuables. On arrival at the Hospital, the patient must be advised of the conditions relating to personal possessions and should be asked to sign a disclaimer: Patient's Property – Disclaimer Form (Appendix 1).
- 5.1.2. At this point, the patient should also be advised that any valuables or cash may be handed over for safe keeping/banking but should be reminded that the UHB cannot be held responsible for items not deposited for safekeeping. Items taken into safe custody must be recorded on a Ward Property Book (On Admission) Form (CS 1).
- 5.1.3. Patients should also be advised that cash handed over for safekeeping will be receipted and banked as soon as possible and returned in the form of a cheque or bank transfer (Appendix 6). Notice will need to be given prior to its return.

5.2. **Emergency Admissions**

- 5.2.1. Where a patient is admitted unconscious or their condition warrants assistance in protecting their valuables, these should be deposited for safekeeping in the General Office. Details must be entered on a Ward Property Book (On Admission) Form (CS 1) and witnessed by two members of staff. In the interest of patient care this may be completed after the patient has been admitted to a ward not necessarily at the point of entry in A&E/AMU.
- 5.2.2. The property (valuables) of a patient who is conscious at time of admission should be handed by the patient to a relative or friend and not given to the Ward staff.
- 5.2.3. If a relative or friend is not present the patient should be encouraged by staff to hand over all monies and valuables. Patients may however retain on the Ward any personal articles of small value. Patients should be notified that cash will be banked and returned in the form of a cheque or bank transfer.
- 5.2.4. Patients must be reminded that the UHB cannot be held responsible for items not handed over for safekeeping. Items taken into safe custody must be recorded on a Ward Property Book (On Admission) Form (CS 1). The patient should also be asked to sign a disclaimer: Patient's Property – Disclaimer Form (Appendix 1).

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5.2.5. The storage of items taken into safe custody should be in accordance with part 3.4 below.

5.2.6. If hospital staff have knowledge of patient's property outside the hospital requiring protective action, the appropriate Local Authority should be informed. It is imperative that any knowledge of property in this category should be notified to the Local Authority immediately, since if a patient dies before they receive this notification, they have no power to act.

5.3. **Disclaimers**

5.3.1. Notices of disclaimer, Patient's Property - Disclaimer Form (Appendix 1) must be displayed on all Wards and other vantage points throughout the UHB premises highlighting personal possessions not handed in for safekeeping are not the responsibility of the UHB.

5.3.2. When children are admitted, the admitting nurse should ensure that the parent/guardian is aware that any mobile phones/tablets/electronic game equipment brought into the Hospital by children is their responsibility and not that of the UHB.

5.4. **Recording of Property & Valuables**

5.4.1. Property taken into safe custody at ward level must be recorded by two staff members (nursing staff or ward clerks) on a Ward Property Book (On Admission) Form (CS 1). The Ward Property Book is an item of controlled stationery and is available from the Hospital's General Office. Forms are pre-numbered and in triplicate.

- The first copy is the patient's receipt
- The second copy is for General Office
- The third copy is retained in the book

5.4.2. The book must be retained in a safe place and be available for inspection by authorised personnel. All spoilt copies must be retained in the book, crossed through and marked 'cancelled'. Completed books must be returned to General Office. On return, this book must be examined and checked to ensure all property has been received for safekeeping.

5.4.3. Property handed over for safe custody should be examined, listed and signed for by two members of nursing staff. If possible, the patient should

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sign agreeing the items listed are correct. The words "gold" or "silver", "diamond", "emerald", etc. must not be used but the description "yellow metal", "white metal", "white stone", "green stone" must be used.

NOTE: Only property handed over for safekeeping should be recorded in the Ward Property Book.

- 5.4.4. If the patient requests a professional valuation to substantiate the entry as "gold", "silver", etc. this may be done and cost to be borne by the patient and the record amended if necessary.
- 5.4.5. Where property has been recorded in the Ward Property Book, but before actually taken into safe custody, it can only be returned to the patient, i.e. (not to the relative) after the appropriate receipt has been completed.
- 5.4.6. Valuables taken into safe custody at Ward level may be kept in the Ward safe. Access to the ward safe should be restricted. Alternatively, property may be taken to General Office to deposit in the UHB safe. If there is no safe on the ward the property must be taken to General Office for immediate deposit in the UHB safe and a signature obtained to confirm receipt from General Office staff. All cash must be deposited in General Office.
- 5.4.7. Outside office hours, any cash and property taken into safekeeping should be deposited in the ward safes if available. If a night safe is not available, then the property must be deposited in a lockable secure cabinet, property or cash must not be placed in a medication cupboard. The contents must be placed in a sealed envelope and witnessed by two members of staff.
- 5.4.8. When the property is returned or taken to General Office the Ward staff must ensure they obtain a signature from the person receiving the property.
- 5.4.9. In the cases of patients who become incapacitated whilst in Hospital Care and are unable to safeguard their valuables, there is an obligation on the part of the UHB to safeguard their articles. In these cases, all valuables should be taken into safe custody and recorded in the Property Book.

5.5. General Office Duties

- 5.5.1. General Office should be given the page from the Ward Property Book (On Admission) when property is taken there for safekeeping. A log of all

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property taken into safe custody must be maintained by each General Office (CS 2). The following action must be followed:

- a. Property envelopes must be labelled and sealed giving the full name of the patient, the patient's hospital number (if known), together with Ward Property Book (on Admission) Form reference number and details of the property.
- b. Cash receipts must either be recorded on a Collection and Deposit (C&D) sheet or receipted directly into the ORACLE financial system.
- c. Cash Receipts must be banked in accordance with the Financial Control Procedure on Cash and Bank.

6. WARD PROCEDURE: LONG STAY PATIENTS

This section is only relevant for those wards/hospitals within the UHB who have patients whose duration of stay is deemed to be long term.

6.1. On Admission

- 6.1.1. The procedures followed on admission will be the same as for short stay patients (Section 3) but it is likely that the patient may require administration and/or financial support services.
- 6.1.2. Where a long stay patient requires the UHB to administer money on their behalf the Officer responsible for Patients' Monies will:
 - a. Set up a patient ledger sheet to record all deposits and withdrawals
 - b. Notify Finance department using a request to open current account form (CS 4).

As a minimum, the patient's full name (first & middle name and surname) should be used on these forms and all future correspondence.

6.2. Monies Deposited including Pensions/Benefits

- 6.2.1. Where a patient is in receipt of pensions/benefits, it is the responsibility of the patient, patient's families or patient's representatives to notify the Department of Work & Pensions as it may affect their right to pension/benefit.

- 6.2.2. The patient may nominate the UHB to collect the pension on their behalf. Pension monies for those patients will be paid automatically into the UHB's main bank account. Upon receipt of the pension monies Finance staff will notify the Officer responsible for Patients' Monies.
- 6.2.3. Ward staff must not pay out monies to patients, but may accompany the delegated officer and act as a witness.
- 6.2.4. Where either cash/cheques are paid on behalf of patients this shall be paid into the General Office and either a Collection and Deposit (C&D) sheet must be completed or the receipt entered directly onto the ORACLE financial system, the receipt should be noted on the patient's ledger sheet.
- 6.2.5. Where a patient is in receipt of a wage for employment, they should inform the Department of Work & Pensions, as it may affect the right to any benefits. For example, a patient may be in receipt of sick pay from an employer. The onus is on the patient to inform the appropriate bodies when their circumstances change. However, with the permission of the patient this may be done by the delegated Officer.
- 6.2.6. The Patients' Monies reconciliations to the ledger will be performed by a Finance Officer on a monthly basis.

6.3. **Investments**

- 6.3.1. Patients' balances will be reviewed bimonthly by the Officer responsible for Patients' Monies within Finance and should any funds be found in excess of patients immediate needs then they should notify the Financial Accountant to move funds to an Investment account. Investments accounts are set up in the patient's name and administered by the UHB.
- 6.3.2. All correspondence and transactions must be directed through the Financial Accounts Section within the Finance Department.
- 6.3.3. Where a patient's affairs are administered by the Court of Protection or its agents then there is a need to ensure that authority has been given to invest the patient's surplus monies. If authority has not been obtained then the delegated Officer should follow the procedure set out in Appendix 2.
- 6.3.4. A Register must be maintained by the Financial Accounts Section, of all patients' investments held. This register must be reconciled with bank statements by the Finance Officer and reviewed by the Head of Corporate Finance (or their representative) on a monthly basis.

6.4. **Patient Spending**

- 6.4.1. Before withdrawals/purchases are made ward staff must check with the Officer responsible for Patients' Monies that sufficient funds are available in the patient's account.
- 6.4.2. Small sums of money (i.e. up to £50 may be paid out of petty cash to patients who have money deposited in an account with the UHB, for their day to day needs. Details of all payments out of petty cash must be recorded on a summary of Patient's Private Monies paid from Petty Cash form (CS 5) and distributed as follows:
 - a. Copy to Finance Department (weekly).
 - b. Copy/copies with petty cash reconciliation weekly/ monthly to Cashiers.
 - c. Copy Hospital Records.
- 6.4.3. There is an upper limit of £50 on daily withdrawals (Monday – Friday excluding bank holidays) of cash from patients' current accounts even where the patient is capable of managing his/her own affairs. There will be no doubling up to cover weekends or bank holidays.
- 6.4.4. Nurses must not be used as agents for paying patients, or for distributing goods, except in the case of patients who are severely disabled or confused, and for whom it is necessary for the Nurse to receive and care for such goods on the patient's behalf. Form Appendix 3 to be completed.
- 6.4.5. A completed authorisation form (Appendix 4) must be obtained from the ward when the patient is unable to receive the monies directly and before purchases are made on the patient's behalf or cash is withdrawn.
- 6.4.6. Where a relative or friend assumes responsibility for a patient's affairs whilst in hospital and pension/benefits are receivable, the ward staff must continually assess that the patient is adequately provided for: where neglect is observed, the ward staff must inform Social Services who will nominate a social worker.
- 6.4.7. Patients are expected to pay for their own clothing. If such a payment would reduce the balances on their current and deposit accounts to less than £100, the Officer responsible for patient's monies must confirm that the patient does have other funds available to them.
- 6.4.8. There is an obligation by ward staff to ensure that patients receive value for money from their purchases.

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6.4.9. Purchases are transacted by one of the following principal methods:

- a. By ordering commodities direct through the Procurement Department of the UHB. When this method is used the name of the patient should be included on the order, and the invoice will be paid under the normal Accounts Payable procedure. When the transaction is complete, Finance staff will notify the Officer responsible for Patients' Monies to debit the patient's account accordingly.
- b. Shopping expeditions may be organised for patients who will be accompanied by escorts. Arrangements must be made in advance with the shop that each patient is invoiced individually where possible. If the shop will not co-operate then the Officer in charge of the expedition should ensure that any charges are in the form of an itemised invoice. In these cases, the Officer in charge must make a record of individual patient's purchases, which should be attached to the invoice and forwarded with the relevant Payment Request Form (CS 6) to the Finance Department for payment.
- c. Shopping days may be organised at the Hospitals where contractors attend. Individual invoices must be rendered and payment made via Payment Request Form (CS 6).

6.4.10. Whenever possible, patients must authorise deductions from their accounts. Patients capable of understanding the transaction, but unable to sign must have all transactions witnessed.

6.4.11. An independent member of staff should examine purchases at Ward level and the articles purchased identified with the patient's name and marked accordingly.

6.4.12. Receipts must be produced for all purchases made on behalf of patients.

6.4.13. Payment requests must be made on the appropriate Payment Request forms (CS 6), and signed by the originating officer and authorised by the relevant Senior Nurse Ward Manager or Patient's Monies Supervising Officer.

6.4.14. Nursing staff who signs for patient's money are expected to control and monitor the spending whether it is inside or outside the Hospital environment. Patients adjudged by a Medical Officer to be capable of spending and appreciating their own money should be given a daily allowance subject to the limits set out in Section 4.4.2.

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6.4.15. Patients considered, on medical opinion, as incapable of looking after and spending their money should receive assistance from Nursing Staff with their purchases. Cash withdrawn by these patients may still require safe keeping on the ward. In this instance a record of all cash held should be maintained and monies should be securely stored in a lockable cabinet. A countersignature from a witness should be obtained in these cases.

6.4.16. Where possible, cash receipts and other documentation must be obtained for these purchases. A reconciliation of patient's money expenditure incurred by nursing staff should be prepared by the nurse in charge and forwarded with receipt to the Officer responsible for Patients' Monies in order to debit the patient's account.

6.5. Finance Department Responsibilities

6.5.1. Details of cheques drawn on behalf of patients will be forwarded monthly to Hospitals by the Finance Department. All debits and credits must be recorded on a patient's ledger spreadsheet. On a monthly basis, Finance will send out details of patient balances to the Officers responsible for Patients' Monies who will confirm agreement with hospital records. Any differences that cannot be resolved should be reported to the Directorate Manager.

6.6. Records of Patient's Clothing

6.6.1. Where possible, a record of items and personal clothing retained on the ward should be maintained at ward level by nursing staff or the ward clerk (CS 7). However, if the patient has regular home visits, shopping trips or visitors who could possibly remove items of clothing then the monitoring of clothing becomes difficult for the UHB. In these cases, as part of the risk assessment process, Directorate Managers may use their discretion to decide whether to maintain these records, as they may be constantly out of date. Reasons for non-completion of the records should be documented and approval sought from the Directorate Manager. Where the records are maintained visitors/relatives should be reminded to notify nursing staff when items are added or removed.

7. DISCHARGE FROM HOSPITAL

7.1. On discharge, any property taken into safe custody should be handed to the patient. The patient should sign the relevant page of the Ward Property Book (CS 1) as evidence of receipt.

7.2. In order to cover immediate needs, a sum of money may be released from Petty Cash by General Office to the patient (up to £75) and a signature obtained. If the patient is unable to collect the cash from the General

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Office, a nominated person may collect it and Form Appendix 3 should be completed. The remaining balance on the account will then be sent direct to the patient's address, by cheque or bank transfer, from the Cashier's Section in Finance. In those instances where an individual does not have a bank account, or no fixed abode, staff may be allowed discretion to pay up to £150 cash on the authorisation of a Senior Nurse or Patient's monies Supervising officer within the UHB. In special circumstances, a higher limit may be agreed, but this must have the approval of the Head of Corporate Finance (or their representative).

- 7.3. Where the patient is incapable of handling money, the cheque/bank transfer may be forwarded to a properly authorised custodian. On this occasion, a letter supporting the change of the cheque/bank transfer recipient will be required from the officer responsible for patients' monies.
- 7.4. In the event of delays in notification of discharge and after every effort has been made and money cannot be returned to the patient or to an authorised custodian within one year of discharge, it should be credited to the UHB's accounts. Should a valid claim be established later, payment may be made and the UHB's accounts debited.
- 7.5. Whenever money or valuables are passed to either: the patient, a relative, a custodian, from one member of staff to another, or transferred to another organisation, a receipt must be obtained.
- 7.6. For long stay patients, prior to the release of the balance of a patient's account or valuables, the Officer responsible for Patients' Monies should ensure that:
 - a. All receipts and payments have been posted correctly to the patient's personal account up to the time of discharge.
 - b. All internal transactions have been posted (e.g. transfers, petty cash).
 - c. The officer should telephone the Finance Department to confirm balances.
 - d. Any bank books, or savings bonds, etc. held in the name of an untraced patient should be returned to the relevant body and a receipt obtained.
 - e. Where a patient's surplus monies are invested and the patient is discharged then the Investment account should be closed. A cheque will be sent to the UHB. Finance will then issue a cheque/bank transfer to the patient/relative.

8 PATIENT TRANSFERS

- 8.1 When a patient is to be transferred to another ward/hospital all belongings (valuables, clothing etc.) should be recorded on a Record of Transfer Form (Appendix 5). The patient should sign the form agreeing the full listing of belongings as being accurate. If the patient is unable to sign the form another nurse or the patient's representative should sign the form as a witness. The form, which is in triplicate should be distributed as follows:
- One copy to be retained by the patient
 - One copy to be sent with the patient to the other ward/hospital (to be handed over on arrival);
 - One copy to be retained in the book
- 8.2 If the patient has been transferred to a ward /hospital within our UHB the receiving officer/nurse should check all the patient's belongings and sign the form. This form should then be filed by the ward staff. Once the patient has arrived on the ward and the form checked and signed, the UHB has no responsibility for the patient's belongings. As is the case for any new admission, the patient will be offered the opportunity to place valuables in the safe custody of the UHB and the procedure above of completing the Ward Property Book (CS 1) will apply.
- 8.3 For long stay patients transferred to another hospital, outside the UHB, prior to the transfer of the patient being made, any balances held on the patient's account will be paid over by cheque or bank transfer. The receiving organisation must be notified in writing of the balances to be transferred.
- 8.4 Where the UHB holds money on behalf of the patient, ward staff must ensure that General Office and the Financial Accounts Department are informed.

9 DECEASED PATIENTS

- 9.1 Where a patient dies on the ward all belongings will be taken into safe custody and recorded in the Ward Property Book by two members of staff. All valuable property will then be passed to General Office and a signature obtained. Following the death of a patient, the delegated Officer will record:
- a. The date of death.
 - b. If the funeral is to be carried out by the Hospital or privately.
 - c. The name(s) and address (es) of the next of kin.

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- 9.2 Where a person is brought into an A&E and subsequently dies without being admitted into hospital, a record of personal effects should be entered in the A&E Ward Property Book (CS 1) and witnessed by two members of staff. Items should then be passed to the General Office for safe keeping.
- 9.3 Where a person is 'dead on arrival' the responsibility for personal property normally rests with the Police Authority. If the Police do not accept this responsibility, the procedure above will apply.
- 9.4 When General Office is closed all property belonging to the deceased person should be logged on the Ward Property Book Form and witnessed by two individuals. The property should be held in a secure cabinet until the items can be handed over to General Office. Non valuable items (clothing etc) may be handed over to relatives on proof of identity and a signature in the book obtained. Valuable items should not be handed to relatives until the necessary indemnity form is signed.
- 9.5 For long stay patients where the UHB has been elected to receive their pension monies, the Officer responsible for Patients' Monies should inform the Department of Work and Pensions and notify Finance immediately so that pension receipts will be cancelled. Any pension monies received after the patient's death must be returned as soon as possible.
- 9.6 The UHB may arrange and pay for the funeral of patients who die in Hospital where no arrangements are made by their relatives or when:
 - a. Relatives cannot be traced.
 - b. Relatives are traceable and cannot afford to arrange for burial.
 - c. Relatives are traceable, but refuse to take responsibility, e.g. on grounds of distance of relationship.
 - d. If the UHB is holding money on behalf of the deceased, this should be allocated towards the cost of the funeral.
- 9.7 Where a patient dies intestate and there is a next of kin, if the value of the property held is less than £5,000, the Officer responsible for Patients' Monies must ensure that:
 - a. The relationship of the claimant to the deceased patient is ascertained and that he/she is one of the persons who are entitled to apply for Letters of Administration i.e. Next of Kin for balances up to £5,000, A Form of Indemnity (CS 8) to be sent to the home address of the known next of kin for completion.

- b. Once the Form of Indemnity (CS 8) is completed by the claimant and independently witnessed, entry is then made in the Hospital Property Book showing release of valuables.
 - c. No transfer of property is made to any person under 18 years, unless the minor's parent(s) or lawful guardian(s) sign the Form of Indemnity. (CS 8)
- 9.8 If the value of the property held by the UHB exceeds £5,000 then Probate or Letters of Administration will be required.
- 9.9 Where a patient dies intestate and there is no next of kin:
- a) If the value exceeds £500, the Estate reverts to the Crown and details should be passed to the Treasury Solicitors by the hospital's delegated Officer.
 - b) If the value is less than £500, it will be credited to the UHB's accounts. Should a valid claim be established later, payment may be made and the UHB's accounts debited.

10 UNCLAIMED PROPERTY

- 10.1 When a patient has been discharged or deceased but not reclaimed their property, the Hospital's delegated Officer must make every effort to trace the patient or next of kin. If this proves unsuccessful the Directorate Manager should be contacted by the delegated Officer in order that further enquiries can be made. If this is not successful, the articles must be kept for a reasonable time before disposal, i.e.
- Clothing and items of low value – three months

Items of value - six years (Limitation Act 1949)

A review of all property held in safe custody should take place on an annual basis by the hospital's delegated officer.

- 10.2 Any cash unclaimed, or monies received from the sale of the abandoned or unclaimed property should be credited to the UHB. Should a claimant at a later date claim property that has been sold, the amount due would be payable from the UHB. The delegated Officer, in liaison with their Manager

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and Finance, must seek expert advice if there is doubt about the value of property to be sold.

- 10.3 Unclaimed bank books, national savings certificate, etc. must be returned by the hospitals delegated Officer to the relevant organisation accompanied by a suitable letter of explanation.

11 Reporting of Overdrawn Balances

- 11.1 Patients' balances should be managed so that patients do not spend money they do not have. Where balances become overdrawn through a failure of controls then every effort must be made to recover the balance. Where balances are not recovered they should be recorded as a loss and reported to the Audit Committee.

12 EQUALITY IMPACT ASSESSMENT STATEMENT

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

13 RELATED POLICIES

- 13.1 The following Financial Control Procedures should be read in conjunction with this policy:

a. FP04 Cash & Banking

14 MAIN RELEVANT LEGISLATION

- 14.1 This procedure should be read in conjunction with the Standing Financial Instructions and other relevant Financial Control Procedures. These can be accessed on sharepoint:
<http://ctuhbintranet/Policies/Policies/Forms/Finance>.



APPENDIX 1

Patient's Property – Disclaimer Form

Name:	Ward:	NHS No:				
_____ has explained to me the procedure for the safe keeping of money and property. I have been offered the opportunity to hand over my personal property and valuables in accordance with that procedure, however, I have decided to keep my valuables in my possession during my stay in hospital and in doing so accept full responsibility for their safe keeping.						
I _____ hereby acknowledge that Cwm Taf Morgannwg University Health Board cannot now accept any responsibility for any loss or damage to my valuables on these premises. All personal property retained by me on the ward or on my person while in hospital is my responsibility and I therefore indemnify the hospital from any liability arising from the loss or damage thereof.						
Signed		Witness (Name & Signature)	By &		Date	
(If patient is unable to sign, friend or relative should sign below)						
Signed		Witness (Name & Signature)	By &		Date	
Does the patient have jewellery?						
YES/NO		If 'Yes' Please State				
Does the patient have electronic devices?						
YES/NO		If 'Yes' Please State				
Does the patient have any cash or any other valuables?						



YES/NO	If 'Yes' Please State	
I understand that these are my responsibility		Signed:_____
Page Number of Property Book:..... COMPLETED		

APPENDIX 2

INVESTMENT OF PATIENTS' MONIES

Patients who are the responsibility of the Court of Protection

1. Address: Cardiff Civil & Family Justice Centre
2 Park Street
Cardiff
CF10 1ET
United Kingdom
2. The UHB's Hospital Patients' Monies Officer must identify through the patient's file whether the Court Order issued by the Court of Protection already gives the power to invest any surplus income on behalf of the patient. If the UHB possesses this then there is no need to involve the Court of Protection.
3. If the UHB does not possess the power to invest, then the Court of Protection should be contacted via the Patient's Money Control Section and the following details supplied:
 - a. The name of the patient.
 - b. Court of Protection Reference Number.
 - c. Date of birth of the patient.
 - d. Details of allowances received (eg. mobility allowance, retirement, etc.)
 - e. Amount received each week in respect of each allowance.
 - f. Details of how the money is collected.
 - g. Balance in the patient's accounts.
 - h. Where it is invested and the current investment rate.
 - i. Where it will be invested and that investment rate.

APPENDIX 3

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

APPLICATION FOR CASH WITHDRAWAL (MAXIMUM £50)

Patient's Name: _____

Hospital No _____ Ward _____

I authorise the withdrawal of £..... in cash, subject to sufficient funds being in my account.

Signature of Patient _____

Authorisation (Nurse in Charge) _____

Date _____

Amount received £ _____

Signature of patient _____

Date _____

**PLEASE RETURN TO OFFICER RESPONSIBLE FOR PATIENTS' MONIES
AFTER COMPLETION**

APPENDIX 4

AUTHORISATION FORM FOR PATIENT’S PURCHASES

HOSPITAL _____

Please complete ALL parts:

WARD:	
DATE:	
Name of Patient:	
Hospital Number:	

I hereby authorise payment / release of money for the above named patient for his/hers private monies account for the purpose of:

.....
.....
.....
.....

Sum of Money to be released:	
Patient's Signature:	
Witness (if Necessary)	
Date documented in Nursing process:	
Signature of qualifies staff:	
Signature of Ward Manager / Senior Staff Nurse:	
Date:	

APPENDIX 5

RECORD OF TRANSFER FORM

Name of Patient _____ Date of transfer _____

Transferring from
Hospital _____ Ward _____

Transferring to
Hospital _____ Ward _____

The following is a correct record of cash and property with the patient on transfer:

_____ Patient or
 _____ Representative _____ Ward Sister /
 _____ Charge Nurse
 _____ Witness
 (Member of Hospital Staff)

PROPERTY	CASH	£	p
	Notes		
	Coins		
	Other		
	Total		
	Total in words:		

	pounds		

	pence		

I confirm receipt of the item detailed above:

Receiving Officer

AUTHORISATION OF BANK TRANSFER

Patient's Name: _____

Hospital No: _____ Ward: _____

BANK ACCT NAME: _____

SORT CODE: _____

BANK ACCOUNT NUMBER: _____

Signature of Account Holder: _____

Print Name: _____

Signature of Nurse in Charge: _____

Print Name: _____

Job Title: _____

Date _____

**PLEASE RETURN TO OFFICER RESPONSIBLE FOR PATIENTS' MONIES
AFTER COMPLETION**



AGENDA ITEM

4.3

AUDIT & RISK COMMITTEE

**POST PAYMENT VERIFICATION PROGRESS REPORT – 1ST APRIL 2022 TO
31ST MARCH 2023**

Date of meeting	19th April 2023

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

1. SITUATION/BACKGROUND

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle, and the two

previous. It also demonstrates the overall performance of the Health Board against the national averages. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as part of an annual plan by NHS Wales Shared Services Partnership (NWSSP). The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

The past year in 2022-2023, PPV have faced challenges associated with the ability to perform 'Business as Usual' due to different factors.

To effectively respond to challenges identified within Primary Care we continued to investigate further avenues to enhance our PPV services which has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

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

- 2.1 General Medical Services (GMS):** Following communications that went out on 20th December, regarding the inability to undertake the entirety of the visits on the visit plan for 2022/2023, we are planning to condense all remaining visits from the 3-year visit plan into 2-year period of 2023/24 and 2024/25.

We also experienced some transitional points with the introduction of the new payment system so a separate assurance exercise is being undertaken by our payment colleagues in SSP for the data range January 2022 to September 2022. As a result, we will begin by checking the data submitted from practices from October 2022.

The length and period of data will extend as time moves forward as it has done historically as part of the PPV assurance.

Regarding the revisits that were raised because of routine visits in the last financial year, and any outstanding visits, we will be utilising the same data, however if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

The visit plan runs on a 3-year cycle for GMS and is agreed by Health Boards.

- 2.2 **General Ophthalmic Services (GOS):** The visit plan for GOS 2022-2023 was agreed by Health Boards after explaining that these visits were subject to change due to beginning a new way of working. PPV began remote access options having full support from Optometry Wales and begun to carry out virtual visits via Microsoft TEAMS which proved successful. Future visits will now be included in the 2023-2024 visit plan, and although we are hoping to increase the number of remote visits, we are also incorporating physical visits to carry us through this transition period of electronic claiming which is being encouraged by Welsh Government. We also continue to undertake the GOS quarterly patient letter programme across Wales to provide additional 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 2022/23 NWSSP introduced a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and the Collaborative Working Scheme. We will now be going 'Live' in April 23/24 with the Quality and Safety scheme and seeking approval for our GPS visit plan from our Health Boards.
- 2.4 **Additional Services**
- As requested by Welsh Government in 2022/2023 we have both verified Bonus Payment checks that were claimed and paid to all Health Service staff in 2021 and verified the PPV declaration for additional community pharmacy payments that were paid in 2022/2023.
 - We are providing a new service check for dispensing data and after a successful pilot we rolled this out nationally in August 2022 using the quarterly data form April-June 2022. This will continue as a quarterly service for all Health Boards across Wales.
- 2.5 The GMS snapshot and statistics tab now separate the routine and the revisit errors and averages.
Revisits are generally higher percentages due to 100% of the claims checked over a longer period.

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

- 3.1 The reports detail 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.



4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outlined 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.
Legal implications / impact	Not required
Resource (Capital/Revenue £/Workforce) implications / Impact	There are no specific legal implications related to the activity outlined in this report.
Link to Strategic Goals	There is no direct impact on resources as a result of the activity outlined in this report.
	Improving Care

5. RECOMMENDATION

- 5.1 The Audit & Risk Committee is requested to **NOTE** the contents of this report.

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GMS

	Health Board			All Wales		
	2020/2021	2021/2022	2022/2023	2020/2021	2021/2022	2022/2023
Number of practices visited	18	27	3	187	218	36
Average claim error rate	13.66%	6.32%	25.94%	11.66%	12.96%	17.93%
Recovery amount	£25,938.12	£33,477.99	£6,894.85	£232,012.10	£361,438.45	£50,339.13
	Health Board - ROUTINE			All Wales - ROUTINE		
	2020/2021	2021/2022	2022/2023	2020/2021	2021/2022	2022/2023
Number of practices visited	13	21	1	122	138	29
Average claim error rate	6.03%	4.76%	3.33%	5.88%	6.03%	7.01%
Recovery amount	£7,210.07	£11,487.89	£191.20	£68,772.35	£75,523.00	£7,257.32
	Health Board - REVISIT			All Wales - REVISIT		
	2020/2021	2021/2022	2022/2023	2020/2021	2021/2022	2022/2023
Number of practices visited	5	6	2	65	80	7
Average claim error rate	33.50%	11.76%	33.33%	14.46%	16.31%	20.74%
Recovery amount	£18,728.05	£21,990.10	£6,703.65	£163,239.75	£285,915.45	£43,081.81

GOS

	Health Board			All Wales		
	2020/2021	2021/2022	2022/2023	2020/2021	2021/2022	2022/2023
Number of practices visited	N/a	0	6	N/a	4	30

Average claim error rate	N/a	0.00%	2.59%	N/a	11.41%	4.31%
Recovery amount	N/a	£0.00	£554.27	N/a	£1,777.37	£4,753.21
	Health Board - ROUTINE			All Wales - ROUTINE		
	2020/2021	2021/2022	2022/2023	2020/2021	2021/2022	2022/2023
Number of practices visited	N/a	0	6	N/a	4	30
Average claim error rate	N/a	0.00%	2.59%	N/a	11.41%	4.31%
Recovery amount	N/a	£0.00	£554.27	N/a	£1,777.37	£4,753.21
	Health Board - REVISIT			All Wales - REVISIT		
	2020/2021	2021/2022	2022/2023	2020/2021	2021/2022	2022/2023
Number of practices visited	N/a	0	N/a	N/a	0	N/a
Average claim error rate	N/a	0.00%	N/a	N/a	0.00%	N/a
Recovery amount	N/a	£0.00	N/a	N/a	£0.00	N/a

Cwm Taff Morgannwg University Health Board

GOS and GMS PPV Progress Report: 1st April 2022 to 31st March 2023

		0-4%	Low risk				UHB GOS Claim error % Ave (Routine)	2.59%		UHB GOS Claim error % Ave (Revisit)
		5-9%	Medium risk							
		10%+	High risk				Apr-Mar-2023 recovery amount	£554.27		Apr-Mar 2023 recovery amount
GOS Routine		Visit 1			Visit 2					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type
Practice 1	May-15	Routine	3.00%	£109.80	Nov-18	Routine	0.97%	£68.10	May-22	Routine
Practice 2	Dec-13	Routine	0.00%	£0.00	Nov-17	Routine	2.00%	£80.20	Jul-22	Routine
Practice 3	N/a	N/a	N/a	N/a	Feb-19	Routine	1.94%	£99.70	Apr-22	Routine
Practice 4	Jun-17	Routine	8.00%	£352.10	May-18	Revisit	16.67%	£2,346.20	Jan-23	Routine
Practice 5	Jan-18	Routine	3.00%	£161.60	Jun-19	Revisit	4.00%	£521.60	May-22	Routine
Practice 6	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	Oct-22	Routine
								UHB GMS Claim error % Ave (Routine)	3.33%	UHB GMS Claim error % Ave (Revisit)
								Apr-Mar 2023 recovery amount	£191.20	Apr-Mar 2023 recovery amount
GMS Routine		Visit 1			Visit 2					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type
Practice 7	Sep-15	Revisit	3.69%	£2,046.62	Mar-19	Routine	1.69%	£127.79	Oct-22	Routine
Practice 8	May-19	Routine	4.00%	£121.10	Mar-21	Revisit	33.33%	£749.25	Dec-22	Routine
GMS Revisit		Visit 1			Visit 2					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type
Practice 9	Jan-19	Revisit	20.03%	£4,326.44	Nov-20	Routine	11.43%	£1,131.86	Apr-22	Revisit
Practice 10	Aug-15	Extended	13.73%	£4,340.33	Feb-21	Routine	13.25%	£927.89	Nov-22	Revisit

3

error % Ave	No Revisits undertaken	
Recovery amount		

Visit 3

Sample size	Claim errors	Claim error %	Recovery
103	2	1.94%	£126.42
103	1	0.97%	£21.22
103	4	3.88%	£132.80
103	3	2.91%	£83.00
103	4	3.88%	£163.43
103	2	1.94%	£27.40

error % Ave	33.33%	
Recovery amount	£6,703.65	

Visit 3

Sample size	Claim errors	Claim error %	Recovery
210	7	3.33%	£191.20
Visit file in progress			

Visit 3

Sample size	Claim errors	Claim error %	Recovery
441	130	29.48%	£5,330.13
201	84	41.79%	£1,373.52

AGENDA ITEM

5.1

AUDIT & RISK COMMITTEE

ANNUAL REVIEW: RISK MANAGEMENT FRAMEWORK

Date of meeting

19.4.2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Cally Hamblyn, Assistant Director of Governance & Risk

Presented by

Cally Hamblyn, Assistant Director of Governance & Risk

Approving Executive Sponsor

Chief Executive

Report purpose

ENDORSE FOR BOARD APPROVAL

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

Committee/Group/Individuals

Date

Outcome

Board Member via Email

3.4.2023 –
12.4.2023

Endorsed

Executive Leadership Group –
Risk Appetite Statement

11.4.2023

Reviewed

ACRONYMS

None identified.

1. SITUATION/BACKGROUND

- 1.1 As good governance on an annual basis the Health Board reviews its risk management framework which is made up of the following suite of documents:
1. Risk Management Strategy
 2. Board Assurance Framework
 3. Risk Appetite Statement
 4. Risk Domain & Scoring Matrix
 5. Risk Management Policy
 6. Risk Assessment Procedure
- 1.2 This annual review focusses on items one to four and during April 2023, Board Members considered these areas of the risk management framework in terms of its continued adoption for a further 12 months.
- 1.3 The Risk Management Policy and Risk Assessment Procedure were reviewed and approved in 2022 with the next review date set for 2025. However, if the Board supports the approval of items three and four these documents will be updated to include the latest revisions of these items as appropriate.

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

- 2.1 This section is broken down into the review of the relevant component parts of the framework.
- 2.2 ***Risk Management Strategy*** (Appendix 1) - The purpose of the strategy is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.

The Strategy has been subject to minor amendments to the main body of the document with more detailed review on the appendices as outlined below in sections 2.3, 2.4 and 2.5.

The revised Strategy also incorporates any changes in response to the findings captured in the Internal Audit Report on the BAF completed in April 2023.

All changes have been reflected in red.

- 2.3 ***Risk Appetite Statement*** (Appendix 2) - An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored



responses is the conscious and dynamic determination of the organisation's risk appetite.

During the recent review of the Risk Appetite Statement, the following key changes were included:

- Two additional domains have been added:
 - People Risks
 - Operational Performance Risks
- In relation to the Financial Stability risks domain the following changes were made:
 - Removal of "*Minimalist – as to risk relating to breaching individual control totals*". This activity is captured in the other areas.
 - Additional area added in relation to the Health Board's financial breakeven duties.

All changes have been reflected in red.

- 2.4 **Risk Domain Scoring Matrix** (Appendix 3) – In response to the annual review, an additional domain has been added to the matrix in relation to 'Fraud & Bribery'.

All changes have been reflected in red.

- 2.5 **Board Assurance Framework (BAF)** - The BAF is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation.

There were no changes to the concept and/or strategic risks in the review of the BAF.

It should be noted that a recent Internal Audit review of the Board Assurance Framework resulted in an outcome of Substantial Assurance.

The BAF and current nine principal risks are captured in Appendix 5 of the Risk Management Strategy.

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

- 3.1 The principal risks are outlined in the BAF, which is reviewed at all routine meetings of the Health Board. No new risks have been escalated at this time and no risks have been removed.



4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	To ensure that there is a system and process so that all risks which could cause harm are identified and that control mechanisms are implemented;
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Yes
	See Policy and Strategy Document.
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	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to

- **ENDORSE APPROVAL** of the Risk Management Strategy.
- **ENDORSE APPROVAL** of the changes to the Risk Appetite Statement and agree that it is implemented for the next 12 months with assurance that it is set to ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve.
- **ENDORSE APPROVAL** of the Risk Domain & Scoring Matrix and additional domain relating to 'counter fraud / bribery'.
- **ENDORSE APPROVAL** that the Board Assurance Framework remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board.

5.2 If endorsed for approval, the documents will then proceed for formal approval by the Board at the end of May.

RISK MANAGEMENT STRATEGY & BOARD ASSURANCE FRAMEWORK

Ref:	RM 01
Document Author:	Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance / Board Secretary
Approval / Effective Date:	
Review Date:	
Version:	Version 7 - Draft

Target Audience:

People who need to review this document in detail	All Staff with the responsibility for undertaking risk assessments. All staff who approve risks as a risk owner or manager.
People who need to have a broad understanding of this document	All staff.
People who need to know that this document exists	All staff.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 20.11.2020 Outcome: No potential negative impact identified.
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	23.11.2020
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

Approval Route:

Where	When	Why
Audit & Risk Committee		Endorse for Board Approval
Health Board		Approved



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

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1. Introduction and Aims

- 1.1 Cwm Taf Morgannwg University Health Board (CTMUHB) is committed to developing and implementing a Risk Management Strategy (and Board Assurance Framework) that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives and delivering against its Integrated Medium Term Plan (IMTP). The Board Assurance Framework (BAF) will be used by the Board to identify, monitor and evaluate risks which impact upon strategic objectives. It will be considered alongside other key management tools, such as workforce, performance, quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.
- 1.2 The purpose of this document is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.
- 1.3 It aims to:
- set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation;
 - set out responsibility for Board committees, in particular, the Audit and Risk Committee; and
 - describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives.
- 1.4 The objectives of CTMUHB's Risk Management Strategy (and Board Assurance Framework) are to:
- minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management;
 - ensure that risk management is an integral part of CTMUHB's culture;
 - maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;

- maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- minimise avoidable financial loss;
- ensure that CTMUHB meets its obligations in respect of Health and Safety and Quality and Safety;
- Manage all potential risks CTMUHB are exposed to.

2. Scope

2.1 The Risk Management Strategy (and Board Assurance Framework) covers the management of Strategic/Principal and Organisational risks and the process for the escalation of risks for inclusion on the Organisational Risk Register and Board Assurance Framework.

2.2 A risk can be defined as: “the chance of suffering harm caused by a hazard, loss or damage or the possibility that the CTMUHB will not achieve an objective”.

Risk is the uncertainty surrounding events and their outcomes that may have a significant effect, either enhancing or inhibiting:

- Achievement of aims and objectives
- Operational performance
- The meeting of stakeholder expectations

Types of Risk

2.3 **Strategic/Principal Risks:** are significant risks that have the potential to impact upon the delivery of Strategic Objectives and are reviewed and monitored by the Strategic Leadership Group (SLG), Board Committees and the Board.

2.4 **Organisational Risks:** are risks that are mainly operational in nature and arise from the CTMUHB’s day-to-day activities.

2.5 The Board Assurance Framework (BAF) is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation. It also summarises the controls and assurances that are in place or plans to mitigate them. The BAF aligns strategic/principal risks, key controls and

assurances on controls alongside each of the Health Boards strategic objectives.

- 2.6 The BAF identifies the assurances reported to Board and Committees in relation to the strategic/principal risk identified. It also highlights the gaps in controls and assurances. This enables the development of an action plan for closing the gaps and mitigating the risks, which is subsequently monitored by the Board for implementation.
- 2.7 This Strategy applies to those members of staff that are directly employed by CTMUHB and for whom CTMUHB has legal responsibility. However, the culture of risk management and discussion of risk with partners and stakeholders, where appropriate should be encouraged.
- 2.8 The Risk Management Strategy is intended to cover all the potential risks that the organisation could be exposed to.

3. Risk Management Organisational Structure

The Board

- 3.1 Executive Directors and Independent Members share responsibility for the effective management of risk and compliance with relevant legislation. In relation to risk management, the Board is responsible for:
 - articulating the Strategic Objectives/Goals of CTMUHB;
 - articulating the Strategic/Principal Risks of CTMUHB;
 - protecting the reputation of CTMUHB;
 - providing leadership on the management of risk;
 - approving the risk appetite for CTMUHB;
 - ensuring the approach to risk management is consistently applied;
 - ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;

- reviewing **and approving risks on the** Board Assurance Framework **and the organisational risks scored 15 and above at each meeting;**
- endorsing risk related disclosure documents;
- approving the Risk Management Strategy and Board Assurance Framework on an annual basis.

Audit & Risk Committee

- 3.2 The Audit and Risk Committee has a specific role in relation to **undertaking an annual review** of the effectiveness of the Risk Management Strategy and the Board Assurance Framework.
- 3.3 In relation to risk management, the Audit and Risk Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:
- all risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit Opinion and/or other appropriate independent assurance, prior to endorsement by the Board.
 - the structures, processes and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation. This will be addressed by ensuring there is a periodical review that risk registers are in place and updated for corporate and clinical areas.
 - the Health Board's organisational risk register and the adequacy of the scrutiny of risks by assigned Committees. This will be addressed by ensuring all significant risks (i.e. those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) are assigned to a Board Committee for scrutiny, and ensuring that updates on actions to mitigate the risks are provided at each committee meeting.
 - the Board Assurance Framework.
 - the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements. By identifying and assessing regulatory, legal and code of conduct issues that could have been prevented by more effective management of risk and assurance of controls in place.

- the operational effectiveness of policies and procedures, through regular review of policies and procedures.
- the effectiveness of risk identification, management, escalation and monitoring. This will be addressed by reviewing the number of risk registers in place, the frequency of updates to the risk register and the escalation of high risks to the **Locality Care Group /Central Function** and Organisational Risk Registers.

All Board Committees

3.4 All Board Committees have a role to play in ensuring effective risk management in particular they will:

- Receive and scrutinise risks and provide onwards assurance to the Board in relation to risks assigned to them to provide oversight and scrutiny.
- will receive updates in terms of actions taken to mitigate the risks, and provide feedback and challenge to risk owners on the actions taken and any further action required.

~~Strategic Leadership Group (SLG) Executive Leadership Group (ELG)~~

3.5 The **SLG ELG** undertake the following duties:

- Promote a culture within the Health Board, which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Health Board.
- Ensure appropriate actions are applied to organisational risks.
- Enable risks which cannot be dealt with locally to be escalated, discussed and prioritised.
- Ensure **Care Groups and Central Corporate Functions Localities, System Groups, Clinical Service Groups and Corporate Department** Risk Registers are appropriately rated and action plans agreed to control them.

- Review the risks on the Organisational Risk Register (those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) to determine whether they will impact on the Health Boards Strategic Objectives/Goals, and if so, the risk will be added to the Board Assurance Framework (BAF) aligned to the appropriate Strategic/Principal Risk.
- Review the Organisational Risk Register and Board Assurance Framework prior to its presentation to the Board and Committees as appropriate.
- Review and monitor the implementation of the Risk Management Strategy and Board Assurance Framework.
- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Governance Statement, outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.
- Approve documentation relevant to the implementation of the Risk Management Strategy and Board Assurance Framework.
- Provide assurance to the Board that there is an effective system of risk management across the Organisation.

Care Groups / Local Services Groups / Corporate Central Functions Leads

- 3.6 Care Groups, Local Service Groups / Corporate Central Functions are responsible for risks within their areas of operation and providing assurance to the SLG on the operational management and any support required in relation to the management of risk.
- 3.7 These functions are responsible for the implementation of the Risk Management Strategy and relevant policies, which support the Health Board's risk management approach.
- 3.8 Specifically they will:
- promote a risk culture which encourages open and honest reporting of risk with local responsibility and accountability;
 - use the Datix Risk Management system for recording and reviewing risk.
 - ensure a forum for discussing risk, risk management and organisational learning is maintained within their system

group area of responsibility;

- co-ordinate the risk management processes which includes risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- update **SLG ELG** on the management and mitigation of risk for their area;
- provide reports to the Management Board and appropriate Committee of the Board that will contribute to the organisational monitoring and auditing of risk;
- escalate service risks graded 15 and above all those not able to be managed to the Strategic Risk Owner for consideration and review at the **SLG ELG** for escalation to the Organisational Risk Register and Board Assurance Framework;
- contribute to the organisational monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
- ensure the moderation and calibration of risks across the Health Board to avoid duplication, ensure compliance and alignment with the Risk Management Strategy and ensure shared learning across the Health Board;
- review and updating of existing risks, consider new risks for inclusion and escalate/de-escalate risks as appropriate to the Executive Team Member assigned as the Strategic Risk Owner for the risk being escalated.

3.9 CTMUHB's 'Risk Management Process – Service to Board' is included at Appendix 3.

4. Duties

4.1 The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

All Staff

- 4.2 All members of staff are accountable for maintaining risk awareness, and identifying and reporting risks as appropriate to their line manager.
- 4.3 In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for CTMUHB and attend/complete risk management training as appropriate.
- 4.4 They will:
- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Health Board's business;
 - report all incidents/accidents and near misses;
 - comply with the Health Board's incident and 'near miss' reporting procedures;
 - be responsible for attending mandatory and relevant education and training events;
 - participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed; and
 - be aware of the Health Board's Risk Management Strategy and Policy documents, and Board Assurance Framework and processes and the local strategy and procedures and comply with them.

All Managers (Leaders of Teams, Service Managers, Area Leads etc)

- 4.5 The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks, within a structured risk management framework.

- 4.6 Managers at all levels of the Organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/area operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff attend relevant mandatory and local training programmes.
- 4.7 Managers must be fully conversant with the Health Board's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

Director of Corporate Governance

- 4.8 The Director of Corporate Governance will, with the support of the Assistant Director of Corporate Governance & Risk:
- work closely with the Chair, Chief Executive, Chair of the Audit and Risk Committee and Executive Directors to implement and maintain the Risk Management Strategy and Board Assurance Framework and related processes, ensuring that effective governance systems are in place;
 - work with the Board of CTMUHB to develop a shared understanding of the risks to the CTMUHB's strategic objectives/goals;
 - develop and communicate the Board's risk awareness, appetite and tolerance;
 - develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein;
 - monitor the action plans and reporting to the Health Board and relevant Committees.

Executive Directors

- 4.9 Executive Directors are accountable and responsible for ensuring that their areas of responsibility are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

4.10 Specifically they will:

- act as strategic risk owner for risks within their remit escalated to the Organisational Risk Register;
 - use the Datix Risk Management system for recording and reviewing risk;
 - communicate to their staff the Health Board's strategic objectives and ensure that ~~Locality, System Group, Care Group~~, Clinical Service Group and Corporate Departments and individual objectives and risk reporting are aligned to these;
 - ensure that a forum for discussing risk and risk management is maintained within their area which will encourage the proactive management of risk;
 - co-ordinate the risk management processes which include: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
 - ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
 - provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
 - ensure staff attend relevant mandatory and local training programmes;
 - ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
 - ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process;
- and

- ensure that the BAF and the risk management reporting timetable are delivered to the Health Board.

Chief Executive

4.11 The Chief Executive as Accountable Officer of the Health Board has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, finance, and organisational control and governance.

4.12 The Chief Executive has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Strategy and Board Assurance Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place which provides assurance to the Health Board in relation to the management of risk and internal control;
- putting in place and maintaining an effective system of risk management and internal control.

4.13 The Welsh Government requires the Chief Executive to sign a Governance Statement on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Internal Audit

4.14 Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide the Health Board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards

and good practice. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Risk Committee as appropriate.

5. Risk Management Process

- 5.1 CTMUHB is committed to developing a pro-active and systematic approach to risk management.
- 5.2 Appendices 2 and 3 outline the risk management and risk quantification process.

Risk Assessment

- 5.3 Each service within the Health Board needs to identify risks through the completion of risk assessments and ensure that risk assessments are completed and regularly reviewed on an ongoing basis.

Organisational Risk Register (Risks Rated 15 or above and/or those that cannot be managed locally)

- 5.4 The Organisational Risk Register is a record of all the risks identified across the Health Board through the Risk Management process, their controls, score and risk treatment/mitigation.

Management of Local Risks (Risk Rated below 15)

- 5.5 Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and eight, can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each service area / department.
- 5.6 Any risks identified and evaluated as having a medium rating, i.e. a score between 9 and 12 are managed as follows:
 - If a risk is scored below 12 and can be managed at Service Group Level it will not require escalation, however, it is felt that the risk can no longer be managed at Service Group level and requires more Senior input and support then it will be first

escalated through the relevant structure e.g. **Locality Care Group** Group.

- If a risk is scored at 12 or above it should be escalated to the **Locality Care Group** Group. or relevant escalation point within the function.

5.7 All local risks should be reviewed and updated regularly in accordance with the risk grading. This may need to be more frequent if circumstances require. Risks have been reviewed more frequently (i.e. Monthly) as a consequence of alignment to the new operating model and the new revised Organisational Risk Register.

5.8 If a risk is scored 15 and above it should be escalated as outlined in Appendix 3.

Board Assurance Framework (BAF)

5.9 The Health Board's revised Board Assurance Framework was approved by the Board on the **Pending for 2023**. The BAF is reviewed on annual basis by the Audit & Risk Committee for onward approval by the Board.

5.10 The BAF will be articulated via a Board Assurance Report (BAR) presented to Board that brings together the Health Board's strategic goals and the principal/strategic risks, which may prevent them from being achieved.

5.11 The BAR identifies the controls in place to manage these risks and the assurances, which show whether they are working.

5.12 The BAR will:

- Incorporate action plans for the strategic risks within the "Mitigating Actions" section of the BAR which are closely aligned to the gaps in controls and/or assurances;
- ~~provide action plans to fill any gaps in controls or assurances;~~
- link to key measures of performance and National Priority Measures;
- align strategic risks to operational risks on the Organisational Risk Register.

5.13 The benefits of the BAF include:

- that it is designed specifically for Board-level oversight
- it is a structured and evidence-based assessment of the key risks facing the CTMUHB.
- can be used to shape cycles of business and the work of the Board & committees
- enables Independent Members to focus their scrutiny and constructive challenge
- supports strategic decision-making

5.14 The table below articulates how the BAF differs from the Organisational Risk Register:

Board Assurance Framework	Organisational Risk Register
• Strategic/Principal risks aligned to the Health Board's four strategic priorities • Includes only nine principal risks • Risks identified advised by the Executive Team and agreed by Board ('top down') • Decisions to add, remove or re-score risks are taken by the Board • Risks are organisation-wide in scope	• Mostly operational risks arising from the CTMUHB's day-to-day activities • Includes over 50 of the highest level (currently scored over 15) risks • Risks usually identified by individual services or departments ('bottom up') • Agreed by Executive Senior Leadership Group following triage by Care Group Localities/relevant leads • Some are organisation-wide, others are specific to services or directorates, but require involvement by the Executive Team or other services

5.15 The Health Board will monitor and ensure the BAF remains up to date by the following activity:

- Each strategic/principal risk has a Lead Executive(s);
- The Assistant Director of Governance and Risk will review the risk score, action plan and current performance with the Lead Executive(s) in readiness for reporting to the Board;
- Each principal risk has a lead Board Assurance Committee;

- More than one Board Committee will monitor some principal risks. These committees will scrutinise and seek assurances on the principal risks which they own;
- ~~The BAR will include a trend line for each principal risk, showing how the score has changed over time;~~
- The Board should consider annually whether the principal risks are comprehensive, or if risks need to be added / removed / changed.

5.16 The Audit and Risk Committee, as a Committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

Risk Quantification and Escalation & De-escalation

5.17 The approach to quantifying risk is described in Appendix 2. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target risk score (after completion of actions). A risk-scoring matrix to describe the quantification of risk is also included in the Procedure.

5.18 The process of risk escalation and de-escalation will be monitored by the Audit and Risk Committee, through monitoring new risks hitting threshold scores and being escalated as appropriate and/or current risks having their risk grading reduced so that the risks are appropriately de-escalated from the Organisational Risk Register.

5.19 The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and where it should be reported. The Board defines as "High" any risk that has the potential to damage the Organisation's objectives. General guidelines are:

High Risk	Score 15 - 25 and above or a risk which can no longer be	Report immediately to relevant Executive Director and escalate to the Organisational Risk Register. Where a risk is considered appropriate, the Executive Director will escalate to the SLG.

	monitored locally	In the event this causes delay, the ~~Care Group Locality~~ Director can report directly to the Chief Executive. Formally record on Datix.
Medium Risk	Score 9-12	9-11 – reports to Clinical Service Group 12-14 – reports to ~~localities~~ Care Groups /Corporate Functions Formally record on Datix.
Low Risk	Score 1-8	Report to Service Lead / Team Lead with proposed treatment/action plans, for particular monitoring. Formally record on Datix.

Risk Appetite

5.20 At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.

5.21 Decisions on accepting risks may be influenced by the following:

- the likely consequences are insignificant;
- a higher risk consequence is outweighed by the chance of a much larger benefit;
- occurrence is rare;
- the potential financial costs of minimising the risk outweighs the cost consequences of the risk itself;
- reducing the risk may lead to further unacceptable risks in other ways.

5.22 Therefore, a risk with a high numerical value may be acceptable to the organisation, but that decision would be taken at an appropriate level.

5.23 The Board will review its risk appetite on an annual basis to ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve.

5.24 The matrix has the following risk levels:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.

Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

5.25 The Health Board's Risk Appetite Statement is included at Appendix 4.

6. Information / Support

- 6.1 Support and guidance is available from the Assistant Director of Governance & Risk via cally.hamblyn2@wales.nhs.uk.
- 6.2 Risk Assessment templates and training information is available via the following site on SharePoint:
<http://ctuhb-intranet/dir/HealthandSafety/default.aspx>

7. Appendix 1 - Definitions

Assurance	Confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved. Sources of assurance include; reviews, audits, inspections both internal & external.
Assurance rating	This is the rating which has been given regarding the level of assurance: (1)= Management Reviewed Assurance (2)= Board Reviewed Assurance (3)= External Reviewed Assurance
Control Measures	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method, or device that modifies or manages risk. Risk treatments become controls, or modify existing controls, once they have been implemented.
Current Risk Rating	The risk rating whilst risk responses are in the process of being implemented. Some controls are probably in place but others required are still being actioned & will be shown as gaps in control & actions until implemented.
Initial Risk Rating	The risk rating before any controls have been put in place.
Risk Actions	Actions required to mitigate the risk. Actions should be SMART & have clear owners assigned. This will allow action progress to be tracked & monitored & issues with action completion to be visible & dealt with.
Risk Appetite	At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.
Risk Assessment	Risk assessment is a process that is made up of three separate processes: risk identification, risk analysis, and risk evaluation. Risk identification is a process that is used to find, recognize, and describe the risks that could affect the achievement of objectives. Risk analysis is a process that is used to understand the nature, sources, and causes of the risks that you have identified and to estimate the level of risk. It is also used to study impacts and consequences and to examine the controls that exist. Risk evaluation is a process that is used to compare risk analysis results with risk criteria in order to determine whether or not a specified level of risk is acceptable or tolerable.
Risk Description	A structured statement describing the risk usually containing the following elements: sources, events, causes and consequences / impact. A well-written risk statement captures three main parts; If, Then, Resulting In.

Risk Management	Risk management refers to a coordinated set of activities and methods that is used to direct an organization and to control the many risks that can affect its ability to achieve objectives. The term risk management also refers to the programme that is used to manage risk. This programme includes risk management principles, a risk management framework, and a risk management process.
Risk Owner	Senior person best placed to keep an eye on the risk with decision making authority. This person is accountable for the Risk & should be aware of its current status.
Risk Rating	This is calculated by multiplying consequence x likelihood (impact x probability). Consequence: is the outcome of an event and has an effect on objectives. Likelihood: is the chance that something might happen. Likelihood can be defined, determined, or measured objectively or subjectively.
Risk Treatment	This is a risk modification process. It involves selecting & implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls. Treatment options include; Avoidance / Remove the source of the risk Reduction Transference Retain / Accept the risk Also known as the four T's – Treat, Transfer, Tolerate & Terminate
Strategic Risk Owner	Usually the Executive Director in relation to the risk area.
Target Risk Rating	When action is taken to treat risks, it may eradicate the possibility of the risk occurring. However, actions are often more likely to reduce the probability of the risk occurring, leaving the residual risk. The remaining level of risk after all treatment plans have been implemented is the residual risk. Generally the target level is the level at which the organisation is saying it's happy to live with. All agreed controls are in place & assurance is being provided that controls are working as planned. At this point the risk should be closed unless further actions are deemed required.

Risk Domain and Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low-level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event, which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low-level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.
Fraud/Bribery	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation, which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint)	Could result in material loss or reputational damage. (Moderate risk to the organisation, which may result in reduction of service. Material loss of up to £10000. Reputational damage across the NHS with a high potential for complain or a low risk of litigation)	Could result in high material loss or reputational damage (may result in temporary loss of service or material loss of up to £50,000. Reputational damage widespread and outside of NHS with a likelihood of litigation.	Could result in significant material loss or reputational damage. (High risk, which may result in, prolonged loss of service or material loss of over £50,000. Nationwide media coverage causes reputational damage, which is likely to lead to criminal prosecution or external investigation.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

RISK REVIEW

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

8. Appendix 3 – Risk Management Process – Service to Board Escalation

	TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
1.	Risk Assessment Identify Operational and Strategic risks through the completion of risk assessment and for ensuring that risk assessments are completed on an ongoing basis. Training is available for Risk Assessments and for the Datix System Please contact: Cally.Hamblyn2@wales.nhs.uk or visit: Risk Assessment - Risk		Each: It is everyone's responsibility to identify risks however, escalation would be through the - Care Group - Central Leads - Corporate Function Lead - Executive Lead	N/A	No
2.	Risk Register Use the Datix Risk Management System to record all risks identified through the Risk Management Process, their Controls, and score and risk treatment/mitigation and generate risk registers.		Each: - Care Group - Central Corporate Function - Executive Lead	N/A	No
3.	Management of Local Risks - Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and eight, can be managed locally within the relevant area. - These risks can typically be resolved quickly and relatively easily if the correct actions identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each service area/department. - All local risks should be reviewed and updated as per the frequency captured in Section 9 of the Risk Assessment Procedure.	Scored Between 1-8	Each: - Care Group - Central Corporate Function - Executive Lead Held and Managed Locally	Local Risk Register	NO If it can be managed locally. YES If it is felt that the risk can <u>no longer be managed locally</u> and requires more Senior input and support then it will be first escalated by the risk owner up through the using the notification / escalation via the Datix system Care Group Director Triumvirate or Central Corporate Functions as appropriate
4.	Clinical Service Group Risks - Risks Identified at a Service Level should be recorded by a relevant Manager on a Service Group Risk Register. - Reviewed <u>at least</u> bi-monthly at the relevant Service Group / Directors meeting.	Scored Between 8-12	Central / Clinical Service Group Held and Managed at Service Group Level	Central / Clinical Service Group Risk Register	NO If it is scored below 12 and can be managed at Service Group Level YES 1) If it is felt that the risk can <u>no longer be managed at Service Group level</u> and requires more Senior input and support then it will be first escalated up through the Care Group Director Triumvirate as appropriate through the using the notification / escalation via the Datix system And 2) If the risk is scored at <u>12 or above</u> it should be escalated to the Care Group Director Triumvirate
5.	Central and Care Group Risks - The Central Function Director Lead and Care Group Director Triumvirate should have sight of the Service Group Risk Registers and ensure that risks scored at 12 or above are recorded. - Care Group Risk Registers should be monitored at Care Group QSPE Meetings and considered for escalation to the Organisational Risk Register at the Operational Management Service Board. - Central Function Risk Registers should be received at Senior Management Team meetings and considered for escalation to the Organisational Risk Register at the Operational Management Service Board.	All Risks	Central Functions Care Group Director Triumvirate Held and Managed at Care Group Level	Care Group Risk Register Central Corporate Functions Risk Register	NO If scored below 15. YES 1) If it is felt that the risk can <u>no longer be managed at Central and Care Group Level</u> and requires Executive Level input and support then it will be first escalated up through the Operational Management Board (OMB) or the Executive Leadership Group (ELG) as appropriate to consider escalation to the Organisational Risk Register 2) If the risk is scored at <u>15 or above</u> and/or novel or contentious it should be considered for escalation by the Operational Management Board (OMB) or Executive Leadership Group (ELG) as appropriate to the Organisational Risk Register

Appendix 4 – Risk Appetite Statement

Cwm Taf Morgannwg University Health Board

Risk Appetite Statement

1. Introduction:

Public sector organisations cannot be culturally risk averse and be successful. Effective and meaningful risk management in government remains more important than ever in taking a balanced of risk and opportunity in delivering public services. Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's **risk appetite**.¹

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - **its risk appetite** – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.²

The challenge for the Board in managing risk whilst balancing **quality & safety, people, performance activity and financial duties** is not underestimated, and the intention of the Risk Appetite Statement is to support an informed risk based decision.

2. Cwm Taf Morgannwg University Health has adopted the following Risk Appetite Matrix:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

3. Cwm Taf Morgannwg University Health Boards Risk Appetite Statement:

The Health Boards risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives.

The Health Board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

- **Quality and Safety risks** - (including physical and/or psychological harm) of its patients, **people** and the **population**) – the Health Board has adopted a **Cautious** stance for quality and safety risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **People risks** - (including physical and/or psychological harm) to people directly engaged by the Health Board as staff or volunteers – the Health Board has adopted a **Cautious** stance for people risks, with a preference for consideration of the impact on the well-being of staff, including insufficient staffing numbers, unmanageable workload, burnout, or any safety risks, tolerating a cautious degree of residual risk and choosing the option most likely to result in a positive, healthy experience of work for our people, while also balancing service provision to our population.

¹ Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0

² The Orange Book – Section A

- **Operational Performance risks** – the Health Board has adopted an **Open** stance for Operational Performance risks, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of its patients, people and the population.
- **Reputation / Adverse Publicity (Trust in Confidence) risks** - the Health Board has adopted a **Cautious** stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **Business Continuity risks** - the Health Board has adopted a **Cautious** stance for Business Continuity Risks. The Board will receive ongoing assurance from the testing of business continuity plans.
- **Legal / Regulatory Compliance risks** – the Health Board has adopted a **Cautious** stance for Legal, Regulatory and Compliance risks, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. The Board will receive assurance that compliance regimes are in place.
- **Data and Information Management risks** – the Health Board has adopted a **Cautious** stance for data and information management risks seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. There is acceptance for the need for operational effectiveness with risk mitigated through careful management of information sharing and limiting distribution.
- **Financial stability risks** – the Health Boards stance for financial risk is varied as follows:
 - **Averse** for financial propriety, statutory and regularity risks with a determined focus to maintain effective financial control framework accountability structures.
 - **Averse** – in terms of risks related to the Health Boards qualification of accounts, associated process and deviation from reporting timescales.
 - **Cautious** - in terms of risks related to the Health Board's financial breakeven duties set out in the NHS Wales Finance Act (Wales) 2014, recognising the need to ensure appropriate balance with the Duty of Quality.
 - ~~**Minimalist** – as to risk relating to breaching individual control totals.~~
 - **Cautious** – In relation to the Health Boards budget, spend with the intention that it should maximise the use of resource each year. The Health Board will seek safe delivery options with little residual risk that only yield some upside opportunities. The Board would receive ongoing assurance through reporting structures that policies and procedures are in place to comply with HMT guidance.
- **Assets and Estates risks** – the Health Board has adopted **Cautious** and **Open** stances for assets and estates respectively, seeking value for money but with a preference for proven delivery options have that a cautious residual risk. this means that the Health Board will us solutions for purchase, rental, disposal, construction, and refurbishment that ensures it protects the public purse from as much risk as possible, producing good value for money whilst fully meeting organisational objectives.
- **Technological advances** - the Health Board has adopted an **Open** stance for risks associated with technological advances accepting that system and technology developments can enable improved delivery. Responsibility for non-critical decisions may be devolved in accordance with the Scheme of Delegation. Plans aligned with functional standards and organisational governance.

9. Appendix 5 – Board Assurance Framework (Strategic / Principal Risks)

As at the 1.4.2023, the following Strategic Risks are identified for CTMUHB.

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee(s)
1.	Sufficient capacity to meet emergency and elective demand	Improving Care 	Chief Operating Officer, Exec. Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance
2.	Ability to deliver improvements which transform care and enhance outcomes	Improving Care 	Exec. Dir. Of Nursing, Midwifery & Health Professions; Exec. Medical Director	Quality and Safety
3.	Finance and Resources	Sustaining our Future 	Exec. Director of Finance; Exec. Director for People	Planning, Performance and Finance; People and Culture
4.	Sufficient workforce to deliver the activity and quality ambitions of the organisation	Sustaining our Future 	Executive Director of People	People & Culture Committee
5.	Community and Partner Engagement	Creating Health 	Exec. Director of Public Health	Population Health & Partnerships
6.	Delivery of a digital and information infrastructure to support organisational transformation	Improving Care 	Director of Digital	Digital & Data
7.	Leadership and Management	Inspiring People 	Exec. Director for People	People and Culture
8.	Culture, Values and Behaviours	Inspiring People 	Exec. Director for People	People and Culture
9.	Fulfilling our Environmental and Social Duties and ambitions	Sustaining our Future 	Exec. Director of Strategy and Transformation	Population Health and Partnerships

1. Introduction:

Public sector organisations cannot be culturally risk averse and be successful. Effective and meaningful risk management in government remains more important than ever in taking a balanced of risk and opportunity in delivering public services. Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's **risk appetite**.¹

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - **its risk appetite** - and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.²

The challenge for the Board in managing risk whilst balancing **quality & safety, people, performance activity and financial duties** is not underestimated, and the intention of the Risk Appetite Statement is to support an informed risk based decision.

2. Cwm Taf Morgannwg University Health has adopted the following **Risk Appetite Matrix**:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

3. Cwm Taf Morgannwg University Health Boards **Risk Appetite Statement**:

The Health Boards risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives.

The Health Board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

- **Quality and Safety risks** - (including physical and/or psychological harm) of its patients, **people** and the **population**) – the Health Board has adopted a **Cautious** stance for quality and safety risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **People risks** - (including physical and/or psychological harm) to people directly engaged by the Health Board as staff or volunteers – the Health Board has adopted a **Cautious** stance for people risks, with a preference for consideration of the impact on the well-being of staff, including insufficient staffing numbers, unmanageable workload, burnout, or any safety risks, tolerating a cautious degree of residual risk and choosing the option most likely to result in a positive, healthy experience of work for our people, while also balancing service provision to our population.
- **Operational Performance risks** – the Health Board has adopted an **Open** stance for Operational Performance risks, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of its patients, people and the population.

¹ Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0

² The Orange Book – Section A

- **Reputation / Adverse Publicity (Trust in Confidence) risks** - the Health Board has adopted a **Cautious** stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.
- **Business Continuity risks** - the Health Board has adopted a **Cautious** stance for Business Continuity Risks. The Board will receive ongoing assurance from the testing of business continuity plans.
- **Legal / Regulatory Compliance risks** – the Health Board has adopted a **Cautious** stance for Legal, Regulatory and Compliance risks, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. The Board will receive assurance that compliance regimes are in place.
- **Data and Information Management risks** – the Health Board has adopted a **Cautious** stance for data and information management risks seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. There is acceptance for the need for operational effectiveness with risk mitigated through careful management of information sharing and limiting distribution.
- **Financial stability risks** – the Health Boards stance for financial risk is varied as follows:
 - **Averse** for financial propriety, statutory and regularity risks with a determined focus to maintain effective financial control framework accountability structures.
 - **Averse** – in terms of risks related to the Health Boards qualification of accounts, associated process and deviation from reporting timescales.
 - **Cautious** - in terms of risks related to the Health Board’s financial breakeven duties set out in the NHS Wales Finance Act (Wales) 2014, recognising the need to ensure appropriate balance with the Duty of Quality.
 - ~~**Minimalist** – as to risk relating to breaching individual control totals.~~
 - **Cautious** – In relation to the Health Boards budget, spend with the intention that it should maximise the use of resource each year. The Health Board will seek safe delivery options with little residual risk that only yield some upside opportunities. The Board would receive ongoing assurance through reporting structures that policies and procedures are in place to comply with HMT guidance.
- **Assets and Estates risks** – the Health Board has adopted **Cautious** and **Open** stances for assets and estates respectively, seeking value for money but with a preference for proven delivery options have that a cautious residual risk. this means that the Health Board will us solutions for purchase, rental, disposal, construction, and refurbishment that ensures it protects the public purse from as much risk as possible, producing good value for money whilst fully meeting organisational objectives.
- **Technological advances** - the Health Board has adopted an **Open** stance for risks associated with technological advances accepting that system and technology developments can enable improved delivery. Responsibility for non-critical decisions may be devolved in accordance with the Scheme of Delegation. Plans aligned with functional standards and organisational governance.

Risk Domain and Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low-level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.
Fraud/Bribery	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation, which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint)	Could result in material loss or reputational damage. (Moderate risk to the organisation, which may result in reduction of service. Material loss of up to £10000. Reputational damage across the NHS with a high potential for complain or a low risk of litigation)	Could result in high material loss or reputational damage (may result in temporary loss of service or material loss of up to £50,000. Reputational damage widespread and outside of NHS with a likelihood of litigation.	Could result in significant material loss or reputational damage. (High risk, which may result in, prolonged loss of service or material loss of over £50,000. Nationwide media coverage causes reputational damage, which is likely to lead to criminal prosecution or external investigation.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Last approved: Pending

RISK REVIEW

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.



AGENDA ITEM

5.2

AUDIT & RISK COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting

19th April 2023

FOI Status

Open

If closed please indicate reason

Not applicable - Public Meeting

Prepared by

Cally Hamblyn, Assistant Director of Governance & Risk

Presented by

Cally Hamblyn, Assistant Director of Governance & Risk

Approving Executive Sponsor

Paul Mears, Chief Executive

Report purpose

FOR REVIEW & APPROVAL

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

Committee/Group/Individuals

Date

Outcome

Service, Function and Executive Formal Review

February / March 2023

RISKS REVIEWED

Quality & Safety Committee

16.3.2023

ASSIGNED RISKS REVIEWED

ACRONYMS

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.



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

- 2.1 Following discussion at the Operational Management Board in February 2023, Care Groups are undertaking to review all risks under their areas of responsibility, initial focus will be on the high level risks escalated to the Organisational Risk Register.
- 2.3 The Assistant Director of Governance & Risk and Chief Operating Officer held a workshop with Executive Leads in January 2023 to review the Organisational Risk Register in terms of consistency of risk scoring, robustness of narrative and review of actions being taken to mitigate risks. Executive Leads agreed to undertake a robust review of risks assigned to them to ensure there is consistency and moderation in terms of risk scoring.
- 2.5 Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2023. **388** members of staff trained to date.
- 2.6 Risks on the organisational risk register have been updated as indicated in **red**.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Strategy & Transformation Portfolio

- Datix ID 5374– Fulfilling our environmental and social duties. Risk score of 16.

People & Culture Portfolio

- Datix ID 4679 - Absence of a TB vaccination programme for staff. Risk re-escalated in March 2023. Risk score of 16.

3.2 CHANGES TO RISKS

a) Risks where the risk rating **INCREASED** during the period

Nil this period.

b) Risks where the risk rating **DECREASED** during the period

- Datix ID 4722 - Senior Medical Workforce Shortfall - Adult Mental Health. Risk score decreased from a 16 to a 12.
- Datix ID 3131 – Mortuary Capacity. Risk score decreased from a 20 to a 16.
- Datix ID 5254 - Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour. Risk score decreased from



a 20 to a 16.

- Datix ID 5036 - Pathology services unable to meet current workload demands. Risk score decreased from a 20 to a 16.
- Datix ID 2721 – Capacity to deliver POCT training to Health Board Nursing Staff. Risk score decreased from a 16 to a 8. De-escalated from the Organisational Risk Register. Rationale captured in Appendix 1.
- Datix ID 4149 – Failure to sustain Child and Adolescent Mental Health Services. Risk score decreased from a 16 to a 12. De-escalated from the Organisational Risk Register. Rationale captured in Appendix 1.
- Datix ID 4908 - Failure to manage Legal cases efficiently and effectively. Risk score decreased from a 16 to a 12. De-escalated from the Organisational Risk Register. Rationale captured in Appendix 1.
- Datix ID 4940 - Delay to full automated Implementation of Civica. Risk score decreased from a 16 to a 12. De-escalated from the Organisational Risk Register. Rationale captured in Appendix 1.

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

- Datix ID 4971 – Adult Special Care Dentistry. Risk Closed. Rationale captured in Appendix 1.

3.4 **DICUSSION POINTS**

- Updates to the following risks were received post ELG meeting on the 6th March, however, have been signed off by the Executive / Director lead:
 - Datix ID 4971 – Adult Special Care Dentistry
 - Datix ID 4632 - Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)
 - Datix ID 5214, Critical Care Medical Cover
 - Datix ID 4080, Failure to recruit sufficient medical and dental staff
 - Datix ID 3638, Pharmacy & Medicines Management - Training & Development Infrastructure
 - Datix ID 4590, Critical Care Pharmacist Resource
- At the Quality & Safety Committee on the 16th March 2023, members considered the reduction in risk scores for Datix Risk ID 3131 – Mortuary Capacity and Datix Risk ID 4908 – Failure to Manage Legal Cases Efficiently and Effectively had been reduced prematurely. These points have been deferred back to the risk owner for consideration and will not be fully removed from the Organisational Risk Register until Members consider that sufficient assurance has been received.



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

Consequence	5			4253 3337 4768 4772 2987 3993 5323	4080 3826 4664 4887 5214			
	4				4458 4148 4337 3008 4743 4798 4906 4809 5014 4753 4679 3131	4152 3585 3133 2787 1133 4752 4922 4479 4315 4417 5374 5254 5036	4491 4632 4071 4721 4103 4841 4827 5153 5154 4907 4780 4922 5267	
	3						3638 4691 4732 4920 5207 4699	4672 4671 4512 4590 4691 2808 5040 4217
	2							
	1							
	CxL	1	2	3	4	5		
	Likelihood							

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below. Not applicable for the Risk Register item.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care



5. RECOMMENDATION

5.1 The Committee are asked to:

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

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequenc e X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	IF: the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. THEN: operational delivery of pathology services may be severely impacted. RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to the new system supplier will be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review the new system suppliers revised delivery plan. There has been several meetings between Health Boards, LINC Programme and Commercial Providers. At a meeting held on the 13th December it was agreed by NHS that deployment would be sequential and in the original running order. Health Board configuration meeting scheduled with Commercial supplier for 10th January 2023. March 2023 - Currently awaiting further updates on the contractual arrangements. Board Members briefed at the Board Briefing on the 16th February 2023.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	1.3.2023	31.3.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues. THEN: operational delivery of pathology services may be severely impacted. RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	The Covid-19 Inquiry Working Group are monitoring a number of preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022.	Establish a Timeline for CTMUHB - the timeline will have a few elements and uses and will continue to evolve as information is archived. This Timeline does not include the Health Board Information as this requires the archiving of documents in order to populate it. Archiving Information against the Timeline is yet to commence as the current Covid-19 Information Manager resigned from the role and left the Health Board at the end of August. Recruitment for a successor to the role was unsuccessful and therefore the pace of progress in developing the Health Boards Timeline and gathering key documentation centrally is being significantly impacted which could be detrimental to the Health Board being able to efficiently and effectively respond to requests from the Inquiry. The AD for Governance & Risk is exploring other options for resourcing this role including project management support. Following a briefing meeting with Legal Counsel it was clear that the Health Boards focus should be on the timeline and documentary evidence at this stage which has heightened the risk in terms of the resource afforded to the preparedness for the inquiry. Legal Counsel advised the Health Board to pause the introduction of the All Wales Reflection document at this stage of the Inquiry. At the Covid-19 Pandemic Inquiry Working Group on the 11th October the likelihood of this risk was increased from a 4 to a 5 based on the above risk factors. Update December 2022 - The Covid-19 Information Manager position was re-advertised in December for shortlisting in the New Year. Whilst the success of this latest recruitment exercise is unknown the risk score will remain unchanged. Review 31.1.2023. Update March 2023 - risk score remains unchanged as the Health Board was unable to successfully recruit to the Covid-19 Information Project Manager role at the interviews in February 2023. The post has been re-advertised. Risk to be reviewed end of April 2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	3.3.2023	30.04.2023
4780	Executive Director for People	Central Support Function -Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tonteg is on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role.	Mitigating action is to increase the establishment within the Manual Handling Team by at least one extra Trainer; one extra Assistant and another Risk and Safety Officer. As at 03/05/2022 - Currently the Health Board does not have additional monies to support these posts. To review later in the year to see if improvements in the financial forecast have improved. Review position: 31.8.2022. Update August 2022 - Following recent discussions with the Director for People, an updated business case will be submitted to the Strategic Leadership Group to address additional resources. Review set for the 30.09.2022. Update October 2022 - Risk score escalated in October due to the increased training required by new starters, bank staff and overseas nurses. Update 27.2.2023 - Business case submitted to Executive Director for People for consideration on the 23.2.2023. Next review 30.4.2023.	Health Safety & Fire Sub Committee	20	C4 x L5	4 (C2xL2)	↔	06.08.2021	27.2.2023	30.04.2023
5214	Executive Medical Director / Chief Operating Officer	Planned Care Group	Care Group Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Critical Care Medical Cover	IF: Depleted Consultant Intensivist numbers at Princes Of Wales (POW) continue as a result of medical reasons, retirement and unable to recruit to vacant posts. No Middle Grade medical tier at POW. Consultant intensivist delivered service. Then: Without Middle Grade tier positions the ability to attract and recruit Consultants will be limited. Resulting in: the Health Board being unable to deliver safe patient care with gaps in rota. Potential for days and nights to not be consultant covered. No medical team to manage patients.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care.	Workforce business proposal to fund Middle Grade tier to ELG. Digital solution to provide safe cross site Consultant cover for RGH and POW, requires IT solution across POW and RGH. Develop workforce modelling for next 2 years and 10 years. Appoint Critical Care lead across CTM to establish one department - 3 sites approach (Care Group organisational change). Update 1.3.2023 - Deputy Director of Nursing liaising with Medical and Workforce colleagues to lead the review of this risk and other risks in relation to Critical Care Workforce. Timescale for review April 2023. Therefore no change to this risk as at 1.3.2023. New Critical Care leadership team have taken on reconfiguration and will be involved in this risk review activity.	Quality & Safety Committee People & Culture Committee	20	C5xL4	10 (C5xL2)	↔	19.8.2022	1.3.2023	28.04.2023.
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption	Retrieval and filing of case notes in the POW Medical Records Library	IF: The Medical Records Filing Library at Princess of Wales is full to capacity making it very difficult for staff to retrieve and or file case notes. THEN: Risk of unable to manoeuvre mobile racking, therefore unable to access case notes Risk of fire as case notes close to source of ignition Risk of Fire Service or HSE closing access department Very High risk of upper limb injury Risk of notes falling from height causing injury (some case notes are in excess 8.3kg) Risk of Fire Service or HSE closing access to department RESULTING IN: If we could not retrieve any case notes, Consultants would be unable to make clinical decisions impacting on patient care. If the whole library was affected, this would impact 100 of thousands of patients care. Admissions/Outpatients would have to be cancelled staff refusing to continue to work in unsafe environment. Multiple and serious injuries to staff, possibly death.	(The case notes are very tightly packed on shelves. Mobile racking is failing due to age, lack of maintenance, and weight Case notes are being stored inappropriately on floors under desks, and insecurely at height. The working environment is congested, with no dedicated storage space for large ladders. Significant force is required to retrieve each file (123.N - this is 3 times higher than what is considered to be high force).) Broken Racking at Bridgend Offsite Stores - Repairs have been carried out with damaged racking in Bridgend North Rd Offsite stores. Temporary use of container deployed on site. Broken Racking at POW - On each occasion the racking has failed, the engineer has been able to repair it (£500 + VAT) but it continues to fail. Please see progress notes for more information. Access to this specific racking is permitted to Supervisors only, who only access it once a day. The Filing Library is closed to non-Medical Records staff, aside from the Porters who require access for emergency OOH admissions. Task and Finish group establish to address the above risks. Capacity has been identified at Glanrhyd and noticed served to SBUHB to vacate. It is hoped that we will be able to relocate notes to this area in mid-July, which will address the immediate H&S issues. Currently waiting for procurement process to be completed.	Relocation of Case Notes from POW/Bridgend Off-site Store to Glanrhyd Site. Timeframe 19.8.2022 Replace racking and review office environment of POW filing Library. Timeframe 30.01.2023 Creating additional long term storage space. Timeframe 31.07.2023 Update 31.10.2022 - Approx. 30,000 records have already been redistributed across POW, North Road Offsite Store and Glanrhyd Library, to improve conditions at POW. Work is still ongoing at POW to redistribute records safely. Original broken rack mostly vacated but other racks holding notes have similar issues. Glanrhyd partly vacated by SBUHB but not fully available for use yet. The Medical Records Department plan to relocate 10 Registration Medical Records staff to the Library Offices in this space. Proposal put forward by an Operational Services Manager to relocate additional 17 Appointment Booking Centre staff into these same offices and also the Library area. This Library space is already identified for boxed records, compromising room for future growth and safer storage; this will affect the ongoing position at POW and North Road. Risk to be reviewed in 6/52, when SBUHB should have fully vacated and a decision made as to who/what will occupy remaining space at Glanrhyd Library. Update January 2023 - Relocation of Case Notes Action: 30,000 case notes relocated to Glanrhyd. This action was closed 16.12.2022. Update 02/03/2023 - Lead IPCN to speak to the Nurse Consultant for IPC (HARP TEAM) to determine if she could support the scoping work planned in primary care. IP&C team to continue to work through how community support can be delivered within the current resource, to be further discussed at the April 2023 IP&C. No change to risk score.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	10 (C5xL2)	↔	27.10.2021	02.03.2023	28.04.2023
4827	Executive Director for People	Central Support - Health, Safety & Fire Safety Function	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses e.g. Covid, flu, etc; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	SBAR completed outlining the requirements regarding Fit Testing. As at 3.5.2022 it has been confirmed that there is no funding available and it has been added to the Health Board's priority list. Further update is awaited from the Strategic Leadership Team. Update June 2022 - 23/06/2022 - No further update from the Senior Leadership Team and this risk is now increasing due to the current risk in the UK from Monkeypox. Update August 2022 - Discussions to take place between the Director for People and Deputy Director of Nursing due to the continued requests for this training. Meeting to be arranged ASAP. Review date 30.09.2022. Update October 2022: Meeting took place in September 2022 with Deputy Director of Nursing and ILG Nurse Directors to review the possibility of staff being nominated to undertake qualitative (bitter/sweet) fit testing in each ILG area. H&S Team have committed to providing courses to ensure these fit testers are competent. Further meeting to be arranged to confirm arrangements. Review 30.11.2022. Update March 2023 - no change to mitigation and risk scoring. Next review 31.3.2023.	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	30.11.2022	31.3.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	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: - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified. Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	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. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023. Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each specialty now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities. Update September 2022 - Continue delivery of the Planned Care Recovery Actions. Reconfiguration orthopaedic inpatient operation. Commissioning the insourcing of the workforce to deliver to Theatres. Amalgamation of Health Board wide capacity plans. Significant work ongoing in relation to FUNB which is being captured in the performance reports. Update October 2022 – Procurement exercise commenced 20 Oct 22 re the insourcing of the workforce to deliver to Theatres. Recruitment to theatres transformation role from 28 Oct 22. Amalgamation of Health Board wide capacity plans. Significant work continuing in relation to FUNB which is being captured in the performance reports. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	28.10.2022	30.11.2022
5153	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2022/23.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2022/23 (including funding for Covid response costs and Exceptional items) . Then: The Health Board will not be able to deliver a break-even financial position for 2022/23. 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. The context is that the draft financial plan for 22/23, submitted to WG at the end of April, has three elements : A core plan which has a planned deficit of £26.5m, excluding Ongoing Covid response costs of £32.3m and Exceptional Items of £19.0m. Assumed non-recurring funding for the Covid and Exceptional costs has yet to be confirmed by WG. Delivery of the Core plan is also predicated on a the delivery of efficiency savings of £17.3m which is a significant step up in savings compared to recent years.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Further discussions needed with Welsh Government to understand the likely funding position for 22/23. Update September 2022 Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid response costs. Update 24.10.2022 - Position remains as reported for September 2022. No change to risk score. Update 3rd Jan 2023. The funding position for 22/23 in relation to Exceptional items and ongoing Covid -19 response costs has now been clarified by WG. The forecast Core plan overspend for 22/23 at M8 is still £26.5m and there is no change to the risk score.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	8.7.22	3.1.2023	01.3.2023
5154	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to reduce the planned recurrent deficit of £28.0m at the end of 2022/23.	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 2023/24. Then: The Health Board will not be able to develop a break-even financial plan for 2023/24 and deliver it. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	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. Further develop the savings planning processes via the Value and Efficiency programme. Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid response costs. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Update October 2022 - The M6 YTD position is a £14.6m deficit. This represents a £1.4m adverse variance compared to 6/12th of the £26.5m Core plan deficit. The M6 Savings position is forecasting £17.5m of Savings in 22/23 but only £10.4m on a Recurrent basis. (Savings target for 22/23 = £17.3m). The forecast underlying recurrent deficit at 31/3/23 is now £34.9m. This position represents a £6.9m deterioration from the planned recurrent deficit of £28.0m and is due to the forecast shortfall in recurrent savings delivery in 22/23. Further develop the savings planning processes via the Value and Efficiency programme. Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid response costs. Update 3rd Jan 2023 - The M8 YTD position is a £18.0m deficit. This represents a £0.3m adverse variance compared to 6/12th of the £26.5m Core plan deficit (£17.7m). The M8 Savings position is forecasting £17.5m of Savings in 22/23 but only £10.6m on a Recurrent basis. (Savings target for 22/23 = £17.3m). The forecast underlying recurrent deficit at 31/3/23 is now £47.6m. This position represents a £19.6m deterioration from the planned recurrent deficit of £28.0m and includes forecast shortfalls in recurrent savings delivery in 22/23 (£6.7m) and forecast recurrent overspends in Care Groups and directorates (£11.0m). The key actions are to further develop the savings planning/recovery planning processes via the Value and Efficiency programme and the Financial Plan for 2023/24.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	8.7.22	3.1.2023	01.3.2023
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update September 2022 - Score remains unchanged. Recovery actions continue with focus on Urology and Lower GI. Improvements are being recognised in Gynae and Breast Surgery which are currently ahead of plan. Cancer treatments remain higher than pre-Covid levels. Update October 2022 - Score remains unchanged. New Cancer Assurance cycle from November 2022. Recovery actions continue with focus on Urology, Lower GI and Dermatology. Improvements are being recognised in Gynae and Breast Surgery which remain in line with plan. Cancer treatments continue to be higher than pre-Covid levels. Update December 2022 - Score remains unchanged. Health Board is now in targeted intervention for cancer. Additional assurance meeting with WG, WCN and DU underway. New cancer assurance cycle from November 2022 embedding. Recovery actions continue with focus on Urology, Lower GI and Dermatology. Improvements are being recognised in Gynae and Breast Surgery which remain in line with plan. Cancer treatments continue to be higher than pre-Covid levels. Referral rates are higher than pre Covid, but reducing from their highest levels. Challenges remain with diagnostic capacity, short term outsourcing has improved wait times, but longer term solution needed. The mobile endoscopy unit is also providing additional capacity, and reducing waiting times, but a longer term solution is required for after this. 104+ day harm review panels are paused on two sites, recruitment underway for administration support to recommence. Confirmation received 27.1.2023 from the Cancer Business Team that there are no additional delays to cancer patients as a result of the pausing of the harm review panels. Update for March: Overall cancer performance continues to decrease as the long waiting patients are treated. A deep dive into Urology pathways is underway. The breast cancer team are undertaking LEAN training to enable them to look to streamline pathways. A change from 104+ to 146+ day cancer harm reviews, in line with Welsh government guidance, has been approved.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	03.03.2023	31.3.2023
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety	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 affecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	In terms of recruitment the following actions are underway over the next 6-12 months: • Meeting with Executive Director for People held on 24.11.2022 to discuss Medical Workforce (MWF) recruitment (including PAs, Specialist's) • Liaising with Care Group Medical Directors regarding their Care Group workforce planning and strategy • Once the Health Board identifies the gaps from the Medical Workforce Productivity Programme group on the establishment work stream it can then target specific areas with either Consultant, Specialist, MG cover • A report is also being prepared on British Association of Physicians of Indian Origin (BAPIO) for international recruitment. These are risks that will continue due to the National workforce availability. The Health Board will need to tackle these issues in a variety of ways – there is no one solution. The approaches include –recruitment, job planning (compliance and standardisation), establishment, new ways of working (MDT and expanding alternative roles), ADH spend and national rate cards, sickness rates, all of these impact on the workforce and are part of the programme. As the Health Board now has a planned stepwise programme it is dealing with the matter with more clarity and direction.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	09.03.2023	30.04.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequenc e X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	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 enacted. - Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). - Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. - Primary and Secondary Care working Groups in place. - Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTc in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (HIS), streamlining pathways. - Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. - All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	November 2022 update: WLI activity commenced W/C 11th November in an attempt to clear the >104 week backlog, primarily for stage 1 long waiting cataracts. Ongoing clinical and non-clinical validation work is being carried out on all pathway stages with a number of patients being removed as treated or no longer requiring treatment. An application has been made to the Governance Board to appoint an extended nursing team specifically for harm reviews - awaiting outcome. Nursing review is being carried out to measure utilisation and productivity. Ongoing discussion with Cardiff & Vale in relation to using the Vanguard theatres between January and March 2023. Revised SOP shared with community optometrist to consider carrying out new patient glaucoma referrals - awaiting SEWROC outcome. CDO and MD met with the Ophthalmologist to outline future plans and expectations. Update December 2022 - There has been a significant decrease in >104 week stage 1 waiting list subsequent to additional weekend activity. At the beginning of November 2022 we were reporting 1869 RTT cases >104 weeks, The Health Board has carried out 66 additional sessions, primarily addressing cataracts and General Ophthalmology. Scheme extended into January. Consequent to this piece of work, all stage 1 cataract conversions will be sent to C&V during February and March for assessment and procedure. C&V are providing capacity for 500 stage 4 patients, CTM currently have 228 stage 4 conversions >104 weeks and this number will increase whilst we continue with the weekend activity. Validation work is being carried out in tandem with the booking of weekend work and RTT rules. Progress has been made with the regional programme, an Option Appraisal presentation has been circulated to all HB's to include 6 delivery models for local preference ranking. All options are being explored and evaluated against a set of agreed criteria. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	23.12.2022	30.1.2023
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation) harm	IF: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM THEN: avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care RESULTING In: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	- Executive-led Stroke Strategy Group in place, with targeted task and finish under development. - Toll and membership of Strategy Group updated. - Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway - Board briefing to ensure all sighted to challenges - Quarterly briefings to Quality and Safety Committee - Performance data regularly presented to Performance, Planning and Finance Committee - Regional and National Stroke Programme Boards established and progressing developments. - Unified, evidence-based pathway developed for thrombectomy - Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy - Designated senior operational lead for performance and improvement leadership for stroke pathway	Update March 2023 - The CTM Stroke Strategy Group has agreed an integrated action plan with a number of short, medium and long term actions, some of which have resource implications. Progress is being made in a number of areas: - Following the resignation of Consultant Stroke Physician at Prince Charles Hospital, recruitment process ongoing following recent job planning exercise. In the meantime, the CSG continue to work with medical staffing agencies with the recruitment of a Locum Consultant. - A CTM-wide stroke consultant rota, with joint working between POH and POW consultants, in place enabling a more stable rota. Continued dialogue with C&VUHB to look at long term solutions, feeding into the South Central Wales Regional Programme Board. - Regional developments with C&VUHB continue, representatives from both UHBs attended a national programme workshop on Friday 13th January to inform the development of modelling, optimal stroke pathway and service specifications. Successful recruitment has been made to the role of Clinical Lead for Stroke for the South Central Wales Stroke Delivery Network which will enable further progress to be made in response to national service specifications. - Board briefing in January 2023, with input from national stroke leads. - Prescribing nurse has been identified to support the initiation of the AF and BP project in Primary Care, with support of the GP with special interest and possibly additional pharmacists, commencing next month. The blood pressure element will be initially targeted at those patients previously identified through the Health Check programme where they will be reviewed in terms of ensuring their management is optimised. The AF element will be initiated in 2 or 3 clusters in the Bridgend area and work again commenced next month. - Work ongoing to develop services in CTM UHB to respond to planned 24/7 access to thrombectomy in Bristol: - Awaiting final approval for radiographer approved CTA - Implementing CT perfusion (CTP) scanning to extend the window of thrombolysis and thrombectomy - Development of new stroke thrombolysis and thrombectomy pathway in anticipation of new stroke guidelines to be published in April 2023 - Task and Finish group to look at implementation of Braininox, AI software for interpretation of CTA and CTP to help streamline thrombectomy. - Awaiting confirmation of date from alternative Hospital to commence 24/7 thrombectomy for patients in Wales	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	5.3.2023	30.04.2023
4664	Executive Lead: Director for Digital. In Committee	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Legal / Regulatory	Ransomware Attack resulting in loss of critical services and possible extortion	IF: The Health Board suffers a major ransomware attack. Then: there could be potential data loss and subsequent loss of critical services. Resulting in: Catastrophic service loss to all clinical and business services adversely impacting on population health management, patient care, business continuity, health and wellbeing of staff, organisational relationships, substantial financial risk and the UHB's other routine and improvement work - culminating in a culture of mistrust of the Health Board and all things digital leading to the likelihood of the opportunities that present from digital transformation being less likely to be achieved.										
4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety	Failure of appropriate security measures / Safety Fencing	IF: there is a failure in security measures. Then: there is an increased likelihood of patients having unrestricted and inappropriate access on the site. Resulting In: absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	Funding Bid for approx. £385K has been submitted by Estates Update April 2022: The Car Park Security Fencing in the Bridgend Locality is now largely complete with minor 'snagging issues' to close off. Door systems in Ty Llidard CAMHS have been upgraded to include an alarm system on the Mag-lock doors. If the Mag-lock does not engage within a set time frame, then an alarm will sound. Multi storey Car Park at Princess of Wales Hospital has had anti-climb security fencing fitted. This was a WG Capital scheme and is awaiting final project sign-off to complete the works. The only outstanding area is the stairwell which will require more detailed technical design work to identify a solution. That work has commenced and once complete the works can be tendered. This will require further funding in 22/23 Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACG. This work should commence in the early autumn completing within the financial year. Update October 2022 - Deputy COO Acute Services to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	1.11.2022	31.12.2022
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	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. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. Expansion of the bed capacity in VS 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 September 2022 - Risk reviewed by Nurse Director for Unscheduled Care, risk to be closed owing to multiple changes to structures and reporting systems since original risk was opened. Risks to be reviewed and understood against new frame work outlined by the Six Goals Board local governance, quality and safety feedback mechanisms and unscheduled care quality and performance reporting mechanisms. Risk will be closed once the detail has been agreed and new risk superseding this current risk. Update 3.11.2022 - mitigations to improve flow and discharge at POW now being addressed through workstreams 2, 3 and 4 of the UEC 6 goals programme, with rapid focus on reducing lost bed days due to discharge delays, formal launch of D2RA model and pathways Dec 22, along with launch of e-whiteboards/discharge referral forms.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	03.11.2022	31.12.2022

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4907	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to manage Redress cases efficiently and effectively	If: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: • Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. The Health Board has secured Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Update September 2022: The Health Board are starting to realise the risk with evidence of redress cases being moved into claims due to delays, which are being settled for less than £25k, which is non reimbursable through WRP procedures for a claim, however can be reclaimed under redress. An invest to save bid has been developed to address the redress backlog. Update October 2022: Invest to save bid has been developed and submitted. Some resource has been identified through the proposed Quality Governance Operating Model, which should provide some capacity within the service. Update December 2022 - A considerable redress backlog remains, with CTM realising the risk of cases being transferred out of redress into claims, therefore having inability to recoup full costs. This continues to pose a significant reputational and financial impact on the Health Board. Invest to save bid has been unsuccessful therefore other funding options are being explored. Some limited capacity has been identified through the operating model review in respect of quality, safety and governance, however, more resource will be required to begin to manage cases in a timely manner.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	19.12.2022	31.01.2023	
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Director of Nursing & Quality	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	If: the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) Then: The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. Resulting in: The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends • Targeted approach to areas of specific concern reported via finance, workforce and performance committee The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Nurse Roster Policy now approved, ratified and implemented in December 2023. This includes KPIs which will allow monitoring of effective roster management. Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work- provides more rigor to roster management at ward/ department level.	NURSE ROSTERING Nursing Productivity Group actions are progressing well through this forum. Registered Nurse Off contract agency in hours and out of hours forms have been in place for two months - there has been a noticeable reduction in usage and thus spend on off contract Registered Nurses. Workforce and finance teams are working together to provide joint metrics and monitoring of agency usage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group. SAFER CARE Roll out continues on all sites. ENHANCED SUPERVISION Corporate nursing team are due to undertake focused work on areas who have a high number of HCSW agency requests to understand the demand in terms of whether HCSW's are required to support the supervision of an individual or group of patients, whether the requests are related to the increase acuity or due to high sickness/vacancy rates and/ or poor fill rate from bank HCSW requests. The risk score for this risk has been increased to 20 in January 2023 due to the fact that severe operational pressures in the clinical areas, including the opening of several different areas of unfunded beds and frequent "boarding" of additional patients on some wards mean the frequency of the likelihood which was scoring 4 ((Frequency: At least weekly) is now scored at 5 (Frequency: At least daily). This score will be reviewed in March 2023 Update 1.3.2023 - Deputy Director of Nursing liaising with Medical and Workforce colleagues to lead the review of this risk and other risks in relation to Critical Care Workforce. Timescale for review April 2023. Therefore, no change to this risk as at 1.3.2023.	Quality & Safety Committee	20	C4xL5	C4xL3	↔	25.10.2022	1.3.2023	28.04.2023	(It should be noted that although the new reframed risk opened in October 2022 the previous iterations of this risk - Datix ID 4106 and 4157 were opened on the 01.06.2015 and 01.01.2016 respectively)
3131	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Mortuary Capacity	If: There is insufficient Mortuary capacity across the Health Board, including bariatric capacity THEN: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demands), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. RESULTING IN: bodies not being placed in storage that is in compliance with HTA licencing standards. No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nufwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4x4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Long Term Mortuary Capacity Plan. (5 year lease of additional capacity based at PCH has been approved by Executive leadership team in November 2022. Additional unit delivered and preparation and equipping underway to go live by the end of January.) Ongoing discussions with the Coroner have resulted in a 1 year reprieve of post mortems by CTM staff but continuing use of Mortuary space at PCH for external Medical examiners to use from January 2023. SLA being drawn up. Plan to implement electronic white boards for mortuaries in 2023-24. Update February 2023 - Submit paper to HTA board regarding releasing deceased on MES certificate. By releasing deceased following MES certificate this will improve flow of deceased. Timeframe 28.4.2023. Review processes in conjunction with Funeral Directors - Timeframe 30.06.2023 **At the Q&S Committee on the 16th March, members considered it premature to de-escalate this risk score as the action plan has not been completed. This has been deferred back to the risk owner for consideration on the 17.3.2023.**	Quality & Safety Committee	16 ↓ 20	C4xL4	C3xL2	↓ Risk score reduced from a 20 to a 16 in March 2023	05.03.2018	27.2.2023	15.05.2023	
5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Service Director - Diagnostics, Therapies and Specialties Care Group	Improving Care	Patient / Staff /Public Safety	Pathology services unable to meet current workload demands.	If: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022 Update 30.12.2022 Outsourcing to continue in Q4, backlog clearance has helped reduce internal turnaround time for cancer diagnostics to around 10 days (with exception of complex sampling) some serious incidents have been reported through from what was expected to be routine samples but have returned and confirmed cancer samples (gynaecology). Macmillan have supported a 3 year post for haematology. Service Director awaiting response from Executive colleagues regarding sustainable funding post 2026 from SLA repatriation. Bid to continue use of LD Path outsourcing being prepared for 2023-2024 while regional collaboration discussions progress in tandem. Improvement team have been approached to undertake a process mapping exercise to see if we can "lean out" the processes in cellular pathology and haematology. In addition Wales Cancer Network has been approached to support Demand and capacity as internal resource are not adequate to assist in a timely fashion. Update 27.2.2023 - Outsourcing has effectively addressed much of the backlogs in Cell Path, however ongoing outsourcing will be required for the remainder of 22-23 and the whole of 23-24, unless significant changes are made within the HB and across the region. There is ongoing further work required more widely across Pathology to address the staffing and estates challenges. Risk score reduced to 16 to reflect current position, this is dependent upon ongoing review and continued investment from the HB.	Quality & Safety Committee	16 ↓ 20	C4 x L4	6 (C3xL2)	Risk Score reduced from a 20 to a 16 in March 2023	02.03.2022	27.2.2023	30.04.2023		
5254	Executive Director of Nursing.	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	If: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: • New incident framework developed • Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty • Reports run on predicted case numbers • Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update December 2022: Invest to save bid unsuccessful, therefore alternative options for funding being explored. National impact assessment is being developed, which will be reviewed and localised for CTM. New operating model, should give some limited capacity, however, focus will be to target the backlogs within the department. Update March 2023 - A plan has been developed for the implementation of Duty of Candour within CTM. The National Impact assessment is in progress. The new operating model is now at implementation phase, with any vacancies now being advertised. Focus will be to target the Redress backlog. The impact of the Duty of Candour is not yet fully known. Likelihood reduced to a 4.	Quality & Safety Committee	16 ↓ 20	C4xL4	8 (C4xL2)	↓ Risk score reduced from a 20 to a 16 in March 2023	07.10.2022	02.03.2023	30.04.2023	

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5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Infrastructure	Fulfilling our environmental and social duties	If: the health board's decisions fail to reflect our values or consider the long term environmental or social impact Then: we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles Resulting in: negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • CTH 2030' delivery focusses on community developments, employment and local procurement where possible. • CTH becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTH Decarbonisation Group which will have oversight and delivery of CTH's decarbonisation agenda • CTH 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTH Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases	Build environmental and social impact sections into Health Board project paperwork/cover sheets to ensure these have been considered as part of decision making processes. Timeframe: 28.06.2024	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	New risk escalated to the Org Risk Register March 2023	21.2.2023	21.2.2023	28.04.2023
4479	Executive Director of Nursing & Midwifery	Central Support Function - Infection Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety	No Centralised decontamination facility in Princes of Wales Hospital (POWH)	If: there is no centralised decontamination facility in POWH Then: there are a number of areas undertaking their own decontamination via automated/manual systems. Resulting In: possible mismanagement of the decontamination processes/near misses/increased risk of infection/liigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty – clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. APD/Support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs in place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 – In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. 02/08/21 - Operational lead for Decontamination has requested assurance from the lead endoscopy decontamination officer in POW. Timeframe 30.11.2021. 15.12.2021 - risk peer reviewed and agreed that the risk remains as a 20. Development of a business case to create a single centralised decontamination facility on the POWH site has commenced with Welsh Government Funding support. Business case expected to be completed by Spring 2022. Availability of WG funding to create the unit remains a risk. Update June 2022 - Risk reviewed at Infection Prevention Control committee 28/06/2022 and update provided - JAG have agreed to extend accreditation in Princes of Wales for a further 6 months and have requested a progress report on plans for central decontamination. Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Action Plan with no updates reported for August. 17/08/22 - contingency plan being developed with key service users. Central decontamination facility at detailed design stage and business case should be ready for submission by end of January 2023 Update 6.1.2023 - actions as reported in August 2022 currently on track. Next review scheduled for January 2023. Update 28.2.2023 - Activity ongoing - Business case needs to be sent to Welsh Government by May 2023. No change to risk score.	Quality & Safety Committee	16	C4xL4	2 (C1xL1)	↔	30.12.2020	2.3.2023	28.4.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	If: the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; Then: the Health Board will be unable to deliver safe, high quality services for the local population; Resulting in: compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTH. Boundary change and challenges across CTH continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress. Update September 2022 - Nurse Director Review 7/9/22: Unscheduled care group to review immediate workforce resource across all three acute sites by end of October 2022. Actions to then be decided in terms of immediate measures for distribution of staff, governance lines to be agreed (nursing, AHP and Medical) and immediate plan for winter months to be agreed and acted upon. Medium term and substantive plans for workforce requirements and innovations to be worked through as part of six goals board and advanced practice board.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	12.10.2022	07.03.2023
2787	Executive Director for People	Central Support Function - Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Absence of a robust Health Surveillance Programme for employees.	If: there is no monitoring in place for staff who work in areas of the organisation where known health risks could develop e.g. Hand, Arm Vibration (HAVs), noise, skin conditions such as contact dermatitis, respiratory etc. Then: then this means that the organisation may not be able to identify the areas and departments within the organisation that require Health Surveillance intervention. Should a reportable incident occur CTMUHB will be liable to criminal repercussions by the HSE Resulting in: it not being possible to develop a robust HS programme for the organisation without this baseline intervention as required by the Health & Safety Executive (HSE). Criminal Actions by the HSE.	OH linking with H&S to re-establish the skin surveillance programme. Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme.	Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme. August 2022 Update: Health & Safety Coordinator from the H&S Team is to link with the Head of Service from Occupational Health to agree a plan to undertake workplace assessments and referrals to Occupational Health. Review date set as the 30.09.2022. Update October 2022: Scoping Exercise for Health Surveillance remains ongoing. Review date set for 31.12.2022. Update February 2023 - H&S Team linking in with colleagues in Occupational Health to agree a plan to undertake workplace assessments and referrals to OH. Work is underway to provide SOPs for Noise, HAVs and Respiratory Risks. A report will be provided to the March 2023 Health, Safety and Fire Committee on this topic.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8 C4xL2	↔	26.06.2017	27.2.2023	31.3.2023
3008	Chief Operating Officer	Children and Families Care Group	Raised by Obstetrics in PCH.	Improving Care	Patient / Staff /Public Safety	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. Update August 2022 - mitigating actions two registered nurses to undertake train the trainer and initially cascade to community midwifery staff commencing Sept 22. Care group will seek out any opportunities for online updating to support current practice. Review date 01/11/22. Based on the improvement since the re-start of face to face training this risk is being reviewed for de-escalation. Update October 2022 - Head of Health, Safety & Fire - mitigating actions monthly module B training to facilitate improvement in knowledge and skills to be rolled out by Lead . Next review date 30/11/22.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	30.08.2022	30.11.2022
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety	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. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update: December 2022 Medical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the Health Board. As of December 2022 the current Medical Gas training details for CTMUHB are as follows: Total Staff Requiring Training - 2287, Staff Trained - 168, Compliance Percentage - 7.34%, Untrained Staff - 2119. The current risk rating will remain unchanged until Medical Gas Training Compliance increases significantly. As this remains at high risk, a review will be completed in 3 months (DG DW 21/11/2022). Action: Med Device Trainer to review with another UHB what can be delivered via e-learning to support some elements of this subject. Timescale: 31/05/2023. Medical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the UHB. As of Dec 22 the current Medical Gas training details for CTMUHB are as follows: Total Staff Requiring Training - 2287, Staff Trained - 168, Compliance Percentage - 7.34%, Untrained Staff - 2119. No significant increase in compliance. Attendance still poor for this subject matter, Med Device Trainer reviewing with another UHB what can be delivered via e-learning to support some elements of this subject, such as refresher training, however attendance would be required for initial training (WG 21/02/2023). The current risk rating will remain unchanged until Medical Gas Training Compliance increases significantly. As this remains at high risk, a review will be completed in 3 months	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	3.3.2023	31.05.2023

ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3585	Chief Operating Officer.	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational: - Core Business Objectives - Environmental / Estates Impact - Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	If: the toilet and shower facilities are not increased within the Emergency Department. Then: at times of increased exit block the facilities are insufficient for the needs of the patients in the department. Resulting In: Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. 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 August 2021 - No Change.RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and some phases complete. X references to ID4458 & ID3826:Update: Awaiting update from Capital team to confirm start date for next phase of works. Patient toilet is the next priority. Update from Capital Team 6.5.2022: The ILG have been requested to provide availability for a prioritisation meeting for the 2/2/23 limited discretionary funding that is available - this will need to be discussed alongside their outstanding risks and prioritised for funding. Update June 2022 - Additional toilet works not yet commenced. Agreement from Capital / Estates teams to undertake the work. No start date yet. Update 3.11.2022 - WG funding secured to have works undertaken. CTM capital team progressing ASAP. Update February 2023 - Commencement of capital works in ED which will include a second, disabled access patient toilet. This will be situated within the main department and will be accessible for within the clinical area.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	06.02.2023	30.04.2023
4148	Executive Director of Nursing & Midwifery	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	If: the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. Then: the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLS legislation Resulting in: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2023 review of this risk the control measures have been revisited and streamlined. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog. - Welsh Government have agreed to a change of use of current 22/23 funding to appoint an agency to clear the current backlog. This agency includes Best Interest Assessors and section 12 Doctors to undertake assessments. - The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised. - A further part time and full time Best Interest assessor were appointed in December 2022, their induction is now complete and they are fully integrated into the DoLS team.	The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUIHB have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLS Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLS authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUIHB. Update February 2023 - WG have confirmed that further funding will be provided for 23/24 to continue to address the backlog of authorisations. Procurement are supporting the team to agree a contract with an agency to work with CTMUIHB to address the backlog. WG have agreed to a change in use of funding to proceed with this action.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	10.2.2023	30.04.2023
4152	Chief Operating Officer	Diagnostics, Therapies and Specialities Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety	Back log for Imaging in all modalities / areas and reduced capacity	If: there is a backlog of imaging and reduced capacity Then: waiting lists will continue to increase. Resulting in delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. 30.12.22: Cancer waits have reduced significantly and are getting towards the 10 day internal target with exception of CT. CTC pathway work has identified overuse of this test and pathway redesign will help realign the demand to optimal pathway reducing inappropriate testing. CTM Improvement team have undertaken a process mapping exercise showing variation and some opportunities for streamlining processes. Wales Cancer Network are supporting a demand and capacity exercise in Radiology as internal support is stretched and unable to support in a timely fashion. Consideration for additional sessions to reduce backlog quicker through Planned care recovery board have been declined. Further bids will be submitted for 2023-2024 as diagnostics are key to planned care recover pathways. 30.01.2023 - Risk reviewed and score and mitigation remains unchanged.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	30.01.2023	08.05.2023
4315	Executive Director for People	Central Support Function - Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Non Compliance of Fire Training - Provision	Insufficient staff (Fire Officers) available to provide mandatory face to face fire training. If Limited number of places available due to the restrictions posed by social distancing so the amount of staff that can be trained at one time has been significantly reduced. THEN Risk of injury or loss of life from smoke inhalation, burns. Prosecution from the Fire Authority for not meeting the requirements of current legislation(RFISO). RESULTING IN Legal action by an individual against the UHB should an incident occur and staff not suitably trained.	Fire Officers are trying to provide training when they and suitable rooms are available. The training is based on a risk based approach and follows the approved Training Needs Analysis. However due to the restrictions posed by social distancing the amount that can be trained at one time has been significantly reduced. Learning & Development is currently working with the Health Board Fire Officers to reinstated the fire element of Corporate Orientation, so progress is being made to address those who have had no CTMUIHB fire training at all. Fire Officers in conjunction with the Nurse Education Lead continue to provide face to face training for these staff.	Recruit additional 2 Fire Officers to support the existing provision and assist in providing training across all sites/ILG. Timeframe 31.5.2022. New Fire Officer appointed 1.9.2021 on 12 month fixed term contract. Business case will be presented to extend funding to substantial appointment. Due to long term sickness and 1 x FO retiring in March 2022, this risk remains. 19/04/2022 - Due to financial constraints on the Health, Safety and Fire budget these 2 posts are on hold and will not be released until financial stability is achieved. Linked to risk 4356. Overdue/Out of date fire risk assessments due to resource issues and the amount required to be undertaken Update June 2022 - Due to financial constraints unfortunately one of the Fire Officer posts has been sacrificed to achieve financial balance. This will impact on training provision and conducting Fire Risk Assessments going forward and this risk is likely to increase over time. August 2022 Update: No change so risk as was reported in June 2022. Review set for end of October 2022. Update 1.11.2022 - No change to risk since last report Update 30.11.2022 - No Change to risk mitigation and scoring. Update 27.02.2023 - No change since last report. Risk has increased slightly due to a fire officer vacancy within the team and subsequent recruitment challenges.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	05.10.2020	27.02.2023	30.04.2023
4337	Executive Lead- Director for Digital.	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: - Core Business Objectives - Environmental / Estates Impact - Projects Including systems and processes, Service /business interruption	Integrated IT Systems Integrating Patient Records across the Health Board	If: The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers Then: The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	Key Controls 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. SBUHB have no process in place to incorporate the needs of Bridgend users in their developments. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems Numerous delays in NHS Wales progressing open architectural approach Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Update August 2022 - Regarding the Bridgend/CT aggregation: Programme as set out in IMTP progressing to plan. Discretionary capital programme has made provision to support priority areas of the plan. Business case for all Wales PAS development which incorporates Bridgend / CT aggregation has been funded for the next 3 years(recd 24/8/22). All Wales programme for opening up the architecture starting to develop via National Data Resource however there are numerous challenges and delays faced in getting system and service changes and improvements being put in place. UPDATE 28/10 ICT Risk meeting: Regarding the Bridgend/CT aggregation: Programme as set out in IMTP progressing to plan with posts funded by WG being recruited to. Tactical approach to data sharing with primary care yet to be agreed, and funded, noting NDR programme has recently offered a non recurrent financial contribution . All Wales API for 5 data systems expected January 2023 as first step in truly opening up the architecture. UHB has approached DHCW to make a joint appointment to develop and maintain APIs to the Myrdin PAS, which will support the clinical services in managing patient flows within the UHB. Although funding for staff has been allocated, the market for skills of this nature is sparse and this provides challenges in recruiting and retaining staff. Update 27/01/23 - Integrated Bridgend ICT Systems: for WPAS Post(s), not all funded jobs have been filled. DHCW leading the data migration work with 2 year timeline. Some non PAS dependant systems are being moved to CTM instanced before end Mar 23. (MTED, ADT, ETOC, ENDOSCOPY, HDU Washers, DENTAL, TDO, SKOTS, WRIS) Additional funding for ICT Integration of Bridgend -WPAS funding for resource, workstream started Nationally led. estimated timescales arrive at 2025. Risk Score being reviewed in terms of increase in score to a 20.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	27.01.2023	31.03.2023
4458	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	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 ILGs. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Update September 2022 Update - UEC Six Goals Improvement Programme now commenced - workstream 2 (integrated front door) - rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-discharge referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	3.11.2022	31.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map (Consequenc e X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4798	Executive Director of Therapies & Health Sciences	Diagnostics, Therapies and Specialties Care Group	Clinical Director of Allied Health Professionals - Therapies	Improving Care	Patient / Staff /Public Safety	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	If the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPFCS). Then: the critical service will be unable to meet the need of patients requiring therapy. Resulting in: significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response. Update 16-9-21 Continuing with therapy business case as actions below. No other updates	Discussions with all 3 critical care units regarding repurposing of funds to develop SLT posts. Nursing leaders aware and case being taken to next Operational Management Board. Three separate organisational critical care risks for workforce (medical, therapies, pharmacy) on Risk Register. Single combined risk has been drafted.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	21.2.2023	2.3.2023	31.5.2023
4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Non Compliance with Mandatory Violence and Aggression Training	training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Module D PMVA Training Provision / Programme Delivery - Meeting to be arranged with Senior Managers within Mental Health to review the management, coordination and delivery of PMVA training. In late March when revised PMVA report completed. An Audit has been devised and disseminated to Senior Managers to complete to determine the mandatory violence and aggression training requirements. To date 17/06/2022 6 completed audits received. Contact via email to RGH 13/06/22 for their audits. Once received all audits a report will be drafted. Meeting has taken place and Mental Health colleagues are reviewing how best this training provision can be supported by them. Further meeting scheduled for late April 2022. Senior Managers have devised an audit to all specialist clinical areas identifying their violence and aggression mandatory requirements. The PSA has been provided with some audit but this work is incomplete. A further meeting is yet to be arranged. 31/05/22 Still awaiting mandatory training audits to complete the report and rearrange the meeting. Timeframe: 26.8.2022 Update January 2023 / February - Discussions are still underway with Mental Health and draft Business case developed and discussed - Timeframe 31.3.2023. Module D PMVA Training Provision / Programme Delivery: Meeting in January 2023 where draft business plan reviewed. Head Nurse nominated to work with PSA to review the programme. To date private training provider to deliver 3 ,2 day refreshers and 2 ,4 day courses to address the training compliance shortfall train to commence from March 23. TNA to be revised. Mental Health staff groups identified on ESR to be revised. Business plan to be revised with a recommendation to continue with contacted band 4 nurses to deliver the training program. Next meeting scheduled for February 28th 2023. Timeframe 28.7.2023	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	27.2.2023	31.03.2023
4906	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety	Failure to provide evidence of learning from events (Incidents and Complaints)	If: The Health Board is unable to produce evidence of learning from events. Then: the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. Resulting in: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: • Monitored and reported through the weekly Executive Quality & Safety meeting. • Regular engagement and meetings with the Executive team to assist in gathering of learning. • Improvement plan implemented by WRP with monthly targets to submit the backlog. • Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated • LFER 'How to Guide' devised and disseminated • Ad-hoc training available on request. • Internal targeted monitoring in place.	The Health Board are developing a Learning Framework to ensure Learning is captured and shared across the organisation. Currently at consultation stage. The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023 Welsh Risk Pool have implemented a targeted improvement plan. Initial target was marginally missed, however, work continues to meet the overall deadline for 1st June. Update September 2022 - Work continues in this area, however this is still proving a challenging area of work. The new operational model has ensured that this area of work is included as part the Care Group Governance Team. Update October 2022 - A data reconciliation with WRP has demonstrated that the data held by CTM and WRP now correlate. This has been achieved through updating data and an in depth data validation. This will be invaluable going forward as service areas will have a clear position in relation to LFERs. The Governance teams continue to support service areas with the completion of LFERs. Guiding principles for the governance and accountability for quality and safety have been developed to support service areas through the transitional process to the new operating model. Update December 2022: - The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. LFER reports are now available per care group, ensuring better monitoring. Update March 2023: The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams, with Patient Safety Improvement Managers taking a lead of facilitation. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. Better LFER reports are available per care group to allow for better oversight by the Care Group triumvirate. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	27.2.2023	30.04.2023
4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping in RTE Locality. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. Identify the measures needed to protect patients at risk. Record the significant findings. Led by Leads in the relevant ILG Sections. Timeframe 31.5.2022. Health Board Learning: Learning has been shared via HBS groups. Local action to be taken by managers. Bridgend Review requested in April 22 Health Safety and Fire Group to ensure action plans are active and risks have been re reviewed. Timeframe July 2022. Update June 2022: - BILG - 21/06/22 Version 7 of the Risk Assessment document updated and circulated to the Director of Operations and colleagues within the BILG to highlight progress made and areas outstanding. Night shift planned for 25.6.22 and a further update will be provided. Revised review date due to outstanding remedial work required and change of ward occupancy, resulting in a further review and ongoing monitoring. Timeframe 30.09.2022. - RTE - Locality Director of Operations currently reviewing all other areas in the ILG. Timeframe 30.09.2022. Update August 2022 - position as reported in June with a review date of the 30.09.2022. Update October 2022 - Deputy COO Acute Services and Deputy COO for Mental Health, Community and Primary Care to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022. Update January 2023 -Meeting held in POW 24.01.23 to confirm progress with highlighted work to improve the general security of the site and in line with the risk assessment V10.1. Action plan and progress has been updated and included within the document section of Datix if required. Further update being sought.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	31.1.2023	31.3.2023
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Head of Service - Employee Health Wellbeing Service (Occupational Health)	Improving Care	Patient / Staff /Public Safety	Absence of a TB vaccination programme for staff	If: the Health Board is not providing TB vaccination to staff Then: Staff and patients are at risk of contracting TB Resulting in: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update Jan 2023 - Training is now arranged 16th and 18th Jan for OH Nurses and a support group via Cardiff & Vale is being implemented to provide peer support going forward. Update March 2023 - Unfortunately the training did not take place as planned in Jan. The training and implementation of TB screening and vaccination within Occupational Health in CTM UHB has been delayed and is on hold due to a fundamental link in the chain which permits such screening and vaccination taking place. This is in the form of the signing of the Patient Specific Directives for Mantoux delivery and therefore a reform of our process must now be implemented prior to service training and delivery. This will need to be passed through Pharmacy. A meeting is arranged on 16th March to progress this. This risk has therefore increased in score and been re-escalated to the Organisational Risk Register.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	Risk Re-escalated March 2023	09.06.2021	17.02.2023	30.04.2023
5014	Chief Operating Officer	Children and Families Care Group	Children and Families Care Group Service Director and Clinical Services Groual Manager	Improving Care	Patient / Staff /Public Safety	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital	IF patients continue to present at the ED at the RGH with obstetric and gynaecology related issues and if boundary changes and divers at times of high demand lead to increased risks for this patient cohort . THEN they will need to transfer to the ED at PCH where the appropriate services are in place. RESULTING IN a delay in the provision of appropriate care and treatment and this could lead to in-utero death, neonatal injury or disability, death of a pregnant lady due to blood loss and a loss of reproductive ability.	Pathways in place and subject to regular review. WAST is aware of the patient pathway and the need for O&G patients to go straight to PCH. Patients self presenting at the RGH ED would be prioritised for transfer to PCH Emergency cases would receive immediate general surgical care from non O&G specialists	Update October 2022 - The Assistant Director of Governance & Risk met with the Care Group Director and the Clinical Services Group Manager for the Children and Families Care Group regarding this risk and agreed that a review will be undertaken by the end of December to consider if the implementation of the On Call rota has mitigated this risk sufficiently to reduce the risk score. This will include engagement with the Executive Medical Director. Review by 31.12.2022	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	15.02.2022	01.11.2022	31.12.2022

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2987	Executive Director of Finance	Central Support Function - Estates Improvement Project	Central Support Function - Estates Improvement Project	Improving Care	Patient / Staff /Public Safety	Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses	IF: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has been completed and the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated (remediated c2000m2 of c18000m2). In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN. Ongoing maintenance of fire systems. Increased knowledge on site of the fire issues, fire training. Initial works carried out on areas as part of the scheme already.	Ground and first floor major project approved by WG to address the fire notification on PCH. In progress with completion due 2026 / 27. Annual reviews as to remediation progress are held with SWF&RS and the Health Board is required to evidence continued progression in the shortest timescale. If satisfied SWF&RS issue an annual extension letter against the FEN. The current extension runs to the 31/07/22. The Phase 2 programme has now reached a point where an additional c 3500m2 of FEN accommodation has been handed to the contractor (End of Jan 2022) as the next section to be remediated, having now decanted these areas to alternate fire compliant accommodation. An extension of a further 12 months has been granted by the Fire Service and will now expire on 31/07/2022. Update June 2022 - Phase 2 Update - The need for capital investment is recognised and is recognised on the Health Board list of schemes. The plans have been drawn up so the project can be progressed when the funding becomes available. Update August 2022 - Risk has been reviewed by Head of Health, Safety and Fire as has wider organisational implications for fire safety management. Risk remains unchanged. Update Dec 22 - Phase 3 Update - The need for further capital investment is recognised and is on the Health Board list of schemes. Phase 3 FBC funding request has been submitted to WG (approval pending) with the intention plans are drawn up in a timely fashion so the project can be progressed when the funding becomes available and capacity to accommodate the works is possible later into Phase 2. No Change as at March 2023 - review date set for 30.06.2023	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	15	C5xL3	6	↔	29.11.2017	08.12.2022	30.06.2023
2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety	Waiting Times/Performance: ND Team Impact on the safety - Physical and/or Psychological harm	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Non-recurrent investment of the below posts have been given for 12 months, but Clinical Service Group has highlighted the requirement for these posts to be made permanent. *1.0 wte Psychiatrist (clinical lead role) *Uplift from 8a to 8b 0.6 wte Pharmacist *1.0 wte Band 3 admin *0.6 wte Band 3 HCSW Additional clinics are currently being held on weekends to address longest waiters. (WLI has been carried out in the service since 6 months of the service being set up) Meetings with National Lead for Values Based and Prudent Health Care arranged to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Within Bridgend the Directorate is reviewing the feasibility of repatriating the SLA from Swansea Bay so that a local service can be developed	Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022. September 2022 Update - It was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift to for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker. In addition, Welsh Government has announced that there will be funding for ND services across Wales over the next few years. The funding will be allocated to Regional Partnership Boards for distribution in-line with Regional Integration Fund aligned to the six national models of care with emphasis on taking a whole system approach with education, social care, health and 3rd sector working to deliver new models of care. October 2022: Risk remains unchanged however, review underway with Clinicians. Next review 31.12.2022. Next review scheduled for 1.3.2023 regarding mitigating action - Consideration required for further investment in service.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	03.1.2023	01.03.2023
3638	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Inspiring People	Patient / Staff /Public Safety	Pharmacy & Medicines Management - Training & Development Infrastructure Impact on the safety - Physical and/or Psychological harm	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 Menthry where we have established a 'grow our own' model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	This CTM Pharmacy issue that has stalled at various times in the past which has added to delay. Initially started in 2018 as an SBAR propose increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority, as part of the PRIMARY CARE pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. As such is in place and continues to run. Funding approved for primary care lead pharmacist - commenced in post April 2019.SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up. SECONDARY CARE elements were not supported in the IMTP prioritisation process	Update 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 from 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. Update November 2021 - as reported to the Quality & Safety Committee: Discussion with HEIW have resulted in a delay to the financial changes until 2024, which will allow the service related impact to be better transitioned into the planning cycle. Update February 2022 - Risk remains as funding for the posts will be significantly reduced from 2023 onwards as HEIW will reduce from 50% to 20% funding. The shortfall in funding between establishment and post costs remains the risk. The funding resource is being captured in the IMTP submission for 22-23 in preparation for the impact in 2023-4. Funding gap is approximately £90k pa. This equates to 2 posts. Decision of funding is required by March 2022 to allow for recruitment process in 2023. Update August 2022 - Bid submitted to CTMUHIB IMTP prioritisation panel. Bid not successful. Reduced student numbers submitted to HEIW, will only be able to take on 3 acute sector trainees in 2023, reduced from 6. This will have implications for clinical service delivery and staff recruitment & retention. September 2022 - New Chief Pharmacist in post. Aware of the risk and need to address. This is forming part of their plans in addressing a number of issues within Pharmacy service. December 2022 - risk remains as little change in mitigation. Actions are being updated as risk is reliant on HEIW continuing funding. Similar position recognised in other Health Boards. Risk reviewed 9.3.2023 - no changes. Medical Director and Chief Pharmacist overseeing this risk.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	08.3.2023	30.04.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety	Fire Enforcement Notice - POW Theatres. Impact on the safety - Physical and/or Psychological harm	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. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022. WG have requested an options review be urgently undertaken on this as the preferred decant option is indicatively costed at £50M. The ILG are confirming availability for a management review of alternative options for delivery prior to a stakeholder session. Post this a report will need to be prepared for and discussed with WG to determine the way forward in terms of business case processes and timings. Update September 2022: from Capital & Estates - initial meeting with WG indicated that further work required to follow up on alternative options to the 6 theatre modular build so follow up WG meeting being arranged for late October / early November. Supply Chain partner reengaged to undertake more detailed engineering and design works. Update November 2022 - Risk remains unchanged as the options work is ongoing and meeting with WG is likely to be at the end of November with an outcome to the options review being discussed at that meeting. It is expected that this meeting will confirm the preferred way forward. Updated Dec 22 - WG and SWFRS meetings deferred until January due to potential crossover of enabling and decant options with the planned procurement of the BA site in Llantrisant. Clinical engagement and option appraisal session planned for the 11th January to confirm preferred options for provision of decant theatres to support the main works taking place. Mobile theatres (revised design) have been visited and are being reconsidered as an option.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	31.12.2022	28.02.2023
4512	Chief Operating Officer	Unscheduled Care Group	Care Group Director - Unscheduled Care	Improving Care	Patient / Staff /Public Safety	Care of patients with mental health needs on the acute wards. Impact on the safety - Physical and/or Psychological harm	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. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	02.11.2022	31.12.2022
4590	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Improving Care	Patient / Staff /Public Safety	Critical Care Pharmacist Resource Impact on the safety - Physical and/or Psychological harm	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. INCLUDED in the Reconfiguration Group work for sustainable model. New Chief Pharmacist aware o f issue and forming part of their evaluation of Pharmacy model across CTM. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. 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 CTMUHIB 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 Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022. Update August 2022 - Currently 40% gap in staff in post vs standards (1.5 wte) across all acute sites. Funding agreed for RGH and staff recruited into post. Currently non-recurrent. Funding request submitted within IMTP. UPDATE DECEMBER 22 - new Reconfiguration Group to address all workforce shortfall issues (nc Pharmacy), also part of new CP plans to establish changes across CTM. Update March 2023 - - Deputy Director of Nursing liaising with Medical and Workforce colleagues to lead the review of this risk and other risks in relation to Critical Care Workforce. Timescale for review April 2023. Therefore no change to this risk as at 1.3.2023. New Critical Care leadership team have taken on reconfiguration and will be involved in this risk review activity.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	08.03.2023	28.04.2023

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4671	Executive Lead: Director for Digital. In Committee	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	IF: The Health Board suffers regular local and/or national network issues and/or outages to critical clinical and business systems or performance issues in accessing and using systems. Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated. Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks. Mistrust by staff of the ICT systems and services they are using										
4672	Executive Lead: Director for Digital.	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	IF: The Health Board is not able to record information accurately and reliably, with complete and up to date information Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days of maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Operational controls: Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DNHCW annual coding quality audit Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT ontology server, WCP & E-forms etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days of maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update August 2022 - Consideration being given to Cessation of creating scanned records for any more new patients enabling scanning capacity to be put towards address backlog of active patients who already have a record in the scanning system - Development of a Health Board coding strategy for the development of the profession developed and being taken forward - Natural Language Programming (NLP) and data linkage being used to autocode targeted spells, improving levels of coding completion, based on Snomed-CT - Adoption of data level standards based architecture, - Coding transformation plan, - Opportunity for bi-directional real time integration between primary and secondary care available - National Data Resource (NDR), Clinical Data Repository (CDR) and integration programme Update October 2022 - Consideration being given to Cessation of creating scanned records for any more new patients enabling scanning capacity to be put towards address backlog of active patients who already have a record in the scanning system - Development of a Health Board coding strategy for the development of the profession developed and being taken forward, which underpins the coding transformation plan - Natural Language Programming (NLP) and data linkage being used to autocode targeted spells, improving levels of coding completion, based on Snomed-CT identified as increasingly successful and cost effective - Adoption of data level standards based architecture, - Opportunity for bi-directional real time integration between primary and secondary care available but requires tactical decision by UHB Board - National Data Resource (NDR), Clinical Data Repository (CDR) and integration programme UPDATE 28/10 ICT Risk meeting - no further update	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	22.10.2022	01.12.2022
4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KP11 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022 Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place. Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	07.09.2022	03.10.2022
4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	IF: The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. Then: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. Resulting In: •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	Update 22/02/2023) We are now ready for the installation of the software upgrade to the 13-stage press. All items needed for the upgrade have been received by the supplier. The in-house electrical work has been completed. The supplier has provided an installation date for the end of March 2023- beginning of April 2023. This will allow the installation of the new chemical system to be installed prior to the upgrade. The upgrade comes as part of a new chemical contract between NWSSP and Ecolab who will be providing the equipment as part of the contract. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the software has been installed .	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	03.03.2023	31.05.2023
4920	Executive Director of Therapies & Health Sciences	Diagnostics, Therapies and Specialties Care Group	Deputy Head of Occupational Therapist	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	IF: clinical capacity remains significantly reduced due to staff sickness and vacancies Then: clinical service delivery will be negatively compromised. Resulting in: increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily Update September 2022 - Last review 30.8.22 next rv 31.10.22. No change to mitigations, recruitment in progress, and improvement in staffing is expected by November. Update October 2022 - No change to mitigations, recruitment still in progress. Update 28.12.2022 - two vacancies are anticipated to be recruited to March 2023 following the return of maternity leave and retire and return employee. Ongoing discussion with staff member temporarily re deployed due to Long COVID regarding returning to substantive post. Review 31.3.2023 Update February 2023 - No change for this period, next planned review is due 31.3.2023.	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	↔	27.11.2021	23.2.2023	31.3.2023

ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5040	Executive Lead: Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	IF: The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrdind strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their fulfility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISc) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB appointment process has commenced. WG funding for £7m awarded to support PAS integration 24/8/22 UPDATE 28/10 ICT Risk meeting - no further update October 22 - National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales & implementation date set for Jan 23 - will be limited in nature. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB & DHCW appointment process has commenced. Included within this is a post for PAS integration developer.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	22.10.2022	02.12.2022
3337 Linked to RTE Risk 4813 and M&C 4817.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	IF: Mental Health Services do not have a single integrated clinical information system that captures all patients details. Then: Clinical staff may make a decision based on limited patient information available that could cause harm. Resulting In: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups established and aligned to this Programme board. 4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 5. Deployment order in place for all existing WCCIS mental health staff users 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8. CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 9. Project manager has been recruited. This role is leading on the development and implementation plan. 10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables. Patient Safety Controls: • CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. • CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. • Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. • RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical record keeping and monitor ongoing IG process/ workstreams (Meeting date in November to be confirmed).	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Business Case pending approval. 2. Director of Digital, CTMUHB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager. 3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case. A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	28.10.2022	31.12.2022
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	IF: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	The mitigating environment and staffing measures put in place last year are still in place. Anecdotally it is reported that the ward feels safer by night, the challenge for the ward team is to now use QI methodology to make a case for continuing with these staffing levels after the capital work is complete. No incidents involving suspended ligatures have been reported since these measures were implemented. This is reflected in Bridgend CSG risk register. Annual revisiting of all patient ligature risks progress Statement of Needs via capital process for any ligature risks assessed as needing resolution RTE CG - RTE specific environmental risk mitigation plan in place and under regular review. RGH MHU are currently in the process of extensive anti-ligature upgrades as part of a capital work scheme, including all doors and ensuites on ward admissions/21/22 and PICU being upgraded. M&C CG - SRU/Pinewood - ligature work has been completed. Update 31.12.2022 Bridgend All works have been completed at: Ward 14 PICU Angelton. RTE Ward 21 - Completed Ward 22 - Completed Admissions - Completed PICU - 1 Bedroom still to complete All wards scheduled to have returned to their home location and works fully completed by 13th January 2023	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A strategic case to be prepared and submitted to Welsh Government -COMPLETE Strategic Outline Document submitted and agreement to commence a Strategic Outline Business Case received. 3. If the strategic case conversation is supported by Welsh Government, develop a strategic outline business case. Timescale March 22 4. If the strategic outline business case is accepted, progress to the development of a full business case. 5. Full Business Case paused due to pandemic. Resource to be identified to progress full Business Case. 6. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop to take place early 2023. 7. Recruitment has taken place for Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommending a new capital business case for a new Mental Health Unit. Updated - 31.12.2022 with no change to risk rating	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	31.12.2022	5.3.2023
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	IF: the rising costs of delivering care in private facilities drives a number of providers to cease trading. Then: there will be a loss of capacity within the system. Resulting in: exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority 21.2.2023 - no change in mitigation or scoring. Scheduled for a further review at the end of April 2023.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	21.2.2023	28.04.2023
4699	Executive Lead: Director of Digital	Central Support Function - Digital & Data (Information Governance)	Chief Information Officer	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	IF: The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care Then: There will be a loss of trust and confidence in the Health Board from its patients, population, staff and care providing partners and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. Resulting in: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	Key Controls: - Adoption and implementation of All Wales IG and Data protection policies, - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc) - Mandatory training in Information Governance with auditing functionality (such as NIAS) built in to monitor compliance, - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI - Professional (clinical) training and approach to maintain an accurate and timely medical record Gaps in Controls: 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom of Information and Subject Access Requests	Cyber and Data Protection Improvement Plans being taken forward. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking with other organisations in Wales undertaken. (SB have 9wte, CTM 2.5wte funded, 1.5 wte now --> 0.5wte by end of Sept.) Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Update August 2022 - Further attempt to recruit to two vacated positions in progress Re-allocation of coding staff to IG function on very short term basis to provide some continuity and cover. UPDATE 28/10 ICT Risk meeting - No further update October 22 - Actioning of Cyber and Data Protection Improvement Plans decelerated due to staffing. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking with other organisations in Wales undertaken. Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Re-allocation of 1 coding staff to IG function and appointment of agency head of IG for 3 month period made, to sure up IG function. Recruitment process underway for Head of IG. IG Officer post currently delayed via the recruitment process.	Digital & Data Committee	15	C3xL5	12 C3xL4	↔	18.06.2021	22.10.2022	02.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function - Infection, Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety	No IPC resource for primary care	If there is no dedicated IPC resource for primary care. Then: the IPC team is unable to provide an integrated whole system approach for infection prevention and control. Resulting In: non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g., bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021 07/10/2021 - Lead IPC Nurse is a member of an All Wales task and finish group looking at the IPC workforce across Wales. Report to IPCC once national work complete - Due to complete in December 2021. August 2022 Update: Risk score amended based on control measures in place. No additional measures implemented. Lead IPC Nurse to scope primary care services in next 4 weeks. reviewed by Lead IPC Nurse and Deputy Executive Nurse Director 06/09/2022, risk reduced from 20 (4x5) to 15 (3x5). Consequence score amended and reduced to 3 (from 4). Update 11/10/22 - scoping work delayed but plans to start in next 4 weeks. Update 6.1.2023 - The scoping work has been delayed due to the increased respiratory viruses circulating/ number of outbreaks which the IPC department have had to respond to. This will be reviewed at the end of January 2023. Update 02/03/2023 - Lead IPCN to speak to the Nurse Consultant for IPC (HARP TEAM) to determine if she could support the scoping work planned in primary care. IP&C team to continue to work through how community support can be delivered within the current resource, to be further discussed at the April 2023 IP&C	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	02.03.2023	28.04.2023
4721	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. No change to mitigation or risk score. Update September 2022 - Following review of this risk scoring by the COO the consequence score has been reassessed as a 3. This risk remains under constant review.	Quality & Safety Committee	15	C3xL5	12 (C3xL4)	↔	28/06/2021	11.10.2022	30.11.2022
5323	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Fluoroscopy Room has become Obsolete	IF room 3 in POW is not replaced THEN there will be situations where there is no interventional Radiology service at POW (during maintenance and potential break down of Room 6) RESULTING IN having to transfer very unwell patients to other hospitals, pressure on staff and services at other sites to accommodate. Overall poorer patient experience and potentially outcomes.	Utilising Room 6 to its full capacity Some Barium lists being performed at RGH when possible	Completion of SON to support replacement of Room3 - Timeframe 27.1.2023 30.1.23 RGH has list every other Friday SON submitted, initial agreement to fund new room	Quality & Safety Committee	15	C5xL3	C5xL1	↔	23.12.2022	30.01.2023	08.05.2023

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
4722	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Senior Medical Workforce Shortfall - Adult Mental Health	If the gaps in the senior medical workforce in RTE are not addressed (2wte vacancy OP, 1wte LTS, 1wte Non clinical duties plus paternity leave and isolation) Then routine work such as clinics will be cancelled, clinical decision making will be delayed and emergency escalation compromised along with the ability of the service to discharge the powers of the Mental Health Act. It is also possible that the training of junior doctors will be negatively affected. Resulting in poor quality and unsafe patient care, increasing concerns, risk of litigation, compromise of the UHB's reputation and removal of UHB from Psychiatry training programme.	Regular meetings with interim CSGD and Consultants to plan cover arrangements and support on weekly basis. Medical model change to functional inpatient at the RGH MHU covered by 3 Locum Inpatient consultants (22 sessions - 12/6/6) to cover 2 x Treatment Wards (28 beds) and 1 x PICU (6 beds). Recruitment - Vacancies out to advert for locum and substantive contracts. Exploring options for overseas recruitment. All staff being offered additional hours. In-patient team has been bolstered by an additional Registrar and 2 x SHOs ANP's covering appropriate PCMHSS AND CMHT clinics.	Update 06/06/22 - Vacant post in Rhondda Adult MH and been notified that Locum for Taff Ely who also covers in patient wards 1 day a week will be leaving the end of this weak. This leaves 2 vacancies in sectors for adult and an inpatient day short fall. Update Sept-22 - All adverts agreed to go in BMJ as part of wider recruitment drive. JDs have been reviewed and refreshed. Update November 2022 - Locum cover secured to mitigate partial risk pending substantive appointments. Recruitment exercise underway an interest has been received. Medical Director appointed into the Mental Health and Learning Disability Care Group to provide oversight and leadership on sustainable medical workforce activity.	People & Culture Committee Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	6	The rationale for this score reduction is that the service area can now report that there is a Consultant Responsible Clinician for 3 areas, with CD Responsible Clinician for 1 area. Community Consultants are stable and set to improve with appointments in early February (Locum). Risk to be monitored by the MH and LD Care Group.
2721	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity to deliver POCT training to Health Board Nursing Staff	Currently there is insufficient POCT staff resource to effectively deliver essential training to Nursing/Medical/HCSW staff across the HB. In addition there is no training facility to deliver this training to large cohorts of staff, this is an issue across the HB. The POCT testing repertoire has significantly increased, and will continue to increase across the HB as the drive for near patient testing increases.	POCT have worked with L&D to move POCT glucose e-learning refresher training to ESR (this can prove troublesome and the training dept. have removed their support). Issue has been previously escalated to HoN. Temporary staff from Covid funding has alleviated some of the pressure (post currently vacant). Working with training dept. to try an block book training rooms, but this is difficult as there are no definitive timescales. Some cascade training in place (also a risk of dilution of scientific knowledge)	SBAR in progress to describe current issues with delivery of POCT training and recommendations on how this can be improved moving forward. Covid funding has been agreed previously for POCT (Band 4) until March 23. This post is currently vacant, therefore we need to recruit into this post 30.12.22: Discussion of risk and options to be discussed at Improving Care Board in January 2023.	Quality & Safety Committee	8 (C4xL2) reduced from a risk score of 16.	C2xL2	Risk score reduced as POCT associate practitioner employed on a fixed term contract to progress training provision. Replacement of blood gas analyzers across the health board has provided the opportunity to re-train all operators on the new instrumentation. Over 700 operators were trained, competency assessed and validated for the next 2 years.
4149	Chief Operating Officer	Improving 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 (covering locality CAMHS in CTM and Swansea Bay as well as specialist CAMHS services commissioned by WHSSC - Inpatient Unit at Ty Llidiard and FACTs service) Then: there could be an impact in maintaining a quality service Resulting in: recruitment and retention challenges and detrimental impact on wellbeing of existing workforce, long waiting times; inability to implement new models of care required to meet increasing demand; supporting patient pathways via services and standards of care planning required by the All Wales Mental Health Measure. If the specialist WHSSC commissioned services are not sustained the impact	o Reported local and Network pressures across the CAHMS Network with variable problems dependent on the area of the network. o 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. o 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. o New investment impact being routinely monitored internally via the SMT and via monitoring meetings with the ILG Monthly commissioning meeting discussions taking place across the Network in relation to service pressures and funding. Additional funding received for investment in services • Implementation of the Choice and Partnership Approach (CAPA) with a new service model introduced ensuring the service aligns itself with All Wales Mental Health Measure. All referrals accepted to CAMHS will now receive a Part 1 Mental Health Assessment to determine the level	Risk reviewed and updated the controls provement in community CAMHS performance in relation to waiting list - Swansea Bay waiting list reduced down from 462 to 90 in September. CTM waiting list reduced from 365 in May 2022 to 200 in September. Work ongoing to improve compliance with part 1a and 1b. New SIF MH bids funding received and in progress of recruitment. Further work required for community CAMHS performance on part 2, improvement plans in both areas. Continued improvements being made in the escalation plan for Ty Llid via the Improvement Board. values and behaviour leadership survey undertaken which demonstrates good feedback from colleagues on improvement but also helps identifies areas for improvement. FACTs service - consultant interviews taking place on 1st November. Progressing recruitment plan to address vacancies Update 29.11.2022 - Improvement in compliance for SB CAMHS for MHM Part 1a 83% in October and backlog addressed. Slight improvement for CTM CAMHS in MHM Part 1a but waiting list has increased due to increased demand in October. SB meeting Part 2 compliance but numbers reported low. Improvement plan in place for CTM Part 2 compliance. Continued improvements being made in Ty Llidiard, NCCU attended in November and reviewed clinical notes and positive feedback. Awaiting formal feedback via WHSSC escalation meeting on 5th December. Weekly audit reviewing clinical records in place using QI methodology and demonstrating improvement. Ty Llidiard Away Day planned in December to focus on developing the team approach. New therapies lead starting in December, FACTs service - consultant appointed awaiting start date. Ongoing recruitment to vacancies in service. Plan to advertise clinical lead role once consultant has been appointed	Planning, Performance & Finance Committee & Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	C4xL3	Risk score decreased due to many mitigating factors/control measures. Enhanced Single Point Of Access, Waiting List Imitative, close monitoring through fortnightly CTM Action Plan meetings, Performance Meetings, review of job plans, D&C plans and regular monitoring through a daily tracker.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
4908	Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Meetings with Care Groups to be established in respect of complaint responses to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. Update September 2022 - Benchmarking exercise completed, which demonstrates low staffing to workload capacity with counterparts across Wales. Invest to save bid has been drafted with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review and workshop is being held in Sept 2022 to review skill mix in the claims handling team. Update October 2022 - Invest to save bid has been completed and submitted for consideration, with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review. A workshop has been held with the Legal Services team to review ways of working moving forward into the new operating model. Update December 2022: - Invest to save bid was unsuccessful, therefore alternative funding options being explored. Some limited capacity will be realised in the new operating model for quality, safety and governance. CTM commissioned Legal and Risk to provide assistance and direction on the historic redress cases, however L&R have no capacity to take these over. Therefore, will have to be dealt with in turn, as part of the backlog.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	8 (C4xL2)	Invest to save bid was unsuccessful, therefore alternative funding options being explored. The new operating model is now at implementation phase with any vacancies being advertised. Once in post, there will be some extra capacity. An action plan to prioritise older cases has been developed. Extra capacity will be used to focus on the backlog in readiness for the implementation of Duty of Candour. Risk score has been reduced as a result of the above mitigation. At the Q&S Committee on the 16th March, members considered it premature to de-escalate this risk score as the action plan has not been completed. This has been deferred back to the risk owner for consideration on the 17.3.2023.
4940	Executive Director of Nursing	Improving Care	Quality, Complaints & Audit	Delay to full automated Implementation of Civica	If: the Information team are not be able to complete the necessary data extraction requirements, Then: there will be a delay to the roll out of the automated survey process within the Civica system, Resulting in: a lack of service user feedback and opportunity to areas of improvement as well a good practice.	The Health Board launched the electronic ""Have your Say"" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. Their will be made available to staff that are providing services in patients' homes. Exploration is taking place as to how the posters/cards can be promoted within he wider non-health board community settings.	Implementation of the Civica System. Information Team has completed provision of all data feeds (August 2022) Whilst the overall consequence and likelihood of the risk is not extremely high, the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. Reactive feedback continues be received and reported on via complaints, claims and compliments. August 2022 Update - SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. CIVICA system piloted in PoW in August using volunteers to capture feedback using the CIVICA system via IPADS. December 2022 Update- The information team have automated 8 patient experience surveys within Civica which is also aligned to the PROMs conducted as part of the VBHC portfolio. However the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. The number of responses seen are low when compared to other HB who are actively using the SMS component. As a consequence of not having the automated SMS component up and running across CTM it has resulted in an increase of paper copies which require resource to manually input the responses into Civica- This resource currently does not exist as only 1x PM is working on the system part time. Update 5.1.2023 - Project Manager is exploring how the Health Board can slowly integrate within specialised surveys as this work is specific within the ask of IT, however the Health Board cannot implement the automatic SMS for all appointments/inpatient interaction with the Health Board at present.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	9 (C3xL3)	March 2023-VBHC Admin support temporarily helping to input have your say cards/ paper copies into the system within the POW area. Active discussions are being held with ED leads across CTM on automating a survey via SMS. Patient Feedback volunteer team are supporting collection of patient feedback in POW as a pilot at present. Due to changes in organisational structure the CTM Civica leads group is meeting in March to discuss how the system can be supported going forward and ensure reflection of representation across the care groups. Due to improvements and review of risk - risk score has been reduced in terms of likelihood.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4253	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety	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.	Bridgend Locality: The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. - o Increased Staff observations in areas where risks have been identified. - o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks - o The use of safe and supportive observations - o Risk assessment process for patients and environment is in situ - o Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	Bridgend Locality: - o action plan developed with support from the head of nursing within the ILG. - o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. - o Use of therapeutic activities to keep patients occupied Update 25.5.2022 - Major Works complete and official handover undertaken on the 25th May 2022 with contractor. Risk scoring reduced from a 20 to a 15. The Target Score has not been met as there are still works to complete internally with Estates. Bridgend 28.10.22 All anti-ligature works in PICU, Ward 14, Angleton have been completed and areas handed over subject to completion of a few outstanding snags by the contractors. Work is awaiting final sign-off. Review end of December 2022 with a review of revisiting the risk score.	Quality & Safety Committee Health, Safety & Fire Committee	Jan-23	Risk Closed 13.1.2023 - Health Board Capital works department have signed off all of the schemes connected to the anti ligature work. On Hold in closure section. This will not be removed from the Organisational Risk Register whilst sufficient assurance is sought to the satisfaction of the Audit & Risk Committee. Confirmation received that the capital works have been completed. Consideration at the Audit & Risk Committee in April 2023.
4971	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety	Adult Special Care Dentistry	If the Community Dental Service is unable to recruit a special care dentist, then there will be no dedicated specialist to undertake the appropriate assessment and dental treatment under GA for vulnerable adults in a timely manner, resulting in more patients waiting, longer waiting times, patients being in pain and some having to access secondary care dental services as an urgent or emergency care.	Patients can be seen within the CDS for advice and treatment under local anaesthesia where this can be tolerated by the patient. A Consultant advert has been placed 3 times alongside a Specialist level post to widen the opportunity for recruitment. No applications received. If either post is recruited in to the risk will be mitigated. Although it will take some time to clear the current waiting list. Patients will be contacted regularly as part of safety netting to check that their condition is not deteriorating and no one is left in pain.	All the patients on the list are being reviewed and contacted regularly to assess if their dental condition has deteriorated or if they are in pain. Consideration is being given as to whether treatment can be undertaken in a local routine dental practice as opposed to the community dental service (CDS). This is very much on an individual basis. Discussions are taking place with Medical Staffing, HEIW and Cardiff Dental School with regard to the possibility of recruiting from abroad. Especially in view this is a national recruitment problem and other Health Boards are in a similar position. Update October 2022 - Recruitment stage to re-commence with interviews likely to take place in January with two potential candidates expressing an interest with continued dialogue and engagement with them. Update March 2023 - Risk to be closed as Special Care Dentists appointed.	Quality & Safety Committee	Closed	The risk has now been closed as 1.6WTE Special Care dentists have now been appointed.



AGENDA ITEM

5.3

AUDIT & RISK COMMITTEE

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Date of meeting

19/04/2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Emma Walters, Corporate Governance Officer

Presented by

Emma Walters, Corporate Governance Manager

Approving Executive Sponsor

Chief Executive

Report purpose

FOR NOTING

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

Committee/Group/Individuals

Date

Outcome

ACRONYMS

1. SITUATION/BACKGROUND

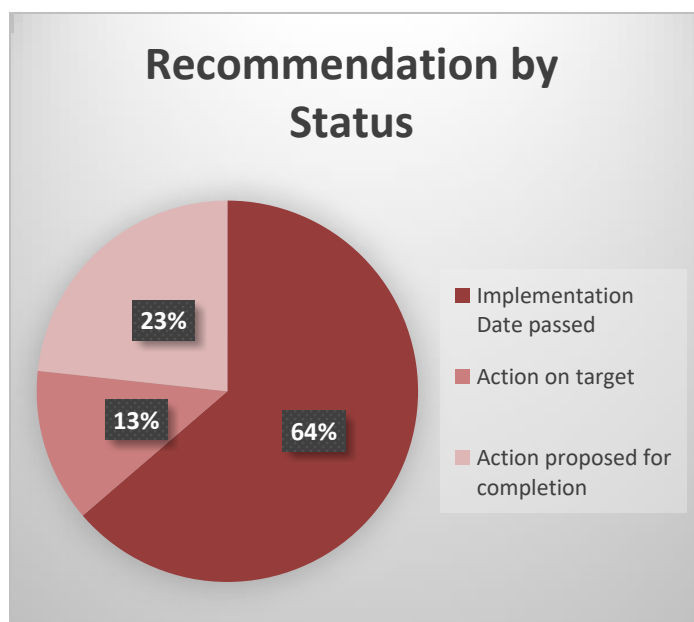
- 1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of Audit report recommendations in the revised format.
- 1.2 This report relates to both internal and external audit review recommendations.

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. Members will note that 34 internal audit recommendations have been completed/closed and are proposed for removal from the tracker, together with 7 external audit recommendations.

Internal Audit

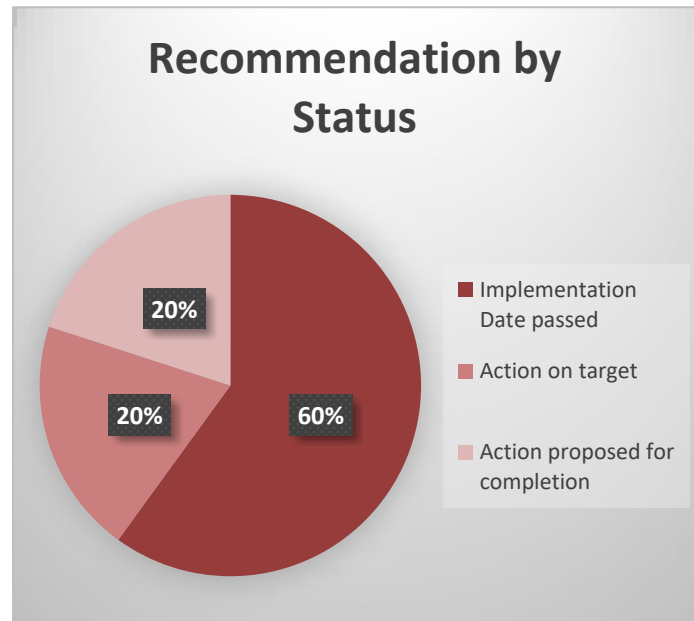
- 2.2 The tables below provide a summary of the current position in relation to Internal Audit Recommendations, noting that the proportion of red status recommendations has deteriorated to 64% compared to the February position which was at 51%.





Recommendations by Priority & Status					
Priority	TOTAL	Implementation Date passed	Action on target		Actions Completed
High	38	22	8		8
Medium	91	60	9		22
Low	17	11	2		4
Recommendations by Executive Lead & Status					
Executive Lead	Total	Implementation Date passed	Action on target		Actions Completed
Director of Corporate Governance	2	1	0		1
Director of Finance	23	21	1		1
Chief Operating Officer	33	26	2		5
Director of Nursing	29	10	0		19
Director of Digital	10	0	4		6
Director for People	24	18	4		2
Director of Strategy & Transformation	15	15	0		0
Medical Director	10	2	8		0
Implementation Date Extended by					
Priority	TOTAL	More than 24 Months	18-24 Months	12-18 Months	6-12 Months
High	19	4	0	2	13
Medium	42	7	12	6	17
Low	7	1	2	2	2

- External Audit (Audit Wales)
- 2.3 The tables below provide a summary of the current position in relation to External Audit Recommendations. You will note that the percentage of recommendations whereby the implementation date has now passed has deteriorated to 60% compared to the 26% reported to the February 2023 meeting.



Recommendations by Priority & Status				
Priority	TOTAL	Implementation Date passed	Action on target	Actions Completed
High/Medium/Low	35	21	7	7



Recommendations by Executive Lead & Status				
Executive Lead	Total	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	2	2	0	0
Director of Strategy & Transformation	10	10	0	0
Chief Operating Officer	1	1	0	0
Director of Finance	5	0	5	0
Director of Digital	2	1	1	0
Director of Nursing	12	5	0	7
Director for People	2	2	0	0
Medical Director	1	0	1	0

Implementation Date Extended by					
Priority	TOTAL	More Than 24 Months	18-24 Months	12 - 18 Months	6 -12 Months
High/Medium/Low	13	4	4	3	2

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

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



4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

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

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
CAMHS Management Arrangements 05	Feb-21	Limited	1. We agree with the planned approach to identify CAMHS related policies in existence and to review them to ensure consistency across the localities. This work should also ensure relevance and alignment to current legislation and expected working practices. 2. Once updated, the policies should be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	High	CAMHS Policy Group newly established, with ToR being developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	Chief Operating Officer	Head of Nursing	Mar-21	01/05/2021 August 2021 Now December 2021 Now September 2022 01/12/2022 to support SharePoint development Now March 2023		Completed	April 2023 Update - Each area has been reviewed and there is an index list of CAMHS related SOPs and operational policies that contains the dates for review and lead for each area. These are signed off via the CAMHS Quality, Safety and Patient Experience Meeting.	March 2021 Update - Update will be available in May 2021. CAMHS Policy Group newly established, with ToR developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on the action taken will be confirmed in August 2021. July 2021 Update. CAMHS Policy Group newly established, with ToR developed. All CAMHS policies identified, to be reviewed and standardised to new format to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan devised to ensure rolling programme. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on the action taken will be confirmed in August 2021. September 2021. Work on the policy reviews continues, the target date remains December 2021. November 2021 Update - nothing further this month. There has been a change in management arrangements and an update on the work that remains ongoing will be ready for the next meeting. February 2022 Update - no permanent CSG Manager in post. Update will be available for the next meeting. April 2022 - Due to changes in nursing structure and gap in CSG Manager the progress on this action has been delayed. Head of Nursing and CSG Manager will meet in April 2022 to review actions outstanding and make a plan to address the review and publication of policies. June 2022 Update - CSG and Head of Nursing have met and discussed approach. Each LMT has been requested to update current policies and database established. Progress has been made with documents drafted. This will be discussed at Senior Nurse meeting on 14th June with an outline of timescales. August 2022 - This was discussed in the QPSE meeting with the senior nursing team and a number of policies and SOP were brought for review and sign off. Agreement to review which are relevant to go through the HB policy group. October 2022 Update - Local SOPs have been reviewed, one around the use of the age appropriate bed in CTM is being developed with Adult Mental Health and will go through the appropriate HB forums for policy sign off. Plans are being developed HB wide and via the Mental Health care group to develop a SharePoint to hold local SOP and policies. December 2022 Update - CAMHS policy page has been added to the CTM UHB SharePoint page to hold relevant specific CAMHS policies for all staff to access and enables a system for review when required. In addition to the age appropriate bed policy highlighted last month a transition policy has been developed and will be signed off by the MH Care Group. Local management teams are currently pulling together the list of other local standard operating policies and ensuring there is central index for staff to access and system for review. February 2023 Update - each area has devised a local index list of SOPs and where required policies, and working through the drafts. Agreed approach for sign off and monitoring via revised Quality Safety and Patient Experience Meeting
Concern s 1.2	Feb-22	Limited	A comprehensive set of Standard Operating Procedures should be developed setting out the process to follow from the point a concern or complaint is received through to the provision of a response. The SOP should include concerns from all sources such as those received via the dedicated email accounts, those made in person or issues raised via local MPs or MSs. The responsibilities of the Corporate Concerns Team and the ILGs should be clearly set out.	High	Review the PTR Guidance alongside the CTM structures to identify what Standard Operating Procedures are required and develop and implement to support the new process.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023 Now February 2023 Now May 2023		In progress	April 2023 Update - Recommendation: incomplete, open/yellow. New SOPs devised. A meeting was held with the Assistant Director of Risk and Corporate Governance to discuss the ratification process. Timetable shared with Managers. The agreement is that the overarching policies will go to the Quality & Safety Committee in May 2023. SOPs can be agreed upon at Q&S Executive Meeting.	April 2022 Update - On hold until changes to the operating model. Central triage complaints resource identified as part of operating model changes. Once new model is in place. Policies and SOPs will be reviewed and amended in line with the new model. August 2022 Update Work continues on the new Operational model, this incorporates 2 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023. December 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023. February 2023 update - Reviews are well in hand, some changes to the proposed operating model will have an effect on some of the SOPs, however these can be changed and ready in line with implementation of the new quality governance structure.
Concern s 3.1	Feb-22	Limited	3.1a A training programme should be developed and rolled out across the Health Board to ensure that staff are suitably trained for the roles they are performing in relation to the Concerns process. 3.1b A training needs analysis should be undertaken in each ILG and for corporate teams to identify the staff that fall into the three levels of training outlined in the Concerns Training Plan. The PADR process could be used in the future to help identify training needs.	High	3.1a CTM Concerns Management training programme to be developed encompassing Putting Things Right, the Once for Wales Concerns Management System and Welsh Risk Pool procedures, more specifically Learning from Events Reports. 3.1b Training Needs Analysis Template to be developed following development of Concerns Management training programme. To be shared with the ILGs for completion and identification of all staff who should receive the training.	Director of Nursing	3.1a Interim Head of Concerns, Redress & Legal 3.1b Interim Head of Concerns, Redress & Legal/ILG Heads of Quality & Safety	3.1a April 2022 3.1b June 2022	Now January 2023 Now February 2023 Now May 2023		In progress	April 2023 Update - Recommendation: incomplete, open/yellow. 3.1a - Training has been delivered on concerns management via Incident Management training and Complaints Management training. Complaints policies/procedures have been updated in line with the new operating model and are in the process of ratification. A workshop has been held for the newly centralised concerns handlers, to ensure quality and consistency. CTM attends the All Wales Duty of Candour Education and Training network. A raft of education and training materials have been developed and are now available on the Health Boards Sharepoint site. 3.1b - Training Needs analysis will be undertaken on completion of the prospectus with the newly formed care groups.	3.1a April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. 3.1b April 2022 Update - To be developed once training package has been completed. June 2022 3.1a New PTR Training package in process of being developed, in conjunction with the new Incident framework. Elements of training have already been undertaken in respect of LFERs and Once for Wales CMS. Weekly LFER drop in training sessions have been underway for the past 6 weeks, which will assist staff with completion of LFERs. 3.1b Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. August 2022 Update 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups. October 2022 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour.
Concern s 6.1	Feb-22	Limited	6.1a A SOP should be developed that documents the quality assurance processes underpinning the end stages of the investigation that lead to the issue of the PTR Concerns Response Letters. The SOP should include who is responsible for quality checking and how quality checks should be documented, including, if deemed necessary, the use of the checklist contained in the policy. Training on the required quality assurance process documented in the SOP should be carried out with relevant staff. 6.1b The Quality Assurance Checklist contained in Appendix 4 of the Concerns Policy should be reviewed and a decision made regarding the expectation for it to be used.	High	6.1a Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above 6.1b QA checklist to be reviewed at the same time as the SOP is develop	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now January 2023 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. Update 6.1a - A new quality assurance SOP has been developed, an audit programme will commence in February 2023. 6.1b - The QA document contained within Appendix 4, has been revised in line with the new organisational Concerns Policy.	6.1a April 2022 Update - On hold until changes to the operating model. June 2022 6.1b April 2022 Update - On hold until changes to the operating model. June 2022 6.1a - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update 6.1b - will be reviewed in conjunction with Governance teams within the new operating model. August 2022 Update 6.1a - Work continues on the new Operational model, this incorporates 2 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 6.1b - QA document will be reviewed in conjunction with Care Group Governance teams within the new operating model. October 2022 6.1a - Work continues on the new Operational model, this incorporates a new Early Resolution team, which includes complaints triage. This should assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. August 2022 Update 6.1a - whilst work continues within NHS Wales Shared Services Partnership: Facilities and Estates, there are no definitive dates when this work will be completed. CTM is fully involved in this work to help support an all Wales solution to this. Update October 2022 - No further progress with this from colleagues in Shared Services. December 2022 Update - Despite chasing them, no further progress with this from colleagues in Shared Services. February 2023 Update: In the interim and whilst waiting for NWSSP Facilities and Estates Services to address the All Wales Fire System, summary data is now available and will be presented to the forthcoming February 2023 Health Safety & Fire sub-committee.
Fire Safety Management 5.1	Feb-22	Limited	Appropriate systems should be developed to allow the production of basic management information in relation to risk assessments.	High	The Health Board will explore the use of the Risk Module in Datix to support the recording and escalation of risks following a Fire Risk Assessment. A Strategic Leadership Group paper will be produced to provide an options appraisal as to how fire risk assessments can be better captured and monitored.	Director for People	Head of Health, Safety and Fire	31/03/2022 30/04/2022	Now November 2022 Now December 2022 Now February 2023		Completed	April 2023 Update: Basic information on compliance with completion of Fire Risk Assessments was provided to the February 2023 Health, Safety and Fire Committee following a manual exercise from the All Wales Fire Safety Package. This will continue until the All Wales Package is either updated or replaced.	

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Patient Pathway Appointment Management Process Follow Up 1.1	Jun-22	Limited	Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	Chief Operating Officer	ILG Directors of Operations / Head of Information	Aug-22	Now December 2022 Now January 2023 Now April 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - Colleagues within the Information Department have commenced work to transition reports to a site based reporting model (away from ILGs) and will be seeking advice on the Service Grouping that the Organisation required to place over Specialty codes. The change in operating model will slow this process - hence the data has changed to January 2023. December 2022 Update - date for completion remains January 2023. February 2023 Update - a list of the officers on the circulation list has been produced and will be circulated to Service Group Managers in the next month to ensure that the right names are included. This will then be sent back to Performance colleagues.
Patient Pathway Appointment Management Process Follow Up 1.3	Jun-22	Limited	On receipt of the outcome reports, management within the CSGs should ensure that they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data or making the errors. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action.	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - Report generated regularly for former ILG structure. Steps will be taken to ensure that the December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead. February 2023 Update - a list of the areas where data is not being updated has been produced and some initial conclusions drawn. Once sense checked with colleagues in Performance, this will be reported to Service Groups for training needs to be established and resolved.
Patient Pathway Appointment Management Process Follow Up 1.5	Jun-22	Limited	Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	High	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - Date remains September 2022. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead. February 2023 Update - no further action to report here. This will be the next area of consideration when the circulation and training is addressed as above.
Patient Pathway Appointment Management Process Follow Up 2.1	Jun-22	Limited	Management should ensure that the correct data detailed within the closed pathway reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - These reports have been reinstituted as a submission to DHCW and can be made available. Once recipients have been confirmed, the Information Department can discuss method and provide the report regularly to the required audience. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead. February 2023 Update - as with 1.1 above, a list of the officers on the circulation list will be produced and will be circulated to Service Group Managers in the next month to ensure that the right names are included. This will then be sent back to Performance colleagues when agreed.
Patient Pathway Appointment Management Process Follow Up 2.2	Jun-22	Limited	Management should ensure that closed pathway reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that the patients are put onto an open pathway. In addition, closed pathways reports should be sent on a regular basis to staff within Bridgend ILG, or checks should be made to ensure managers are accessing this data for themselves.	High	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead. February 2023 Update - this will be undertaken in line with the actions planned above.
Patient Pathway Appointment Management Process Follow Up 2.3	Jun-22	Limited	On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - No formal feedback received from ILGs. To ensure progress, meeting planned for Thursday 25 August 2022 to discuss this audit. October 2022 Update - limited action undertaken in this area. There have been conversations on ADT / Outcomes / FUNB transactions timeliness and correctness in recent weeks that are yielding improvement. Further details will be available at the next meeting. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead. February 2023 Update - this will be undertaken in line with the actions planned under 1.3 above.

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Patient Pathway Appointment Management Process Follow Up 2.4	Jun-22	Limited	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Sep-22	Now February 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - Date remains September 2022. October 2022 Update - Report generated regularly for former ILG structure. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead. February 2023 Update - Initial conversations being undertaken as part of this work - some of which is outlined above - indicate that this is happening but a more formal response will be sourced in the next month.
POW Theatres Fire Safety Works 1.1	Aug-22	Limited	Management should formulate a Project Board immediately, with appropriate terms of reference and attendance as the accountable body for project delivery (as part of defined project governance).	High	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	Immediate	Now November 2022 Now January 2023 Now March 2023 Now April 2023		In progress	April 2023 Update - There is a meeting on 27th March involving the COO,SRO and DoF to consider the best way forward for decant options, post this a revised timeline around, meetings, structure and programme for delivery can be developed	October 2022 Update - This has been delayed whilst resolving the WG questions over the options appraisal to determine the best way to deliver the works. It is expected that a Project Board will be fully implemented by November. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
Digital Operatin g Model 1.1	Nov-22	Limited	An appropriate steering and ownership governance tier should be established that enables stakeholders to own, steer and oversee the delivery of digital objectives.	High	Accept A new governance and ownership arrangement will be created to align to the Health Board Transformation Change Programme and delivery board created as part of the Care Group Model Implementation.	Director of Digital	Director of Digital	Qtr. 3 2022/2023	Propose Qtr. 2 2023/2024		In progress	April 2023 Update - Work has commenced on the relationship of Digital Groups with the new Care Group Governance Model. On Track for completion in Qtr. 2023/2024	December 2022 Update - Executive Leadership Group currently utilised for Digital & Data Prioritisation and Approval. Patient Centre Contact Programme created under the Unified Change Board. Extensive engagement has taken place between the Digital & Data team and the Care Groups during the period. Final Digital & Data Governance Group to be confirmed. February 2023 Update - Work ongoing re: operational management of digital & data services in alignment with the Care Group model
Digital Operatin g Model 2.1	Nov-22	Limited	The Digital Clinical leadership structure should be revised and improved. • The CNIO role should be formalised; and • a network of digital clinical leaders should be established that mirrors the Health Board structure to ensure that each area as a defined leader who can act as a conduit and help embed digital.	High	Accept Digital Clinical Leadership will be developed and formally recognised as part of the Strategic Leadership Group within the Digital & Data Directorate. A new set of roles & capabilities will be identified as part of the new Digital & Data Governance arrangements.	Director of Digital	Director of Digital	Qtr. 3 2022/2023	Propose Qtr. 2 2023/2024		In progress	April 2023 Update - Work has commenced on the relationship of Digital Groups with the new Care Group Governance Model. On Track for completion in Qtr. 2023/2024	December 2022 Update - As part of the IMTP process, formalisation of a digital clinical group is required. Existing Digital Clinical Leaders are undertaken a benchmarking exercise. February 2023 Update - Work ongoing - new Digital & Data Structure is being finalised
Digital Operatin g Model 3.1	Nov-22	Limited	As part of the review of the directorate structure, consideration should be given to ensuring that the structure and resources includes: • appropriate digital leadership within the structure; • ongoing change management support; • digital transformation and project resource; and • Office 365 team and support.	High	Accept A Digital Leadership Change Process will be initiated in the Autumn of 2022. A subsequent review of senior management support and related resources will commence in the first half of 2023.	Director of Digital	Director of Digital	Qtr. 3 2022/2023 Qtr. 4 2022/2023	Now 31 December 2022		Completed	April 2023 Update - OCP now complete. Roles have been offered for prior consideration / preference - anticipated to confirm during April 2023 and commence recruitment for new roles that are then vacant. Propose to close.	December 2022 Update - Digital Strategic Leadership consultation period has ended. Work ongoing on finalising the draft Job Descriptions - plan to complete in December 2022. February 2023 Update - Strategic Leadership structure will be finalised in this Qtr. as proposed
Digital Operatin g Model 6.1	Nov-22	Limited	The Health Board should ensure that appropriate funding is provided to enable equipment to be kept up to date.	High	Accept Appropriate funding will be identified as part of the IMTP process for a 2023 submission.	Director of Digital	Director of Digital	Qtr. 4 2022/2023			Completed	April 2023 Update - Additional funding has been allocated to the Digital & Data function for 2023/2024. This does not cover the complete gap - but an additional £2m for Digital and £1m for Digital patient notes has been allocated. Further in year opportunities will be explored. Propose to close	December 2022 Update - IMTP development will propose required capital and revenue funding to support digital requirements. February 2023 Update - Costs for various schemes have now been identified. Prioritisation of programmes of work to be undertaken during February 2023

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Radiology Service Review 6.1	Dec-22	Limited	In order for absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates.	High	All superintendents will be advised of the need to maintain comprehensive and accurate documentation in relation to each episode of sickness absence and ensuring that all documentation is completed in a timely manner in line with the Managing Attendance Policy. A request will be made to workforce for Sickness/Absence Management Training.	Chief Operating Officer	Site Superintendent Radiographers	31st December 2022	Now February 2023 Now April 2023		In progress	April 2023 Update - Sickness Training Updates are currently being arranged with People's Services for staff on all 3 DGH sites. Training delivered to PCH staff 08/03/23 & 13/03/23 POW staff. Awaiting a training date for RGH staff.	February 2023 Update - Sickness Training Updates are currently being arranged with People's Services for staff on all 3 DGH sites.
Radiology Service Review 9.1	Dec-22	Limited	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. We acknowledge that the service will always need to prioritise clinical activity, but in order to achieve set targets, the service should develop an action plan outlining a realistic approach to tackle the backlog, prioritising those with future increment dates. Consideration must also be given to developing a sustainable way of maintaining PDR compliance rates once the backlog has been cleared. As part of addressing the backlog, staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	High	An action plan will be developed to address the backlog of PDRs and establishing a sustainable system of maintaining PDR compliance in line with the WG and Health Board targets. Robust monitoring arrangements at corporate and at Care Group level will need to be implemented. All staff will be reminded of the importance of having a PDR, including the need for pay progressing, and the need to engage meaningfully in the process.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographer	Jan-23	Now March 2023 Now May 2023		In progress	April 2023 Update - The site leads have developed a programme to undertake PDRs. POW are 100% compliant. RGH/PCH staff are working to pay progression dates. The new admin manager is currently undertaking a programme of PDRs. Ongoing due to clinical commitments.	February 2023 Update - The site leads have developed a programme to undertake PDRs. POW are 100% compliant. RGH/PCH staff are working to pay progression dates. The new admin manager is currently undertaking a programme of PDRs. Ongoing due to clinical commitments.
Radiology Service Review 10.1	Dec-22	Limited	Work should be undertaken to ensure the training requirements and achievements captured in ESR are accurate: • Management should identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Management should identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • If management feel staff are professionally competent then they should be removed from the list of staff to undertake training.	High	The Service will undertake a review of the training requirement and achievements captured in ESR to: • Identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • Identify staff who are professionally qualified above the requirements of any of the ESR modules and liaise with L&D to have this information captured on the ESR records, so that non-completion of the ESR modules does not impact compliance rates.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	Mar-23	Now May 2023		In progress	April 2023 Update - The Learning & Development Team have been contacted around core competencies. The matter is ongoing with corporate team.	February 2023 Update - The Learning & Development Team have been contacted around core competencies. The matter is ongoing with corporate team.
Radiology Service Review 10.2	Dec-22	Limited	• If management feel staff are professionally competent then they should be removed from the list of staff to undertake training. The Clinical Service Group should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	High	The Service will remind staff that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role and that staff are provided with the opportunity to undertake their mandatory training. Ongoing support at Executive Level will be required to address role requirements.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	Mar-23	Ongoing		In progress	April 2023 Update - Ongoing work is underway to drive core compliance. Unfortunately there are some classroom based courses which are unavailable. Time is being allotted to staff balancing clinical commitments. A Module of the Month is sent to encourage staff to complete training. Ongoing	February 2023 Update - Ongoing work is underway to drive core compliance. Unfortunately there are some classroom based courses which are unavailable. Time is being allotted to staff balancing clinical commitments. A Module of the Month is sent to encourage staff to complete training. Ongoing
Radiology Service Review 11.1	Dec-22	Limited	Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.	High	A programme of reviewing consultant job plans has commenced with a target date of completing these by January 2023 and a system is established to ensure that these are reviewed on annual basis	Chief Operating Officer	Clinical Director Clinical Service Manager	Jan-23	Now March 2023		Completed	April 2023 Update - The programme of Job Planning is complete. There are 3 staff members who have requested a subsequent meeting for further requests/changes. An ongoing review will be diarised in line with Job Plan Review dates.	February 2023 Update - A programme of Job Planning is nearing completion with only 2 outstanding Consultant Job Plans.
Medical Variable Pay 1.1	Feb-23	Limited	1.1a A review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be undertaken. From considering the findings from the audit report and reviewing current processes, both documents should be updated to reflect the processes and controls that staff should be adhering to when engaging medical agency staff. 1.1b Updated copies of the updated FCP and SOP should be accessible to all staff and staff should be made aware of their existence. 1.1c Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	High	1.1a The Financial Control Procedure (FCP) and Standard Operating Procedure (SOP) will be reviewed immediately and updated in line with recommendations within this report. They will then go through a ratification process to ensure this is also compliant with the Health Board's scheme of delegation and in place policy and procedures. Both the FCP and SOP were due to be reviewed at the start of this audit, however this was delayed to ensure the recommendations contained in this audit could be incorporated into both documents. The June target date is used as the FCP will have to go through a ratification process. 1.1b Both the FCP and SOP will be hosted on the agency intranet page, also available from the People Directorate on request and issued by Retinue to current users. Every time a new area is added to the system, all staff with access to book agency workers will be issued with the documents, along with training on how to use the system. 1.1c All areas using the agency booking system will be provided with refresher training. A training plan will be developed and provided to all existing users, once the new FCP and SOP are in place. A record will be kept of what areas have had this training and when.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	1.1a and 1.1b June 2023 1.1c August 2023			In progress	April 2023 Update - FCP draft written and sent to finance colleagues for review.	

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Medical Variable Pay 3.1	Feb-23	Limited	3.1a The process for authorising payments that exceed the WG cap rates should be reviewed, with suitable authorisation taking place to approve higher value payments. 3.1b The FCP and SOP should be updated to reflect the correct process to be followed and should provide greater clarity on the cost elements that need to be included when determining if a rate exceeds guidance rates. There should be consistent use of terminology across the FCP, SOP and Retinue system.	High	3.1a The process for payments exceeding the WG cap rates will be fully reviewed as part of the development of the new FCP and SOP. The recommendations of this audit will be incorporated into the FCP and SOP. 3.1b The new FCP and SOP will fully address and unify the inconsistent terminology used currently, to reduce any confusion going forwards. The documents will also clearly set out the authorisation process required for rates that exceed WG cap rates. The process for requesting above WG cap rates will also be included in the refresher training to all areas using agency workers.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23			In progress	April 2023 Update - FCP draft written and sent to finance colleagues for review. Will be reflected in new FCP	
Medical Variable Pay 3.2	Feb-23	Limited	Approval of higher rate payments should be retained in a suitable format that allows future reference if needed.	High	All authorisation of higher rates payments will be recorded fully and provided on request. The way this is captured and accessible for audit will be included in the FCP and SOP for future reference.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23			In progress	April 2023 Update - FCP draft written and sent to finance colleagues for review. Will be reflected in new FCP	
Medical Variable Pay 4.1	Feb-23	Limited	It should be ensured that suitable processes are in place and adhered to for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum. Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used.	High	The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension. Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Aug-23			In progress	April 2023 Update - DE Policy to be written for Care Groups with a clear escalation policy in place	
Medical Variable Pay 6.1	Feb-23	Limited	6.1a The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate. 6.1b The FCP and SOP should be updated to reflect the correct process to be followed.	High	6.1a A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff. 6.1b The recommendations and subsequent processes developed will be included in the FCP and SOP.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Aug-23			In progress	April 2023 - as per new FCP	
Concerns 1.1	Feb-22	Limited	The concerns policy should be reviewed and updated to accurately reflect the structure, roles, responsibilities and active involvement of the corporate function and the ILGs in respect of the management, investigation and reporting arrangements relating to concerns and complaints.	Medium	Changes will be made to the Concerns Policy and management process in line with the Concerns Improvement project. This will be undertaken via a collaborative process between Corporate and the ILGs and in light of any changes to the Operating Model following the current review.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023 Now February 2023 Now May 2023		In progress	April 2023 Update - Recommendation: incomplete, open/yellow. The policy has been reviewed and amended. Awaiting discussion on the ratification process.	April 2022 Update - On hold until changes to the operating model. June 2022 - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 update Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made. These should be updated and in place in line with the operating model in January 2023. December 2022 update - Complaints Manager and Head of Concerns & Business Intelligence now in post, reviews have now started, however, changes to the operating model will need to be finalised before any changes are made, along with consideration of Duty of Candour and the changes to PTR. These should be updated and in place in line with the operating model in January 2023. February 2023 update - Policy has been reviewed and amended however, some minor changes to the operating model will need to be finalised before any changes are made, along with consideration of Duty of Candour and the changes to PTR. These should be updated and in place in line with the operating model in January 2023. 3.3a April 2022 Update - Discussions ongoing. 3.3b April 2022 Update - Email to ESR team to query whether PTR and correspondence in respect of PADRs and training. 3.3c April 2022 Update - Email to ESR. June 2022 There is no unified way of recording training if it isn't on ESR. Various different methods in place. August 2022 Update Engagement with ESR team to ascertain whether training can be captured within ESR. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented. October 2022 Update ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. December 2022 Update - ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. Following the centralisation of quality and safety, a review of training which is not captured on ESR will be undertaken and a consistent method implemented. February 2023 Update - ESR have confirmed training can be captured on ESR, however resource to update ESR would have to be considered. In the interim period the Central complaints team will be retaining training records.
Concerns 3.3	Feb-22	Limited	Records of all training attended in relation to both PTR/Concerns training and Datix Once for Wales Training should be retained.	Medium	Undertake scope on training record management and how this is captured within CTM if it is not retained within ESR Discussion with ESR team to ascertain whether training records can be included on ESR for Concerns Management training Discussion with Organisational Development regarding retention of training records and how this links to PADRs.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Feb-22	Now December 2022 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. ESR has confirmed training can be captured on ESR, however resources to update ESR would have to be considered. In the interim period, the Central complaints team will be retaining training records.	

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Concern s 4.2	Feb-22	Limited	4.2a Management should understand why RTE has not been re-categorising early resolution concerns that were not resolved in the timeframe and take appropriate action to resolve and accurately record in Datix. 4.2b To ensure consistency, a Standard Operating Procedure (SOP) should be in place outlining the process for re-categorising concerns, including who is responsible for performing this task. Training should be provided where necessary.	Medium	4.2a As 4.1 above 4.2b Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above.	Director of Nursing	4.2a Complaints Manager 4.2b Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022 Now January 2023 Now February 2023 Now May 2023		In progress	April 2023 Update - Recommendation: incomplete, open/yellow. 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board, along with benchmarking with NHS Wales colleagues within the Complaints Network. Complaints are centralised in February 2023. A workshop with complaints handlers has been held to ensure quality and consistency. 4.2b - Policies/SOPs have been reviewed and amended. Awaiting ratification	4.2a April 2022 Update - Complaints Manager not in post. 4.2b April 2022 Update - On hold until changes to the operating model. June 2022 4.1a - Audits will be reinstated when Complaints Manager is in post. Further review will be required once the new operating model is in place and established. 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board. 4.2b - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety (including complaints), will ensure a consistent approach to complaints management across the Health Board, with current capacity constraints will be addressed following the implementation of the new operating model. The Complaints Manager post has been out to advert and will be recruited into imminently. This will be supported by a staff member returning from secondment. These are scheduled to take place in August. A key priority will be the review of policies and procedures once the new operational model has been implemented. October 2022 Update 4.1b - A review of all Policies and associated SOPs has begun and will incorporate the new operating model. 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board. 4.2b - Work continues on the new Operational model, this incorporates 3 complaints triage posts which will assist with managing complaints more effectively, promoting early resolutions where possible and appropriate. The centralisation of Quality & Safety April 2022 Update - Partially completed in respect of LFERs and Once for Wales CMS. PTR to be completed. June 2022 A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Training on new policies and SOPs will be included in the training package outlined in 3.1 Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post, this will incorporate any rationale for deviating from policies and SOPs. However, changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. However, training is already taking place since the launch of the new Incident Management Framework. The supporting training covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Training continues with the implementation of the new Datix Incident reporting module with the importance of updating Datix reinforced. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a June 2022 Update - On hold until changes to the operating model. A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update This will be completed by the Complaints Manager, supported by the Senior BI and Complaints Manager during the period of August and September, taking into account changes to the operating model. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme is in the process of being developed. February 2023 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme has been developed and will commence in February 2023, after quality governance model is implemented. June 2022 Update - Complaints Manager not in post. Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post. Changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in August 2022 and rolled out in September 2022. October 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in November 2022. December 2022 Update - This will be included into the Quality Assurance and Audit Programme. There has been some slippage to progress in this area due to shortage of staff within central complaints. February 2023 Update - This has been included into the Quality Assurance and Audit Programme, which commences in February 2023.
Concern s 5.1	Feb-22	Limited	For each concerns investigation undertaken, in the absence of detailed Standing Operating Procedures, the process outlined in the Concerns Policy and Procedure documents should be followed. Comprehensive notes and evidence should be added to Datix in a timely manner to support the process followed, the investigation carried out and the lessons learnt. Where aspects of the policy are not being undertaken at all, it should be established if this is due to staff not being aware of this aspect of the process or if the policy is in fact out of date and in relation to current practices.	Medium	To be included in training programme as per 3.1a and 3.1b above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. The review of Policies and Procedures has been completed and is awaiting discussion on the ratification process. Training is already taking place in line with concerns management (incidents and complaints). Further training material is available in line with the introduction of the Duty of Candour and is available on the HB SharePoint There is a rolling Datix training programme which covers the investigation and the updating of Datix.	
Concern s 6.2	Feb-22	Limited	Evidence should be retained of CSG management's contribution to the quality checking process of review and oversight of the investigation's outcomes and the draft PTR Concerns Response letters prior to their submission to an ILG Director for sign-off.	Medium	Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now October 2022 Now December 2022 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. The review of Policies and Procedures has been undertaken taking into account changes to the operating model. A new QA process has been developed	April 2022 Update - On hold until changes to the operating model. June 2022 Update A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update This will be completed by the Complaints Manager, supported by the Senior BI and Complaints Manager during the period of August and September, taking into account changes to the operating model. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme is in the process of being developed. February 2023 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. Quality assurance and audit programme has been developed and will commence in February 2023, after quality governance model is implemented. June 2022 Update - Complaints Manager not in post. Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post. Changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in August 2022 and rolled out in September 2022. October 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in November 2022. December 2022 Update - This will be included into the Quality Assurance and Audit Programme. There has been some slippage to progress in this area due to shortage of staff within central complaints. February 2023 Update - This has been included into the Quality Assurance and Audit Programme, which commences in February 2023.
Concern s 6.3	Feb-22	Limited	A process of retrospectively reviewing the quality assurance processes applied in ILG should be introduced at a corporate level to ensure oversight, challenge and facilitate learning.	Medium	To form part of the rolling corporate concerns management audit programme	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now December 2022 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. The review of Policies and Procedures has been undertaken taking into account changes to the operating model. A new QA process has been developed	April 2022 Update - Complaints Manager not in post. June 2022 Update Audits will be reinstated as outlined in 4.1a when Complaints Manager is in post. Changes to the operating model and centralisation of complaints management should ensure a more unified approach across the organisation. August 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in August 2022 and rolled out in September 2022. October 2022 Update This will be included into the Quality Assurance and Audit Programme. Due to be reviewed and updated in November 2022. December 2022 Update - This will be included into the Quality Assurance and Audit Programme. There has been some slippage to progress in this area due to shortage of staff within central complaints. February 2023 Update - This has been included into the Quality Assurance and Audit Programme, which commences in February 2023.
Concern s 7.1	Feb-22	Limited	Clarity should be sought, and information documented with a SOP as to when a case should be closed on Datix and the circumstances for when it can be re-opened. To avoid any confusion, information contained in a SOP and the Concerns Policy should align.	Medium	To be included in the development of SOPs as per 1.2 above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now January 2023 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. This has been included in the review of Policies and Procedures.	April 2022 Update - On hold until changes to the operating model. June 2022 Update A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. October 2022 Update The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. December 2022 Update - The review of Policies and Procedures is underway taking into account changes to the operating model. Once this is completed a training needs analysis will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented. February 2023 Update - This has been included in the review of Policies and Procedures. This will be incorporated into the training needs analysis and will be undertaken in conjunction with the central care group governance teams and a training plan will be developed and implemented.
Concern s 7.2	Feb-22	Limited	Prior to closing concerns at early resolution stage, some form of quality assurance process should be followed that ensures all aspects of the concern raised by the complainant have been adequately addressed, thus preventing the case being potentially re-opened at a later date. This process should be documented.	Medium	To be included in the development of SOPs and training as per 1.2, 3.1a and 3.1b above	Director of Nursing	Interim Head of Concerns, Redress & Legal	Jun-22	Now September 2022 Now January 2023 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. The review of Policies and Procedures has been undertaken taking into account changes to the operating model. New QA process has been developed	April 2022 Update - On hold until changes to the operating model. June 2022 Update A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Rationale for reopening of complaints is space on Datix, however, this will be regularly monitored. When the new triage process is implemented, with a view to increasing early resolutions and decreasing formal complaints, a balancing measure will be the number of early resolutions moving onto formal complaints. This will be incorporated into the rolling audit programme. August 2022 Update - The review of Policies and Procedures is due to take place in August and September, taking into account changes to the operating model. The way re-opened complaints are recorded within CTM is different and consequently skews data. Once the centralisation of the quality & safety team is implemented, the way complaints are managed will be more consistent in line with new/revised policies and procedures. October 2022 3.1a - The launch of the new Incident Management Framework and the training which is in place to support this covers a number of elements including family support, psychological safety, staff support, investigation, breach of duty, causation, redress, claims and learning from events reports, sharing of learning. Complaints policies/procedures will be updated in due course in line with the new operating model and changes to PTR following implementation of Duty of Candour. 3.1b - Training Needs analysis will be undertaken on completion of prospectus with the newly formed care groups.

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Concern s 8.2	Feb-22	Limited	Where cases remain open beyond 30 days, ongoing progress contact should be maintained with the complainant and evidence of this retained within Datix.	Medium	Will be addressed in the development of the SOPs as per 1.2 and included as part of the training programme as per 3.1a.	Director of Nursing	Interim Head of Concerns, Redress & Legal	Apr-22	Now September 2022 Now February 2023		Completed	April 2023 Update - Recommendation: complete, closed/green. The revised policies and procedures captures this requirement. This role has been transferred to the administrative support in the new central team	April 2022 Update - On hold until changes to the operating model. June 2022 4A review of all Policies and associated SOPs has begun and will incorporate the new operating model. Progress on this action has been slow due to the Complaints Manager not being in post and focus on changes to the operating model. Completion of Datix will be incorporated into the training package. August 2022 Update - Complaints opened over 30 working days are regularly monitor via the weekly data review meeting and the Executive Patient Safety meeting. Updates to patients/family's will be incorporated into the Quality Assurance and Audit Programme being developed in August. Complaints Polices and Procedures are being reviewed in August and September. The centralisation of the quality and safety function with alignment to care groups should ensure a more consistent approach. Findings of the audits will be shared and acted upon, with current capacity constraints will be addressed following the implementation of the new operating model. October 2022 Update Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. December 2022 Update - Training is taking place in respect of Datix Cymru and the training which has supported the launch of the Incident Management Framework, both include the importance of using Datix Cymru to record all information and ensuring it is regularly updated. This will also be included within any additional training in respect of the new Complaints Policies and Procedures. February 2023 Update - The revised policies and procedures captures this requirement. The quality assurance new checklist monitors this. Management of this going forward will be more achievable in a centrally managed service.
Fire Safety Management 2.1	Feb-22	Limited	Local procedures will be reviewed and updated within specified review periods - and associated uniform approval arrangements applied.	Medium	Agreed A review is in progress to align and standardise procedures.	Director for People	Head of Health, Safety & Fire	Mar-22	Jun-24		In progress	April 2023 Update - work continues within the Fire Team to update the Site Specific Documents where site changes have taken place. Completion should have taken place by the June 2024 deadline.	The Health Board has both area / ward based procedures and overall site procedures. This does not present a major risk, as these are background information utilised for training, rather than being the emergency procedures. These also represent best practice rather than being a legislative requirement, being additional to the area specific procedures. The site procedures are comprehensive procedures, and will be updated over an 18 month period following the recent appointment of a new Senior Fire Safety Officer. The initial priority had been to put in place site procedures for Bridgend, as when this was transferred to CTMUHB it lacked site procedures.
Fire Safety Management 4.1	Feb-22	Limited	Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	Medium	The Health Board will develop a medium term strategy for fire safety across its sites.	Director for People	Head of Health, Safety and Fire Head of Capital and Estates ILG Director of Operations	Mar-23	Now June 2023		In progress	April 2023 Update - the update for April is the same position as February 2023.	April 2022 Update - Work ongoing. August 2022 Update - no further update provided on this occasion October 2022 - No further update provided on this occasion. December 2022 Update - A new Senior Fire Officer has been appointed following the retirement of the previous post holder. The new Senior Fire Officer came in to post on the 7th November 2022 and has been requested to develop this plan over the coming 2 months. February 2023 Update - Risks are reported and profiled to Welsh Government at both the Fire Safety Risk Register, and Estates Facilities Performance and Condition report. However, this does not represent a time-phased strategy to address e.g. for expert resource to drive certain actions, or co-ordination with building works. Management comment - Agreed - however, due to limited All Wales capital finance, this has not been prioritised over the last year.
Patient Pathway Appointment Management Process Follow Up 3.1	Jun-22	Limited	Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members	Medium	This will be addressed by the ILG with colleagues from Performance	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023 Now June 2023		In progress	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.	August 2022 Update - Date remains September 2022. October 2022 Update - no further comment, will be picked up as part of re-focus on this audit. December 2022 Update - progress slow as a consequence of activity on sites. Meeting in diaries to resolve way ahead. February 2023 Update - This item will be considered as part of the process for this audit set out above.
POW Theatres Fire Safety Works 1.2	Aug-22	Limited	The Health Board should appropriately define and operate project linkage to the Senior Responsible Officer.	Medium	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023 Now April 2023		In progress	April 2023 Update - The Director of Strategy and Transformation remains the SRO and has been attending ECMG meetings. The SRO will chair the meeting on the 27th March and the revised meeting structure and programme from this meeting will ensure appropriate linkage to the SRO	October 2022 Update - Whilst appointments and structures are confirmed this remains outstanding. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
POW Theatres Fire Safety Works 3.1	Aug-22	Limited	The Health Board should ensure timely completion of contacts.	Medium	Agreed - though in this case, due to the bespoke nature of the contract - a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Director of Strategy & Transformation	Project Director	At future contracts	Now January 2023 Now March 2023 Now June 2023		In progress	April 2023 Update - As soon as there is a revised way forward the contract methodology and delivery requirements can be appraised following a meeting with WG. This is a future recommendation and will be fully incorporated when the HB is in a position to enter into contract to deliver the next phase of works	October 2022 Update - Until a way forward is agreed with WG this will not be required as no new contracts will be let. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then

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POW Theatres Fire Safety Works 4.1	Aug-22	Limited	The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Medium	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Director of Strategy & Transformation	Project Director	At future contract awards	Now January 2023 Now March 2023 Now June 2023		In progress	April 2023 Update - As with the point above, works are paused with the ongoing review of decant options. For all future awards there will be an emphasis on competition in awarding contracts wherever this is possible. However future contracts will only be awarded after confirmation of an internally agreed way forward which is also endorsed and approved by WG	October 2022 Update - This is a future recommendation at such a time post business case approval. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
POW Theatres Fire Safety Works 4.2	Aug-22	Limited	The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	April 2023 Update - Once the decant phase and internal works phases are agreed then a cost advisor will require appointment and the HB will undertake a competitive process for the appointment of the same	October 2022 Update - This will be reviewed at the letting of a contract for construction stage post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
POW Theatres Fire Safety Works 4.3	Aug-22	Limited	The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	April 2023 Update - As per the point above, once the way forward is known, agreed and approved then attention can be focused on contractor appointment and appropriate processes	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
POW Theatres Fire Safety Works 6.1	Aug-22	Limited	Upon recommencement of the project, management should utilise Key Performance Indicators in accordance with the contract.	Medium	Agreed. These will be applied as required.	Director of Strategy & Transformation	Project Director	Upon re-engagement with the SCP	Now 2023 Now January 2023 Now March 2023 Now September 2023		In progress	April 2023 Update - As per points above, once the way forward is known the KPIs under the Designed for Life framework will be brought in to review the work of the contractors appointed. However this is a future recommendation that will not take effect until contractual works re-commence and have been running as KPIs. Will generally take place quarterly at the end of each quarter post works commencement.	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
POW Theatres Fire Safety Works 8.1	Aug-22	Limited	Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: - contacted sums; - cash flow budgeted to date; - expenditure to date; - forecast out-turn; and - associated variance commentary.	Medium	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	April 2023 Update - This will be fully implemented once the go ahead is given on a preferred option and the project team is reinstated to over see this work	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
POW Theatres Fire Safety Works 9.1	Aug-22	Limited	Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Medium	Agreed. This will be undertaken at the future procurement.	Director of Strategy & Transformation	Project Director	At confirmation of the preferred option	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	April 2023 Update - As mentioned above pending agreement of the preferred way forward and approval by WG all letting of future contracts and awards will satisfy value for money requirements	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then

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

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Digital Operatin g Model 7.1	Nov-22	Limited	The Health Board should clearly state that minimum digital literacy is a requirement, with provision of training if required.	Medium	Accept Digital literacy to be included within the workforce and organisational development plan as part of the IMTP.	Director of Digital	Director of Digital	Qtr. 4 2022/ 2023			Completed	April 2023 Update - Propose to close - digital literacy referenced within IMTP and some of the monies will be allocated to support this in 2023/2024	December 2022 Update - Digital Literacy and training initiatives to be outlined within the IMTP. February 2023 Update - Ongoing in alignment with the IMTP
Digital Operatin g Model 8.1	Nov-22	Limited	The work to restructure support should be finalised, with greater provision of: - fix at first contact; - use of process automation for handling calls; - use of digital champions within services; - a structured SharePoint site; and - how to guides.	Medium	Accept A phased programme of work will be developed alongside the structural review. This programme is likely to run for 12 months.	Director of Digital	Director of Digital	Qtr. 3 2023/ 2024			Completed	April 2023 Update - Propose to close - digital literacy referenced within IMTP and some of the monies will be allocated to support this in 2023/2024	December 2022 Update - New Digital Service Desk launched in November 2022. Work ongoing to complete how to guides. February 2023 Update - Work ongoing
Radiolog y Service Review 6.2	Dec-22	Limited	Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Medium	All superintendents will be advised of the need to maintain accurate documentation of all decision taken including those outside of the Managing Attendance Policy.	Chief Operating Officer	Superintendent Radiographers	31st December 2022	Now February 2023 Now May 2023		In progress	April 2023 Update - All Superintendents have been informed of their responsibilities in terms of sickness management. A training update session is in the process of being arranged with People's Services. PCH & POW staff have attended an update. Awaiting a training date for RGH to attend.	February 2023 Update - All Superintendents have been informed of their responsibilities in terms of sickness management. A training update session is in the progress of being arranged with People's Services.
Radiolog y Service Review 6.3	Dec-22	Limited	The roll out of electronic staff files across the service should progress with all electronic files fully populated with documentation scanned from hard copy files. Consideration should be given to replicating the Standard Operating Procedure developed in other CSGs (such as CAMHS) in relation to the set up and use of electronic staff files.	Medium	The service will liaise with other recommended CSGs who have implemented areas of good practice based on previous findings to establish a Standard Operating Procedures for the electronic files.	Chief Operating Officer	Clinical Services Manager	31st January 2023	Now March 2023 Now May 2023		In progress	April 2023 Update - An electronic staff Personnel File has already been implemented for new staff at RGH and PCH. There is a hybrid system for established staff and a system to scan in legacy documents. Work is underway at POW but the current sickness absence in admin team has delayed progress.	February 2023 Update - An electronic staff Personnel File has already been implemented for new staff at RGH and PCH. There is a hybrid system for established staff and a system to scan in legacy documents. Work is underway at POW but the current sickness absence in admin team has delayed progress.
Radiolog y Service Review 8.1	Dec-22	Limited	a) A review on the approach to how TOIL is managed across the service should be undertaken to ensure there is some level of consistency (between accruing hours and being paid overtime) and staff are being treated equally, whilst meeting the needs of the service in each area. b) Consideration should be given to the number of hours staff are able to accrue as TOIL, given that resource constraints can impact the ability for staff to take the hours back	Medium	a) A review of the approach to TOIL will be undertaken across the three localities to ensure a consistency of approach. b) An agreement will be established to the maximum number of hours that can be accrued as TOIL considering the impact of the ability to take back hours and the potential impact of the service.	Chief Operating Officer	Clinical Service Manager Site Superintendent Radiographers	Feb-23	Now March 2023 Now May 2023		In progress	April 2023 Update - The team have met to review the current HB policy and will implement across Radiology on the 3 sites. Work is underway to streamline across the 3 sites.	February 2023 Update - The team have met to review the current HB policy and will implement across Radiology on the 3 sites.
Radiolog y Service Review 11.2	Dec-22	Limited	Management should ensure that the recently produced job planning procedure is made available. Once planning meetings have taken place, if there are delays in sign off, the steps outlined in the procedure should be followed, to ensure timely sign off. The CSG should continue to liaise with the Allocate team to ensure the data in the system is accurate, all users have the required access and queries get resolved.	Medium	The hierarchy on Allocate is now a true reflection of the consultant establishment and as job plans are being scheduled access to Allocate is being arranged.	Chief Operating Officer	Clinical Director Clinical Service Manager	Jan-23	Now March 2023		Completed	April 2023 2023 Update - The relevant house keeping has been undertaken with the Allocate Team and all current consultant staff are assigned accordingly.	February 2023 Update - The relevant house keeping has been undertaken with the Allocate Team and all current consultant staff are assigned accordingly. There appears to be an issue with the system where the relevant notification is not being received for sign off by clinician. To be addressed through Allocate Support Team.

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Medical Variable Pay 2.1	Feb-23	Limited	2.1a The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. 2.1b The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	Medium	2.1a The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. 2.1b Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23			In progress	April 2023- DE Policy to be written for Care Groups with a clear escalation policy in place	
Medical Variable Pay 2.2	Feb-23	Limited	The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.	Medium	All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health board, which will allow the organisation to target and reduce DE use.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23			In progress	April 23- DE Policy to be written for Care Groups with a clear escalation policy in place	
Medical Variable Pay 5.1	Feb-23	Limited	Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.	Medium	Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	Medical Director	Assistant Director of Finance/ Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23			In progress	April 2023 Update - DE Policy to be written for Care Groups with a clear escalation policy in place	
POW Theatres Fire Safety Works 2.1	Aug-22	Limited	The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Low	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Director of Strategy & Transformation	Project Director	At the business case	Now 2023 Now January 2023 Now March 2023 Now September 2023		In progress	April 2023 Update - A resource schedule will be drawn up to deliver the agreed way forward for decant and remediation works which will be part of a business case submitted to WG in 23/24 during the business case development process	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
POW Theatres Fire Safety Works 7.1	Aug-22	Limited	The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works	Low	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	April 2023 Update - This review will be undertaken once the way forward, contractual mechanism and procurement route is confirmed. The requirement or not and advice will be included in any tender/appointment and business case process	October 2022 Update - This will be addressed on letting the contract post business case approval in 2023. December 2022 Update - Currently there are weekly meetings of an operational team to assess the clinical, operational and performance impacts of the options which is currently being reported through ECMG. It is expected that there will be an internal confirmed way forward in January after a detailed appraisal during the next theatre audit day on 11th January. This will be taken to WG at the end of January 2023. Once this occurs the project will have a confirmed way forward and the new structures can be brought into place. February 2023 Update - There have been some delays to the appraisal of decant options from a clinical perspective which are scheduled to take place in early February. It is planned that further discussions will take place with WG in February over the proposed way forward and these actions can be taken forward then
Radiology Service Review 8.3	Dec-22	Limited	Where paper records remain in use, they should be reviewed and updated to ensure they are fit for purpose and capture all relevant information in format that allows staff and management to manage TOIL effectively.	Low	A review of the current systems to record TOIL will be undertaken to establish which system is most effective and applied across the localities.	Chief Operating Officer	Clinical Service Manager Site Superintendent Radiographers	Feb-23	Now March 2023		Completed	April 2023 Update - All staff members have been informed to complete the appropriate TOIL form and request permission to build up TOIL in the absence of the Heath Roster being implemented across the 3 sites.	February 2023 Update - All staff members have been informed to complete the appropriate TOIL form and request permission to build up TOIL in the absence of the Heath Roster being implemented across the 3 sites.

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Nurse Agency Usage 01	Apr-20	Reasonable	1. Clarity should be provided as to whether the Staff Bank Policy Induction Checklist (Appendix C) should be completed or the more recently revised 'Ward induction checklist for bank and agency workers'. 2. Ward Managers / the Nurse in Charge should be reminded of the importance to complete the induction checklist to ensure that new agency nurses are appropriately orientated and provided with relevant health and safety overview of the ward they are due to work on.	High	Induction check list to be reviewed and agreed by Heads of Nursing, Ward Managers & Senior Nurses to receive updated check list that must be completed for all new Bank and agency nurses. Updated Bank/Agency Nurse Induction Checklist to be included into the revised Staff Bank policy.	Director for People	Head of Corporate Nursing	March 2020/April 2020/August 2020	February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. January 2021 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: Amendments came back via policy infrastructure, which will be incorporated into the policy draft for approval. This will be taken through the Health Board's policy group by Jun-21. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 21 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - Draft Staff Bank Policy scheduled for Policy Review Group on 18th November 2021. January 2022 Update - Policy sent to policy group for Apr 2022 - The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update - The policy has been updated and is progressing through the approval process. August 2022 update - The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for
Nurse Agency Usage 02	Apr-20	Reasonable	1. The Bank / Agency Nurse Quality Monitoring Form should be reviewed to ensure it is fit for purpose and provides a suitable means for the routine monitoring of the quality of work provided by agency staff. 2. Ward Managers should be reminded of the need to complete the quality monitoring form and returning it to the Bank office as a means of formally evaluating the performance of agency nurses and aiding and informing any future acceptance or rejection of potential agency nurses in the event of query or concern. 3. The Clinical Incident Reporting for Agency Staff flowchart and the Staff Bank Policy should be reviewed to ensure consistent guidance for managing and monitoring issues relating to the quality of service provided by agency staff. If the flowchart is the Health Boards preferred approach, all Ward Managers should be made aware that in line with the agreed flowchart, incidents are appropriately and consistently recorded on DATIX to allow effective monitoring. 4. Attempts to cross-reference patient experience data	High	Revised Clinical Incident Reporting flowchart to be placed into the Staff Bank Policy. Bank / Agency Nurse Quality Monitoring Form will be reviewed to ensure it is fit for purpose and amendments made for updated policy in August 2020. The cross-referencing of patient experience and agency use data is something that we will look into. In the first instance we will need to see if data in relation to patient experience can be obtained from colleagues in the Health Board and we will look to see if meaningful reports can be produced. In the mean-time we will continue to review specific concerns that have been raised via our routine processes.	Director for People	Head of Corporate Nursing	Aug-20	October 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support existing and new HB services has meant a delay in starting this policy. January 2021 Update - No further change/update. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 - The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update - The policy has been updated and is progressing through the approval process. August 2022 update - The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for ratification of the policy through the appropriate route. The policy will be taken to the next LPF in September 2022. October 2022 Update - The policy has had to be stalled due to changes needed to the agency booking process required by the Nurse Productivity
Director ate Review Acute Medicine & A&E 13	Aug-20	Reasonable	An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	High	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Chief Operating Officer	General Manager	Apr-21	01/05/2021 August 2021/April 2022 Now September 2022 Now March 2023 Now June 2023		In progress	April 2023 Update - position remains the same as the last update.	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. for focus in the future - further action will be completed asap. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk - and both MC and RTE recognise that it will take time to be complete. The CSG Manager in MC has recently sent out information to staff and anticipates an earlier resolution than RTE but it is recognised in both areas. July 2021 Update - no change for RTE and MC ILGs at present however this remains on the agenda. September 2021 Update. No change to report, the target date remains April 2022. November 2021 Update - Target date is April 2022 - nothing further to report. February 2022 Update - the Directorate at MC has established a link with Procurement colleagues to work on this. In RTE, the pressure of work means that there is no update yet and no further action taken. April 2022 Update - Further improvement in MC - the process has started and the anticipated completion is September 2022. June 2022 Update - target remains September 2022, though this will be difficult given the amount of detailed work that will be required within existing staffing profiles. August 2022 Update. For MC, the completion date remains at September 2022. For RTE, this is still an aspiration but not one that the CSG can support at present. October 2022 Update - the situation remains the same, the view of the Directorate is that there is not at present the capacity to complete this task. December 2022 Update - position remains the same in RTE area. February 2023 Update - position is unchanged from last report.
PCH Redevel opment Governan ce Audit 03	Apr-21	Reasonable	Appropriate arrangements will be made to ensure that vacancies identified within the resource schedule are filled as a matter of priority (O).	High	Agreed. All of the appointments for additional resources are progressing and the Senior Responsible Officer has confirmed that all are permanent positions (Noting that the appointments are for a 5.5 year construction programme and employment rights become permanent due to this duration). Responsibility for the appointments rests with departmental heads to progress these positions with assistance from the Major Projects Unit.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	01/08/2021 Now November 2021 Now May 2022 Now August 2022 Now October 2022 Now March 2023 Now June 2023		In progress	April 2023 Update - Band 7 appointment made with commencement in post 1/06/23.	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. Agreement obtained from NWSSP Audit (E. Jones) that Implementation Date becomes end of July due to new RO in post. July 2021 Update - Arrangements in place to resource the project requirements. October 2021 - Follow up report received which identified that this recommendation was Partially Implemented. Requirements as specified at the Full Business Case for Phase 2 are currently being reviewed for adequacy. A number of posts have been filled with only two posts remaining - having not been filled following advertisement. November 2021 - Of the two posts that remained to be filled, the Estates Officer post has been awarded and is awaiting confirmation of a start date from the appointee. The IPC post has been advertised twice with no applicants showing interest. The grading of the post is being reviewed. February 2022 update - The remaining Estates Officer will be in post by the end of February 2022. The IPC post is currently being re-advertised one more time at Band 7. If there are no suitable applicants, advertising at a Band 6 will be considered to attract a different profile of candidate. April 2022 Update - The Estates Officer appointment is in post. The IPC post has had no applicants when advertised twice. The job description is being revised before being advertised again. In the meantime, the project is being covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. June 2022 Update - In light of inability to attract interest in the post, dialogue is to be undertaken with Welsh Government to request that the funding be used to appoint Band 3 nurses to release the Senior Infection Prevention Control Nurse to the project. In the meanwhile, the project is being covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. August 2022 Update - The post remains unfilled despite repeated advertisements. The project continues to be covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. October 2022 update - The application date for the IPC post closed on 5/10/22 with interviews scheduled for 17/10/22. In the meanwhile, the project continues to be covered by the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer. December 2022 Update - The most recent post advertisement realised only one candidate being interviewed. However, that candidate proved unsuitable. Discussions have taken place between IPC and Capital and determined that a post of lower grade will be advertised which will enable the Deputy Lead Infection Prevention Control Nurse and Decontamination Officer to be dedicated to the project. January 2023 update - A Band 7 post was advertised until 23rd January. Interviews are scheduled for 6th February. The Deputy Lead Infection Prevention Control Nurse and Decontamination Officer continues to work with the project.

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Welsh Language Standards Compliance 04	Oct-21	Reasonable	4.1) Management should review and enhance the reporting and monitoring structures which are currently in place and implement a robust system which provides assurance both to senior management but also provides feedback to the departments and ILGS responsible for implementing Standards. In order to implement this management should consider: • Setting up local Welsh Language Standards working groups within the departments and ILGS which are attended by the key leads from those areas and the Welsh Language Manager, thus allowing localised progress to be given on the status of the action plans and relevant support. • These groups could feed into an overall Welsh Language Group, whose membership should consist of relevant staff from Workforce & Organisational Development along with other areas across the Health Board along with representatives from the local working groups and the Welsh Language Manager. Findings and best practice from ward audits should be shared at this group. • Regular updates against the Standards should be provided to Board, via the People and Culture Committee who are responsible for this monitoring compliance.	High	4.1) The Welsh Language Manager will engage with the ILG SMTs, to determine the feasibility and benefits of establishing local ILG Welsh Language Working Groups and how these would be managed and supported by the Welsh Language Manager. Reporting and monitoring of progress will be strengthened by the requirement for regular compliance reporting, from the nominated Senior ILG leads to the Welsh Language Working Group. The reporting will be further enhanced by having a standard agenda item of "sharing examples of good practice" to assist achievement of compliance in other areas. This information will be provided to the nominated senior ILG lead by the network of ward Welsh Language Champions. The People and Culture Committee when developing its cycle of business for 2022 will incorporate Welsh Language Standards Compliance updates, to be presented and report twice yearly, to provide assurance to the Board.	Director for People	Welsh Language Group Manager/Assistant Director of Workforce/ILG Leads	Oct-21	Now December 2021 Now March 2022 Now May 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	November 2021 Update - A new Welsh Language Committee will meet for the first time in December 2021. Senior leadership will be made aware of their responsibilities in this meeting. Action plans will be distributed and returned to the Welsh Language Manager. Highlight reports and good practice will be shared with the Committee. Formal monitoring and reporting will be via the new Welsh Language Committee to the People and Culture Committee. The first report will be submitted by March 2022 which will co-inside with the writing of the Welsh Language Standards Annual Report. Update Jan 2022 - (4.1) The first meeting of Health Board's Welsh Language Committee was unable to meet in December 2021, due to COVID-19 Service and staff pressures. The meeting has been rescheduled for 17 March 2022. 1.1) The WL Manager contacted senior ILG leads in February and met Bridgend ILG 1.2) A new action plan template document has been created will be dated and version controlled to allow progress to be mapped . June 2022 4.1) The Welsh Language Steering Group arranged for the 17 March 2022 was postponed. The meeting is in the process of being rescheduled. The Welsh Language Services Manager has met with 7 service areas with a further 8 scheduled during May and June to set departmental/service level action plans, and has been invited to RTE ILG governance and business meeting and Senior Nurse Professional Forum in June to progress this work further. The Welsh Language Annual Report is currently being developed and will be presented to the People and Culture Committee in August 2022, prior to being published in September 2022. Welsh Language Standards are now built into People and Culture Committee cycle of business. August 2022 Update - The Terms of Reference for the new Welsh Language Steering Group are currently being revised to reflect the Health Boards New Operating Model and Management Structures. It is anticipated the first meeting of the Welsh Language Steering Group will take place during October 2022. Welsh Language Report etc. for endorsement and approval are being presented to the Executive Leadership Group for endorsement and People and Culture Committee for approval. The Welsh Language Annual Report is currently being scrutinised via this route, in preparation for publication in September 2022. October 2022 update - The Terms of Reference for the Welsh Language Steering Group have been reviewed and amended to reflect the new Operating Model. The first meeting of the WL Steering group has been deferred until December 2022, as some of the key Care Group appointments are still outstanding. The Welsh Language Annual report has been published in accordance with the statutory requirement. December 2022 update - The WL Steering Group has been deferred while some key appointments are still being made within Care Groups. February 2023 Update - Met with the Exec Dir for People on 30 Jan 2023 to plan and confirm meeting dates for 2023/24 Welsh Language Steering Group. First meeting of the Steering Group will take place on the 15 March 2023 and a programme of dates have been agreed for the rest of the year.
Overtime & Additional Hours 5.0	May-22	Reasonable	The functionality available in Health Roster to monitor compliance with the various Working Time Regulations requirements should be used to ensure staff are not in breach of regulations. For those areas not using Health Roster, managers should routinely monitor the hours and working patterns of staff to ensure they are not in breach of WTRs. To do this effectively, they should be aware which staff have opted out of the WTRs and therefore know the upper limit of hours to be worked in a week.	High	The UHB will turn on the Health Roster functionality to block book bank / agency workers to work any non-WTR compliant shifts. The revised Overtime Policy will set out the line manager's responsibility to routinely monitor the hours and working patterns of their staff, to ensure compliance with WTRs, when Health Roster is not used. The Policy will also require the manager to check whether their staff who regularly work overtime have completed a WTR Opt-Out Form. The Overtime Policy will be cross referenced with the WTR Policy	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October 2022 update - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group. February 2023 Update - The revised draft Overtime Policy incorporates the management actions agreed. The required system settings to ensure Working Time Regulations compliance are activated as required by the audit.
Financial Systems 8.1	Jun-22	Reasonable	Management should ensure that staff responsible for approving requisitions and processing purchase orders are aware of the correct procurement process as stated in the Requisition of Goods and Services FCPO and the All-Wales No PO No Pay policy.	High	Procurement will increase the training and cascade information relating to the No PO No Pay policy. We will identify the areas of retrospective ordering, implement a plan and ensure bespoke training to these areas.	Director of Finance	Head of Procurement	Jul-22	Now August 2022 Now November 2022 Now January 2023 Now March 2023 Now September 2023		In progress	April 2023 update - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened, Completion by Sept 2023. FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of local P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). Further lunch and learn sessions being scheduled from April 2023 as part of Procurement Engagement plan to target Non compliant areas.	August 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued by Oct 2022. October 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach going to AW P2P group 17th November. CTM already undertaking focused P2P training, Facilities and Estates completed, further lunch and learn sessions being scheduled monthly to target Non compliant areas. December 2022 update - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued by Jan 2023 - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach approved by AW P2P group 17th November. CTM already undertaking focused P2P training, Facilities and Estates completed, further lunch and learn sessions being scheduled monthly to target Non compliant areas. February 2023 update - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened and re-issued Jan 2023 - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group, the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach approved by AW P2P group.
ICTM Quality Improvement Team 1.2a and 1.2b	Dec-22	Reasonable	1.2a A review of the approach for capturing project initiation information in relation to proposed projects should be undertaken. Where possible a consistent approach, that is not burdensome on staff, yet contains enough detail to allow meaningful initiation decisions to be made, should be adopted. The current 'plan on a page' template could be considered for this but should be reviewed to ensure necessary information is included, especially in relation to benefits and risks and where possible the cost and resource implications. 1.2b The procedural guidance mentioned in 1.1 should set out the criteria of what is deemed small scale and 'safe to fail'. The guidance should sit alongside the 'plan on a page' template to help staff make informed decisions regarding the size and risk associated with their QI project and encouraging them to seek the support and advice of the QI team if they feel their project falls outside the criteria.	High	As part of the response to this audit we will produce an overarching set of procedures and guidance which will incorporate this recommendation. To support this we have already reviewed our procedures in line with the recommendations of this audit. The plan on a page format has been altered to ensure it covers the areas outlined in the audit and a new 'project initiation' form has been created to capture the required details. The project workbook is being used for our pressure damage work and its use will be reviewed and spread as appropriate. Training has been altered to include specific advice on what is deemed safe-to-fail and this will be incorporated into the guidance.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Dec-22	Now January 2023		Completed	April 2023 Update - 1.2a - This review has been undertaken and a process agreed within the teams. All project and participants in training will be asked to complete the template on Life QI software. Each new project on Life QI will be assessed at the monthly ICTM Project group. This group consists of ICTM senior management, our Associate Medical Directorate and representatives from Audit, E&D and OD as well as members of our multidisciplinary faculty. This ensures new projects are subject to a rigorous level of scrutiny. 1.2b the concept of 'safe-to-fail' forms part of the QI training and the criteria by which the monthly project group will assess new projects.	August 2022 Update - All FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of the Finance Delivery Unit AW P2P group,(SRO - DOF Swansea Bay) the No PO policy and exemption list is being reviewed together with a Communications plan through an AW Task & Finish group. Outline paper with planned approach approved by AW P2P group.
ICTM - Quality Improvement Team 1.4	Dec-22	Reasonable	Procedural guidance for use by the QI team in relation to the projects they are directly involved in delivery should be developed and should include, but not be limited to: initiating a project; recording the key elements of a project such as the rationale, expected benefits and outcomes, estimated costs, staff resource requirements and risks; obtaining approval; monitoring and reporting projects. Furthermore, consideration should be given to using the project workbook currently being trailed as the mechanism for capturing QI project information. The workbook should be reviewed and tailored to meet the needs of the Health Board.	High	As part of its response to this audit we are producing an overarching set of procedures and guidance for the ICTM Improvement Team which will incorporate this recommendation. The success of 'project workbook' will be reviewed following its use on our Community Acquired Pressure Ulcer project alongside other tools being developed by the Change Hub with a view to adopting a standard approach. A new form has been created to help us properly assess incoming requests for support in line with the audit recommendations.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Dec-22	Now January 2023		Completed	April 2023 Update - the QI team have developed a project tracker hosted on the shared drive that captures the key project details required. In addition more detailed project plans will be hosted in LifeQI. The project workbook referenced will be considered for use for the more complex projects.	February 2023 Update - Procedural guidance is in draft form for completion in January 2023. The new form is being used to assess new pieces of work as described. The Project Workbook is being used for the Community Acquired Pressure Ulcer collaborative and is under review to assess its suitability for other projects.

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
Radiology Service Review 3.1	Dec-22	Reasonable	a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.	High	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via SharePoint underway.	Chief Operating Officer	Senior Superintendents Clinical Leads Superintendent Radiographers Clinical Leads Health & Safety Leads	June 30th 2023			In progress	April 2023 Update - a) A review of all policies and procedures is an ongoing programme of work. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been ratified.	February 2023 Update - a) A review of all policies and procedures is an ongoing programme of work. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022.
Radiology Service Review 12.1	Dec-22	Reasonable	A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.	High	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Chief Operating Officer	Care Group Service Director Care Group Medical Director	30th November 2022	To be confirmed		In progress	April 2023 Update - Work has been developed within the IMTP framework to address this. IMTP submitted February 2023. A more detailed workforce review is required but is delayed due to the second phase of the wider organisational planning.	February 2023 Update - Work has been developed within the IMTP framework to address this. Draft IMTP submitted December 2022.
Medical Equipment and Devices Follow Up 03	Feb-20	Reasonable	While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Medium	1. Band 2 Equipment library Job Description is now matched - to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Chief Operating Officer	Assistant Director of Facilities	Apr-20	September 2020 April 2021 July 2021 Now March 2022 Now September 2022 Now January 2023 Now July 2023		Part Completed	April 2023 Update - The current RF-ID tracking system Ktrack 1 to Ktrack 2 (new) migration is currently in progress by Clinical Engineering, Kinsetsu and UHB ICT. ICT infrastructure issues are still restricting/expanding use of system in POW, until the specified Swansea Bay desegregation work is completed and fully tested, this will remain an issue (for a number of cross UHB medical device linked projects). Pharmacy are on board with expanding use of system as soon as migration and infrastructure work is completed as there are financial benefits in ability to track CD size cylinders due to the rental costs and lost cylinder charges applicable. Deputy Head Of Clinical Engineering has formulated a bid to expand use of the passive system to support Pharmacy and also by use of new active tag technology exploring costs and infrastructure requirements for active tags which reduce the quantity of passive aerials required for medical equipment tracking as they can in part use existing wi-fi infrastructure in place with reduced modification costs where needed. Costs will have to be funded via capital, however we are working with CTM innovation/R & D department to investigate possible technology funding sources. Due to the above a target date remains 31/07/23.	1. April 2020 Update - B2 equipment library post - advertised - undergoing shortlisting. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - RF-ID - limited area in use - no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. April 2020 Update - RF-ID - limited area in use - no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 1. July 2020 Update - Interviews held. Recruitment checks in progress for successful candidate (WG 02/06/2020). Start date confirmed as 20/07/2020 (WG 16/07/2020). 3. July 2020 Update - Business case to be developed for submitting to Capital/Finance to support phased approach to implementation on each site, with request from Finance to be revenue neutral. (WG 09/06/2020). 3rd draft of business case paper to be finalised with various options and costs for funding (WG 16/07/2020). 3. September 2020 Update - SON submitted to Capital and DOF on 30/07/2020, awaiting prioritisation and decision on funding. WG advised that target date has been amended to reflect this update, date amended to 31/03/2021 (DW 28/08/2020). 2. July 2020 Update - Identified costs in IMTP, some work performed by supplier for COVID equipment tracking for mapping sites. Equipment that is tagged will now update 'Last known location' field on RAM each night in background process if within areas with antennae or by using hand held device. Complete (WG 09/06/2020). 1. Role now in place. Complete (WG 28/08/2020) January 2021 Update - Additional hand-held devices have now been ordered and delivered. Further work is in progress by the supplier to implement the site mapping for the devices to be functional on PCH and POW sites. Further purchase orders are to be submitted for additional works and installation, presentation to be provided at next CMAG and ECMG in February 2021 for planning of future phase rollout. Total cost is £654K (WG 25/01/2021). March 2021 Update - 1 & 2. July 2020 Update - B4 Medical Device training co-ordinator in post, now advised of all new medical equipment installations, and overseeing user training prior to issue. Complete (PJ 17/07/2020). 3. January 2021 Update - New B6 medical device trainer now in post, with all new equipment purchases being referred to Rob Matthews prior to installation. Complete (PJ 06/11/2020). 1. April 2020 Update - Capital bid SON process finalised now following CTM transition and being used with all POWH Capital bid SONs now being added to the correct database for the 2020/21 capital year bids and will be used moving forward. Complete (DW 02/04/2020). 2. April 2020 Update - Capital bid SON process finalised now following CTM transition and being used with all POWH Capital bid SONs now being added to the correct database for the 2020/21 capital year bids and will be used moving forward. Complete (DW 02/04/2020). 3. May 2021 Update - For phase 1 equipment has arrived but further work is needed for implementation such as addressing Wi-Fi connectivity issues at POW, addressing new ICT issues with scanning large amounts of equipment in one area via handhelds, mapping locations into the system at PCH, and final installation of oxygen cylinder tracking and bed store equipment at RGH. This work is scheduled to begin in May / June 2021. Due to this the target date has been moved to 31/07/2021. It should be noted that now in place is that any new equipment is now being tagged as part of the RF-ID system and this will continue moving forward. (PJ WG 12/05/2021). 3. July 2021 Update - Wi-Fi connectivity issues at POW are now resolved. ICT issues with scanning via handhelds has been resolved. Mapping locations is no longer viable under current circumstances with ward moves etc. Department lists will be used instead on Version 2 of software. Fixed reader points have been installed at RGH for extended coverage for oxygen cylinder tracking and bed store equipment. Supplier awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW need to be resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and will now be submitted to Capital for funding. Lead member from Clinical Engineering has now left the organisation, which has made planning and implementing the above works difficult. Based on the above updates, the target date has been moved to 31/03/2022. (WG DW 20/07/2021). 3. September 2021 Update - Supplier still awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW still being resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and submitted to Capital for funding, awaiting decision. (DW WG 20/09/2021). 3. November 2021 Update - CITRIX issue resolved at POW. Remote access issue resolved for supplier to install V2 software for BOC cylinder project.
Nurse Agency Usage 03	Apr-20	Reasonable	1. The Staff Bank Policy should be reviewed and updated as necessary to reflect current practice, process and systems in place within the Health Board. The policy should more explicitly reference the engagement and management of agency nurses as opposed to just focussing on Bank staff. 2. Where other relevant policies exist, such as the Rostering Policy, these should be cross-referenced within the Staff Bank Policy. 3. Where procedures are developed to supplement existing policies, reference should be made to the overarching policy and if necessary, the policy should be updated to reflect the existence of the procedure. 4. Senior Nurse Management across the Health Board should ensure the dissemination and awareness of the recently developed procedure for booking bank and agency nurses for use by Ward Managers and the Thornbury authorisation and approval pro forma.	Medium	The Staff Bank Policy will require updating to include the Collaborative Bank project which is due to commence in April 2020. The updated version will include appropriate references to the UH Rostering Policy. The updated policy will include: ■ The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' ■ The new Request for Thornbury Nurses proforma. ■ The updated e-datix reporting algorithm The following documents will be recirculated to Heads of Nursing. ■ The updated The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' ■ The new Request for Thornbury Nurses proforma. ■ The updated e-datix reporting algorithm Heads of Nursing to ensure all the documents listed above are circulated to Ward Managers and Senior Nurses.	Director for People		March 2020/April 2020/August 2020	October 2020 February 2021 June 2021 Now September 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support existing and new HB services has meant a delay in starting this policy. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. January 2022 Update - Policy sent to policy group for ratification. Apr 2022 - The policy was sent through the ratification route. Comments on the content were made post the policy review group meeting. These comments have been taken away and are actively being worked upon by the Deputy Director of Nursing & the Staff Bank Manager. The Policy will then be resubmitted to the policy group in May, if approved this will then progress to the LPF and be signed off for use in the UHB. June 22 update - The policy has been updated and is progressing through the approval process. August 2022 update - The policy is yet to be ratified. The LPF has not sat since the last audit report return as it was cancelled, to allow for ratification of the policy through the appropriate route. The policy will be taken to the next LPF in September 2022. October 2022 Update - The policy has had to be stalled due to changes needed to the agency booking process required by the Nurse Productivity Programme Board. This renewed process is currently with nursing leadership to approve, which is a part of the bank policy. Once this has been approved, the policy will then progress through the route to ratification. December 2022 - The policy has been completed was sent to the Policy Review Group in November. Unfortunately the meeting was not quorate, however, the policy has been shared with the group members, for final review via comments. Then potential sign off will be achieved on the 15th December, at the next Policy Review Group prior to the final stages of the governance route. February 2023

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
Nurse Agency Usage 04	Apr-20	Reasonable	1. A review of the Temporary Nursing & Midwifery Staffing Decision Checklist (Appendix 5) contained within the Roster Policy should take place to ensure all aspects remain relevant. Consideration should be given if the checklist needs to be completed for every shift filled by an agency employee or if one checklist could be completed covering all agency shifts needed on a week's rota. 2. The importance of completing the checklist should be reiterated to the Nurse in Charge as means of supporting and substantiating the decision to use agency nursing.	Medium	Appendix 5 in the Roster Policy will be replaced with the updated 'Booking Bank & Agency Nurses -Procedures for Ward. Heads of Nursing to ensure the checklist is re-circulated to Ward Managers and Senior Nurses emphasising the importance of the completion of the check list for all new bank and agency nurses to the ward areas/department.	Director for People	Head of Corporate Nursing	April 2020/May 2020	August 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	Appendix 5 has been sent through to the workforce policy review group for the change to be made to the roster policy it is in the agenda for the Aug meeting. November 2020 Update - The Bank Policy is being updated during December 2020/January 2021. The updated policy will consist of a review and update of all the bank and agency forms. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups. APRIL 2021: The Rostering Policy has been updated and is currently in the system for approval. A new Rostering Group has been established with Senior Nurses to ensure appropriate and consistent rostering practice across the Health Board. The Rostering Policy will be approved within the same timeframe as the Bank Policy. A revised July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group before being sent to the policy group for ratification. The revised date for policy being live will slip to September. Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being quorate, the policy has not progressed further. The policy is awaiting agreement in partnership to progress to policy group. November 2021 Update - No further update provided. Feb 2022 Update - Policy sent to policy group for ratification. Apr 2022 - The rostering policy is being reviewed at the next policy group in April 2022. Comments on the content can be made up to 2 weeks after this meeting. If there are none received, it will progress to the LPF and achieve final sign off for use in the UHB. June 22 update - The Locality Nurse Director RTE has completed the policy and
Director ate Review Acute Medicine & A&E 04	Aug-20	Reasonable	1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy.	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Chief Operating Officer	ILG Directors/ General Manager	September 2020/December 2020	01/04/2021 Now April 2022 Now December 2022 Now February 2023 Now June 2023		Part Completed	April 2023 - position remains unchanged.	November 2020 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. RTE ILG January 2021 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. March 2021 Update - Final timing for the completion of this work will be reported by the end of April 2021. May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk for old policies -and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that the new policies that were developed as a result of changes involving covid 19 have been stored in one place and are accessible. July 2021 update: For RTE and MC ILG, no change - remains a key risk area. Will be addressed when capacity allows. September 2021 Update - This remains a key risk and represents a significant amount of work in an area where capacity is stretched. No further action to report, but it remains an issue about which the Service Group is aware. November 2021 Update - no action to report - deadline remains April 2022. February 2022 Update - the Directorate has started a task and finish group to review all policies and procedures and will update them pan CTM if they are organisation wide - support on this from corporate team and policies will be taken month by month through policy group chaired by a Consultant member of the medical staff. Given the size of the task the Directorate says that it will need a year for this to be complete. April 2022 Update - For MC, a monthly task and finish group is in place as part of the ED Improvement Programme. The aim is to review policies and procedures and the Directorate is updating its intranet page. So - for MC, complete. June 2022 - nothing further to add this month, will be pursued for August 2022 for RTE where it remains outstanding and is a challenging area for the CSG. August 2022 Update. For MC, this continues to be included in the Improvement Work underway - so complete. For RTE, this remains a task that the CSG cannot resource adequately. October 2022 Update - position unchanged. Directorate feels that there is not the resource to complete this task appropriately. December 2022 Update - no change within the RTE area as a result of inadequate resources to complete this piece of work. February 2023 Update - position remains unchanged.
Risk Management 2021 03	Feb-21	Reasonable	Whilst we acknowledge that compiling a Training Needs Analysis is a new task that has been included on the Risk Management Improvement Plan, Management need to ensure that all departments and staff are provided with training on the new Risk Management Strategy, and the use Datix to record risks, as soon as possible. This will help ensure consistency of approach across the organisation.	Medium	A training needs analysis will be undertaken early in 2021. In the interim monthly risk training sessions via Microsoft Teams has been scheduled with an open invite for staff across ILG's to attend.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	Apr-21	01/07/2021 Now October 2021 Now December 2021 31.12.2021 - Module 1 Training. Module 2, 3 and TNA - 31.3.2022 Now April 2022 Now October 2022 Now 31 December 2022 Now 31 October 2023 Now		In progress	April 2023 Update - This recommendation remains linked to the Implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A further meeting with the Task and Finish Group of the OFW Implementation is scheduled for late March 2023. A further update will be reported at the next meeting of the Audit & Risk Committee. The revised implementation is approximate whilst a further programme update is awaited from the Implementation Team of OFW Risk Module. In the meantime monthly risk training is scheduled throughout 2023 which is open to all staff. These sessions are publicised on SharePoint and been included in the Staff Newsletter.	Update March 2021 A revised date is requested as the Assistant Director of Governance & Risk is now part of a small Task and Finish Group with other NHS Organisations in Wales to develop a risk training needs analysis that ensures a consistent approach across NHS Wales and avoids duplication. A first draft of a TNA has been developed and will be shared with the Health Board in due course. The training packages to support the TNA are being worked through by the group. Update May 2021 Training Needs Analysis currently being finalised within the Task and Finish Group. Will be shared with the Health Board once the training packages that align have been developed. Update July 2021 Training Needs Analysis completed and will be shared across the Health Board one the training packages that align to the TNA have been developed. Level 1 Training Package- draft being shared with ELearning colleagues w/c 26th July 2021 to start development of ESR module. Level 2 - Training package development to commence August 2021. September 2021 Update - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk is working with peers across NHS Wales to develop Level 1 - 3 Risk Training packages available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. An extension to the implementation date is requested to allow for the launch to coincide with the training packages being made available on E-Learning on an All Wales Basis. The Health Board is working with All Wales colleagues to ensure a consistent approach to risk is adopted and transferable across Wales. November 2021 Update - In Progress: Training Needs analysis complete launch of this will be in conjunction with the completion of the following modules. Module 1 Risk Training - developed and with Learning Management System (LMS) Team to finalise and upload to the LMS. Timescale: 31.12.2021. Module 2 - Risk Management in Practice Module 3 - Board Member Risk Awareness Module 2 development will commence in December 2021 and Module 3 - thereafter for completion by the end of March 2022. The TNA will be issued once all modules are complete. The Risk Community in Practice meet on a monthly basis with All Wales representatives progressing the training programmes as a cohesive group to ensure consistency across Wales in the approach to risk management. The monthly risk training will continue until the above is in place. Update January 2022 The TNA and development of an All Wales Risk Management Training package has been placed on hold whilst the Once For Wales Risk Management Module is finalised. The rationale for this decision is to ensure that any training developed is aligned to the new module that staff will be expected to use. The Health Board is represented on the Once For Wales Monthly Meetings and the more regular task and finish group meetings. In the meantime, risk management training continues within the Health Board with monthly sessions being held virtually over Teams. April 2022 Update - The implementation of the Once For Wales Risk Module within the Health Board is anticipated circa October 2022, with two pilot sites going live from the 1st April 2022. The All Wales Training Modules are being developed to align with the new approach and timescales. The TNA has been finalised and Module 1 of the training is in draft. Progress is monitored via the OFW Risk Module Meetings and the All Wales Risk Community of Practice for which the Assistant Director of Governance & Risk is a member. In the meantime, monthly Risk Sessions remain in place throughout 2022 run by the Assistant Director of Governance & Risk and the Heads of Quality & Safety within the ILGs. June 2022 Update - On track. Risk Training continues to be rolled out to service areas on a
Financial Systems 03	Apr-21	Reasonable	1. As part of the ongoing review of the Charitable Funds FCP the inconsistencies between the FCP and Scheme of Delegation should be resolved, and updates made where processes and appendices have been amended. 2. Consideration should be given to introducing tolerance levels, below which finance can approve variations in payment values, as opposed to requiring fund holder authorisation. 3. Relevant staff should be made aware of the revised FCP and old copies of forms removed from circulation.	Medium	Agreed, FCP needs to be reviewed in line with the Scheme of Delegation and updated.	Director of Finance	Head of Corporate Finance	Jun-21	01/08/2021 Now November 2021 Now December 2021 Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now January 2023 Now April 2023		In progress	April 2023 Update - No further update, we are still awaiting ICT advice on setting up electronic forms online.	July 2021 Update - Charitable Funds have recently been moved onto the Oracle system which allows for greater consistency of governance and controls, these are currently being bedded in and reviewed. The FCP needs to be updated to reflect these changes. September 2021 Update - New Model Standing Financial Instructions are to be adopted by the board in October. Following this will require review of the full suite of FCPs, including Charitable Funds FCP. This has started and will be completed in the next couple of months. November 2021 Update - The Model Standing Financial Instructions are due to be approved by the Board on the 25th November 2021. The review of FCPs and SoDs is currently being undertaken and will be brought to the next Audit Committee for endorsement to the Board. January 2022 Update - The Model SFIs have now been approved. Work is ongoing to update the FCPs for Charitable Funds, in line with the move onto the Oracle system. This has been delayed due to audit of the Charitable Funds accounts, but will be a priority in the next month. April 2022 Update - This still requires updating. A review is currently being undertaken on the governance arrangements of the Charitable Funds which will impact on the FCP. June 2022 Update - The Charitable Funds FCP is currently being updated following the audit of the accounts which has further delayed the update. August 2022 Update - This still isn't completed. This should hopefully be updated when we update FCPs following the change in Scheme of Delegation update due to the restructure. This will be a significant piece of work. Hope to complete by October 2022. October 2022 Update - We have engaged with internal audit to discuss the changes to the forms which are included within the FCP and are in discussion with ICT on how we can make better use of digital signatures for forms. The Oracle process has given an opportunity to simplify the authorisation of expenditure process, which will significantly change the FCP and form. This is a continued piece of work which will streamline and improve current processes. December 2022 Update - Awaiting update from ICT on the change in process for
Sunnyside Health & Wellbeing Centre 01	Aug-21	Reasonable	Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	Medium	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Director of Finance	Head of Capital	Sep-21	Now January 2022 Now 31 March 2022 Now May 2022 Now August 2022 Now December 2022 Now March 2023 Now July 2023		In progress	April 2023 Update - To date, the PQQ (pre qualification questionnaire) period has closed and only 2 submissions were made. They have been scored and only 1 party taken forward to tender. The tender process will close on 5th June and post this time it should be known if there is a viable tender. If there is then a PEP and revised business case will be drafted with the business case submitted for WG approval and funding. The PEP will be taken to Project Board and approved via the capital structure	September 2021 Update - the PEP is being drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the completion contract would have been issued by this time however due to internal process at Linc Cymru this has been delayed to the end of September, as a result the PEP will not be completed until the new contractor is known and this is not likely to be until December 2021 at the earliest. November 2021 Update - the PEP will be drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the completion contract would have been issued by this time however due to internal process at Linc Cymru this has been delayed to mid November. As a result the PEP will not be completed until the new contractor is known and this is not likely to be until late January 2022 at the earliest. January 2022 Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the contents of the PEP. April 2022 Update - ongoing however focus has been on the new contractor appointment and whether a disaggregated tender process will be required as this will completely change the way that reporting and contractual management lines flow. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Previous Updates
Sunnyside Health & Wellbeing Centre 04	Aug-21	Reasonable	Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	Medium	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now July 2023		In progress	April 2023 Update - Once it has been clarified that there is a competitive tender returned and WG have approved the revised funding level then the contractor can be appointed and at that point all revised cost schedules can be drafted in line with the revised template that has already been created. Once this is in place then this will be updated and reported to the project Board on an ongoing basis but this can not be developed if there is no viable tender return and WG approval in the summer	September 2021 Update - Remains in progress to be agreed with the new contractor when appointed. November 2021 Update - Remains in progress to be agreed with the new contractor when appointed. Update 31.01.22 the tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report contents. April 2022 Update - With no contractor appointed as yet and no confirmed revised tender sum this is difficult to implement extended to give time for possible further tender and contractor appointment. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.
Sunnyside Health & Wellbeing Centre 05	Aug-21	Reasonable	Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	Medium	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Director of Finance	Senior Project Manager	Jan-22	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023		In progress	April 2023 Update - Once the tender process has completed and WG have approved a revised works cost then the requirement for WG dashboard reporting will recommence, at that stage CTM will ensure that all dashboards are properly and fully completed. Until tenders are returned in June however the existence of a viable tender and likely timeframe can not be confirmed.	September 2021 Update - Remains in progress to be agreed with the new contractor when appointed. November 2021 Update - Remains in progress to be agreed with the new contractor when appointed. Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. April 2022 Update - With no contractor appointed as yet and no confirmed revised tender sum this is difficult to implement extended to give time for possible further tender and contractor appointment. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 2022 Update - there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.
Sunnyside Health & Wellbeing Centre 07	Aug-21	Reasonable	Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	Medium	These are available and will be supplied by the developer.	Director of Finance	Senior Project Manager	Sep-21	Now November 2021 Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Review July 2023 but could be later depending on timings of approvals		In progress	April 2023 Update - Following the outcome of the current tender process and WG approval of the revised tender sum and works cost, a whole new contract will need to be awarded to the new contractor and the Health Board will ensure that as soon as these are executed that they are made available as copies for the project file.	September 2021 Update - There have been delays in obtaining all of this due to the priority being the completion contract works these are in hand to be provided by the time of the next meeting. November 2021 Update - Remains in progress to be provided by the new contractor when appointed. January 2022 Update - The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report content. April 2022 Update - Awaiting to ensure that the tender will proceed in current format or whether separate continuation arrangements and contracts will be made. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.
Sunnyside Health & Wellbeing Centre 10	Aug-21	Reasonable	Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	Medium	This will be provided when the project restarts and all design works are completed.	Director of Finance	Senior Project Manager	No Date Identified	01/03/2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - Once there is a contractor as per the points outlined above then the contract can be put in place. Variations will be recorded through the project reporting structure	September 2021 Update - To be completed and agreed with new contractor on appointment. November 2021 Update - To be completed and agreed with new contractor on appointment. Update The tender process has been extended at contractors request. The tender process closes on 9th Feb and will need a ca 3 week evaluation process. At that stage the revised costs will need to go back to WG for re-approval. Therefore it has been proposed to change the review date to 31 March 2022 when contractor, costs and timeline should be clearer to inform the report content. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.
Sunnyside Health & Wellbeing Centre 11	Aug-21	Reasonable	The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	Medium	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - As mentioned previously, these communications will be put in place and reported in line with requirements. The newly appointed contractor will be made aware of their requirements to report accurately and in a timely manner	September 2021 Update - To be completed and agreed with new contractor on appointment. November 2021 Update - To be completed and agreed with new contractor on appointment. January 2022 Update - as per the above notes this can only be done post contractor appointment which has delayed due to tender period extensions and confirmed re-approval. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.
Sunnyside Health & Wellbeing Centre 12	Aug-21	Reasonable	A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	Medium	A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	Director of Finance	Head of Capital	Nov-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - A risk register is currently in place but will have to be updated in line with a new contractor and WG approval sum. Once this takes place the risk register will be kept under regular review and updates through the project reporting structure	September 2021 Update - In progress and development - risk of some slippage due to delays in the tender for the completion contract but all steps are being taken to ensure this is completed by November. November 2021 Update - To be completed and agreed with the Employers Agent once new contractor has been appointed. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.
Sunnyside Health & Wellbeing Centre 13	Aug-21	Reasonable	Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	Medium	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Director of Finance	Head of Capital	Sep-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - As mentioned above, once there is a contractor and an approved WG funding sum then the contingency can be confirmed and risks can be measured against this.	September 2021 Update - One off exercise done to date but this will not be actively monitored until construction works recommence. November 2021 Update - One off exercise done to date but this will not be actively monitored until construction works recommence. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.

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Sunnysi de Health & Wellbein g Centre 15	Aug-21	Reasonable	The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	Medium	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Director of Finance	Project Leader	Sep-21	Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - This will take place once the new contractor is appointed and updates on the process and timeframe have been provided above	September 2021 Update - Contracts for all save for the new contractor are complete - for the new contractor this will not be delivered until 2022. November 2021 Update - Contracts for all save for the new contractor are complete - for the new contractor this will not be delivered until 2022. January 2022 Update - see notes above for revised timeline. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023.
Sunnysi de Health & Wellbein g Centre 18	Aug-21	Reasonable	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Medium	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Director of Finance	Primary Care Estates and Development Manager	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now October 2023		In progress	April 2023 Update - Once there is a contractor in place and the revised cost and programme is known then lease arrangements can be developed	September 2021 Update - Ongoing with GPs partners however new contract and revised cost is required now to finalise this. January 2022 Update - this will be delayed until after the new contractor costs and timeline is known. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023.
Sunnysi de Health & Wellbein g Centre 19	Aug-21	Reasonable	Management should confirm an agreed service model with measurable outcomes for front line and support services.	Medium	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Director of Finance	Bridgend ILG Community Lead	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - Once the revised programme is confirmed then regular meetings will recommence and the service planning will need to restart to deliver within the revised works programme	September 2021 Update - Ongoing. November 2021 Update - Ongoing as programme remains unclear until contractor appointment. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023.
Sunnysi de Health & Wellbein g Centre 20	Aug-21	Reasonable	Objectives at the business case should be measurable.	Medium	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023		In progress	April 2023 Update - These will be updated and revised with the resubmitted business case being provided to WG once it is known if the tender process has been successful	September 2021 Update - Ongoing. November 2021 Update - Ongoing. January 2022 Update - may need to be tied in with new contractor appointment. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023.
Sunnysi de Health & Wellbein g Centre 21	Aug-21	Reasonable	Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	Medium	Please see response above .	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023		In progress	April 2023 Update - These will be updated and revised with the resubmitted business case being provided to WG once it is known if the tender process has been successful	September 2021 Update - Ongoing. November 2021 Update - Ongoing. January 2022 Update - as per BRP. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023.
Welsh Language Standards Compliance 06	Oct-21	Reasonable	6.1) The importance of compliance with the Welsh Language Standards should be reiterated to all staff, and the implications of non-compliance should be considered for inclusion on departmental and ILG risk registers and subsequent monitoring. 6.2) The risk register should be reviewed to ensure the controls listed as being in place and the action marked as completed are an accurate reflection of the findings made during the audit review.	Medium	6.1) The Welsh Language Manager will develop regular communications to remind all staff of their responsibilities and the importance and benefits of complying with the Welsh Language Standards. These communications will be distributed to staff via a range of communications media, including social media. 6.2) The nominated senior ILG leads on the Welsh Language Working Group should discuss with department managers, the inclusion of non-compliance with the Standards on their departmental registers, to assist with the monitoring of progress and completion of outstanding actions. 6.3) The Welsh Language Manager will review the actions on the current Workforce and OD and Health Board Risk Registers to ensure that they are up to date and include the risks identified in this audit report. 6.4) The nominated ILG senior members of the Welsh Language Working Group will have responsibility for adding relevant and appropriate non-compliance issue to the ILG risk registers, which are monitored by the respective SMTs.	Director for People	Welsh Language Manager/ILG Leads/Head of Policy, Compliance and Agenda for Change	January 2022/October 2021	Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	November 2021 Update - The Risk Register has been updated. Although the risk register has been updated. The senior leadership of the ILGs have not received communication or action plans as the new Welsh Language Committee hasn't met. This means there is no progress with ILGs monitoring their compliance and updating their own risk registers. Jan 2022 update 6.1) A short communication plan will be written by the recently appointed Welsh Language Manager, including resources to share regarding the Welsh Language Standards i.e. videos and graphics to promote understanding of them. This will be discussed in a meeting arranged with the Asst Director of Communications and Engagement on 3 February 2022. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, with effect from 17 March 2022. 6.3) The Welsh Language Risk Register has been reviewed and appropriate risks added, including the findings of this audit. 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Committee, which is scheduled for 17 March 2022. 6.1) Regular communications are drafted and sent via staff updates with SharePoint reviewed regularly. 6.2) Departmental risk registers will be added to once weaknesses are identified through action planning 6.4) The inclusion of Welsh Language risks on the ILG Risk Registers will be a standing agenda item on the new Welsh Language Steering Group, which was scheduled for 17 March 2022 but new date to rescheduled June 2022 Actions points 6.1, 6.3 and 6.4 have been completed previously. December 2022 update - The WL Steering Group has been deferred while some key appointments are still being made within Care Groups. The first meeting will convene in New Year. 6.2) The inclusion of Welsh Language risks on the ILG Risk Registers will be an agenda item all forthcoming Welsh Language Committee meetings, which is in the process of being arranged. August 2022 Update - Work has continued to remind managers and staff of their Welsh Language responsibilities. This is picked up during routine department audits by the Welsh Language Team and in the bespoke departmental action plans. The identified Welsh Language WOD risks are reviewed and progress noted at the WOD Business Transformation SMT meeting. October 2022 Update - the revised ToR for the WL Steering Group confirms that the membership will comprise of senior Care Group leads who will be responsible for addressing non-compliance issues, monitor progress and ensure outstanding actions are completed and the outcomes reported back to the Steering Group. This process will commence following the first meeting of the WL Steering Group. February 2023 Update - Met with the Executive Director for People on 30th Jan 2023 to plan and confirm meeting dates for 2023/24 Welsh Language Steering Group. First meeting of the Steering Group will take place on the 15 March 2023 and a programme of dates have been agreed for the rest of the year.
CHC and FNC 1.2	Feb-22	Reasonable	1.2 A terms of reference for the Clinical Service Group Panels and Integrated Locality Groups panels should be put in place to set out the roles of each panel, their decision-making responsibilities and membership and quoracy arrangements. When developing the ILG panels terms of reference, consideration should be given to decision making powers of the panel when they are making funding decisions on behalf of another ILG for cases where the individual does not reside in their ILG area.	Medium	1.2 • Clinical Service Group Terms of Reference are in draft and are to be finalised by March 31st 2022, to include decision-making responsibilities, membership and quoracy arrangements. • Integrated Locality Group Unit Panel Group Terms of Reference will be reviewed and updated in line with the CSG ToR above and will be approved by March 31st 2022.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	Mar-22	Now July 2022 Now October 2022 Now December 2022 Now March 2023 Now June 2023		In progress	April 2023 Update - ToR still in draft will be finalised by June 2023.	April 2022 Update - No update this month due to sickness of Lead Nurse. Anticipated that there will be more to report at the next meeting. June 2022 Update. Terms of Reference have been updated, reviewed and are awaiting final sign off. August 2022 Update - no change. Further update at the next meeting. October 2022 Update - Terms of Reference that had been previously agreed, need to be re-reviewed in light of new operating model. December 2022 Update - Await new operating model. Terms to be reviewed in light of this once received. February 2023 Update - ToR still in draft will be finalised by March 2023.

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

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
Overtime & Additional Hours 3.0	May-22	Reasonable	A standardised claim form for capturing overtime and additional hours should be in place, that incorporates the requirement for individuals to confirm the hours they have worked, and for management to authorise the claim ahead of input on pay return. Claim forms also need to be clear about the need to capture time net of breaks.	Medium	A single standardised claim form, for the use in all non-health roster areas will be developed by the WPRG and contained within the Overtime Policy, for all areas of the UHB to access and use. The form will be based on the standardised NWSSP Payroll form for overtime and additional hours claims, which will contain information on the shift worked, the date, time, rate of pay and who has approved and authorised the payment. Once the Overtime Policy is reviewed and ratified all former UHB overtime forms in circulation and use will be withdrawn (removed from SharePoint etc.) and Payroll instructed to only accept and process the new standard form for payment.	Director for People	Head of Workforce Productivity and E-Systems	Nov-22	Now January 2023 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 Employment Policy Review Group. February 2023 Update - As part of the policy development we are developing a standardised claim form using NWSSP payroll template to be used when overtime is not recorded on Health Roster.
Overtime & Additional Hours 4.0	May-22	Reasonable	Now that all Covid related agreements for payment of higher overtime rates have concluded, a review of payroll data should be carried out to identify departments that are continuing to pay staff outside of the AFC terms and conditions. Payroll codes set up specifically for such payments should be closed to prevent usage. Where it identified that payments outside AFC remain, discussions should be held with the departments to ascertain the reasons why. If necessary, the appropriate procedure should be followed to obtain authorisation in line with the scheme of delegation to continue with such payments.	Medium	Review of Payroll Overtime enhancement codes undertaken by Head of Workforce Productivity and e Systems with an NWSSP Payroll manager to ensure all non AFC payroll codes are closed immediately. The revised overtime policy will set out that all overtime and enhanced payments will be paid only in accordance with AFC. Should a department wish to deviate from these arrangements a discussion must take place with Executive Director for People.	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023		In progress	April 2023 - No update received from the Team on this occasion	August 2022 Update - The Overtime Policy will be reviewed by the Workforce Policy Review Group in September 2022. The review will take into consideration the internal audit recommendations. October updated 2022 - A policy task and finish group has now been established to review this policy. The first meeting of the group will take place in October 2022 and will ensure audit recommendations are incorporated. December 2022 update - Work has commenced on reviewing the policy and will be taken to the January 2023 People Policy Review Group. February 2023 Update - The revised draft policy now confirms that all overtime and enhanced payments will only be paid in accordance with A4C and any deviation must be approved by the Exec Director for People. Payroll will only process enhanced payments if prior approval has been given by the UHB. Health Roster can only allow enhanced payments if this is turned on for areas. This can only be allowed centrally and at the instruction of the Director for People.
Consultant Job Planning Follow Up 5.1	May-22	Reasonable	Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	Medium	A paper discussing the principles on which a rate card will be developed has been submitted to Director of People. Agreement of these principles will then result in the engagement of interested parties to develop the rate card.	Director for People	Director for People	Dec-22	Now April 2023		In progress	April 2023 - There is work currently taking place looking at a regional rate card in collaboration with all other Welsh NHS Organisations. This work is being led by NWSSP. • Whilst this work is ongoing we are discussing with finance colleagues about a possible in house rate card for non-Consultant CTM staff. This is in its infancy of discussion. A consultant rate card requires further work and analysis. • Of note there has been a recent rate card released by the BMA in Wales and England for Junior Doctors, SAS and Consultants. These rates are not sustainable or affordable by CTM. As a result engagement events have been held by the AMD for Medical Workforce to all Junior doctor messes and with the wider Medical Workforce.	August 2022 Update - The first meeting of the 'the unified transformation portfolio' sat on the 20th July. The work for the development of the rate card has been folded into the Medical Workforce productivity work stream. The rate card development and delivery has therefore been incorporated into the PID for the medical workforce productivity. October 2022 Update - The rate card development is now one of the work streams identified in the Medical Productivity Programme. The development of a rate card is being led by the Interim Unscheduled Care Group Medical Director, a task and finish group is being formed and further information on the work stream will be shared in due course. December 2022 Update - This work has expanded further than our own Health Boards boundaries. There is now a national group that has met numerous times to decide and recommend a unified approach across Wales for rates paid for ADHs. Antony Gibson, the local lead for the rate card development is a member of this group, along with the AMD for Workforce and the Head of Workforce Productivity & E-Systems. This group will have a recommendation for rates finalised in December 2022. This recommendation will go to Welsh Government for comment, ratification and then implementation if approved. February 2023 Update - An all Wales approach has now developed a rate card. The work is now in its final stages, with all the Health Boards undertaking a cost assessment based on the proposed ADH rates for Wales. There is a meeting scheduled for the 1st week of February where the implementation date will be discussed and set. The implementation date has been estimated as 1st of April 2023, however this will be revised after the meeting in Feb-23.
Welsh Risk Pool Claims 1.1	Jun-22	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes and monitoring takes place to ensure compliance with this requirement.	Medium	1.1a Legal Services SOPs to be reviewed and updated. 1.1b Monitoring process to be implemented in respect of deadlines for various paperwork submissions. 1.1c Spot check audit to be undertaken bi-monthly on paperwork submissions against deadlines i.e. CMRs, LFERs etc.	Director of Nursing	Legal Services Manager	1.1a Dec 2022 1.1b June 2022 1.1c August 2022	Now February 2023 Now May 2023		In progress	April 2023 Update, recommendation, incomplete, open/red. 1.1a Legal Services SOPs have been reviewed and updated. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meetings. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. LFERs have been given as a key responsibility for PSIM within the new operating model.	August 2022 Update 1.1a Legal Services SOP in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meeting. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. Date for submission of cases deferred over 6 months set for end of September. October 2022 Update 1.1a Legal Services SOP in progress of being reviewed. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meeting. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. Date for submission of cases deferred over 6 months set for end of September.
Welsh Risk Pool Claims 2.1	Jun-22	Reasonable	Procedures should be in place that provide staff with clear guidance on how to process claims, especially the dates that are to be used in relation to the 'Decision to Settle' and 'Final Payment', and the circumstances of when these dates should be updated in Datix. Guidance should also cover the other issues we identified including the correct process for capturing financial transactions in Datix and the process that should be followed if a claim is dismissed when taken to court.	Medium	2.1 Legal Services SOPs to be reviewed and updated and staff to be retrained where appropriate. 2.2 SOP to be devised to assist staff through the financial process if a claim is dismissed.	Director of Nursing	Legal Services Manager	Dec-22	Now January 2023 Now February 2023 Now May 2023		In progress	April 2023 Update 2.1 Legal Services SOPs have been reviewed, meeting with Cally Hamblin to discuss ratification 2.2 Financial SOP to be developed	August 2022 Update 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed. October 2022 Update 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed Update - 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed. Update - 2.1 Legal Services SOPs in process of being reviewed. 2.2 Financial SOP to be developed December 2022 February 2023
Financial Systems 8.2	Jun-22	Reasonable	In cases where it is appropriate, management should explore the use of alternative mechanisms for raising orders and paying invoices, for example the use of 'call off' orders.	Medium	As above, we will identify the areas where retrospective orders are raised and review alternative mechanisms for order or payment.	Director of Finance	Head of Procurement	Mar-23	01/09/2023 (aligned to AW T&F exemption list review)		In progress	April 2023 update - Alternative methods of payments will be reviewed as part of AW PO exemption list T&F group by Sept 2023. AW T&F group being led by Head of Corporate finance and Head of Procurement.	August 22 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023. October 2022 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023. December 2022 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023 alongside the PO exemption list. February 2023 update - Alternative methods of payments will be reviewed within the NO PO/Retrospective order review by March 2023 alongside the PO exemption list

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Financial Systems 8.3	Jun-22	Reasonable	Where a retrospective order is deemed appropriate, staff should be encouraged to complete the notes section of Oracle explaining the reason for use of a retrospective order, including details of who requested the goods or service to be procured.	Medium	Where retrospective orders are deemed acceptable, further training will be given to end users to ensure notes are completed within Oracle	Director of Finance	Head of Procurement	Mar-23	Now September 2023		In progress	April 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly	August 2022 Update - Refer to the update provided for 7.1. October 2022 - Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023. December 2022 Update - Refer to the update provided for 7.1. October 2022 - Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023. February 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group, and further training needs will be identified by March 2023 No PO policy and exemption list being progressed through AW P2P and Finance academy. NO PO policy letters issued to HB in December 2022.
Financial Systems 8.4	Jun-22	Reasonable	Documentation to support all orders should be retained made available if required	Medium	Documentation will be made available via SharePoint.	Director of Finance	Head of Procurement	Mar-23	Now May 2023		In progress	April 2023 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by May 2023. Year end demands and stretched resource had delayed development of CTM share point and NWSSP Buyers toolkit	August 2022 - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023, October 2022 Update - Remains the same as the update provide in August 2022 - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023. February 2023 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by March 2023.
Financial Systems 9.1	Jun-22	Reasonable	As sending individual letters to staff when it is identified they are non-compliant with the policy is time consuming, consideration should be given to alternative methods of ensuring departments that are persistently non-compliant are made aware, with support and training provided in an attempt to prevent ongoing non-compliance.	Medium	Training on No PO and retrospective orders will be made available to respective areas. Non Compliance letters will still be issued.	Director of Finance	Head of Procurement	Jul-22	Now October 2022 Now March 2023		Completed	April 2023 Update - CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of local P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). Further lunch and learn sessions being scheduled from April 2023 as part of Procurement Engagement plan to target Non compliant areas. Non compliance letters are issued with retrospective orders - ongoing.	Aug-2022 update - Non compliance letters are being issued in relation to retrospective orders. As above the No PO policy approach is being reviewed within the FDU AWP2P forum and messaging is being strengthened to both HB and Supplier by October 2022. Best practice approach also being developed within FDU AW P2P. October 2022 - AW P2P T&F group work delayed and approach being presented to AW P2P group and SRO 17th November. Training/Lunch and learn sessions continuing and retrospective letters still being issued. Retrospective order review for priority areas being identified by March 2023. December 2022 update - Non compliance letters are being issued in relation to retrospective orders. As above the No PO policy approach is being reviewed within the FDU AWP2P forum and messaging is being strengthened to both HB and Supplier by January 2023 Best practice approach also being developed within FDU AW P2P. AW P2P T&F group work delayed and approach approved by AW P2P group and SRO 17th November. Training/Lunch and learn sessions continuing and retrospective letters still being issued. Retrospective order review for priority areas being identified by March 2023. February 2023 Update - as per December update.
CSG & ILG Quality Assurance 1.4	Aug-22	Reasonable	A review of the quality monitoring arrangements for Surgery CSG within Merthyr Cynon ILG should be undertaken to establish if the remit of the Surgery Governance Group and wider Acute Service Patient Safety Governance Group are able to provide the same level of quality monitoring and assurance that can be provided from a dedicated Quality and Safety Group for the CSG. If necessary, consideration should be given to having a dedicated Surgery Quality and Safety Group in line with other CSGs.	Medium	The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILG's), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSGs for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		Completed	April 2023 Update - Recommendation: action complete, closed. Quality and Safety governance arrangements are now in place for planned care group across CTM which encompasses the surgical directorates. Each committee is structured with supporting terms of reference, agenda and minutes as evidence of the actions taken and learning.	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. December 2022 Update - Care Group governance structures are being developed, The Children and Families Care Group are holding its first meeting on 1.12.22 with representation from both Clinical Service Groups. Structures being reviewed to ensure the golden thread between patient care, Planned Care Quality & Safety meeting and upwards reporting into Operational Management Board. February 2023 Update - no update provided on this occasion
CSG & ILG Quality Assurance 3.0	Aug-22	Reasonable	All ILG Quality and Safety Groups and their constituent CSGs should establish annual quality assurance work plans that will allow focus, monitoring and reporting on their relevant quality issues and objectives in a targeted manner.	Medium	Response as in 1.1; The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILGs), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSG's for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model. In addition, the requirement of annual work plans for Clinical Service Groups will be re-established and monitored through the new Care Group model governance system. Progress against CSG annual plans will be upwardly reported by Care Groups to Quality and Safety Committee on a yearly basis.	Director of Nursing	Assistant Director Quality & Safety Care Group Nurse Directors	Dec-22	Now January 2023 Now May 2023		In progress	April 2023 Update - Recommendation: incomplete, to remain open. Whilst appropriate governance reporting structures exist across the health board and are feeding into the Quality and Safety Committee, a program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. December 2022 Update - Care Group governance structures are being developed, Planned Care held it's first meeting on 22.11.22 with representation from all 3 Clinical Service Groups - Surgery CSG structures being reviewed to ensure the golden thread between patient care, Planned Care Quality & Safety meeting and upwards reporting into Operational Management Board. There are already service wide assurance groups in place for maternity, gynaecology and integrated sexual health. The Care Group is working to align CYP accordingly however CYP already regularly hold Quality and Safety meetings. Both service groups will actively participate in the Children and Families Care Group QPSE Meetings from 1.12.22. Maternity and Neonates have developed a floor to board escalation framework which was updated and approved at Health Board Quality and Safety Committee in September 2022. Work is underway within the Care Group to now align the framework and ensure CYP are included. February 2023 Update - no update provided on this occasion

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CSG & ILG Quality Assurance 4.0	Aug-22	Reasonable	It should be ensured that going forward there is Surgery CSG representation at the PCH Acute Services Patient Safety and Governance Group. Consideration should be given to reviewing the terms of reference for the ILG Quality, Patient Safety and Experience Group to include representatives from the CSGs so that quality matters for those areas can be discussed in greater detail.	Medium	Notwithstanding the pending changes to the operating model, this finding has been relayed to the Nurse Director of Merthyr Cynon ILG who is chair of the ILG QPSE group for corrective actions. This will also be highlighted in the Merthyr Cynon ILG quality and patient safety legacy document in preparation for the change in the operating model.	Director of Nursing	Merthyr Cynon ILG Nurse Director	Sep-22	Now October 2022 Now January 2023		Completed	April 2023 Update - Recommendation: completed, closed. QSRE ToR is updated by both planned and USC nurse directors with a membership of CSG teams who are actively participating in both meetings.	October 2022 update-The handover document is being finalised and will be completed by end of October 2022. The unscheduled care Director of Nursing is working closely with the planned care Director of Nursing during this phase until formal handover has been completed. December 2022 Update - PCH Surgery CSG are actively participating in the Planned Care Quality & Safety meeting which has met for the first time. February 2023 Update - no update provided on this occasion
Medical & Dental Rostering Follow Up Review 3.1	Aug-22	Reasonable	The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff.	Medium	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	Medical Director & Director for People	Head of workforce productivity and E-Systems	Nov-22	Now February 2023 Now March 2023		In progress	April 2023 Update - The policy has been updated and amended as recommended. The policy is now being processed through Policy Review Group. The policy will then be taken to the next Local Negotiating Committee for noting and implementation.	October 2022 Update - no update provided against this recommendation on this occasion. December 2022 update – The MWSG has not met since the policy was completed. The MWSG has now been disbanded as a formal group. The policy will now go through the Policy Review Group, and then progress to the LNC. February 2023 Update - The policy is awaiting review at the LNC. The next LNC is not until March 2023, so the policy will not be ratified until after this. This is however reliant on it passing the committee with no alteration required.
Medical & Dental Rostering Follow Up Review 4.1	Aug-22	Reasonable	Management should ensure that the Study Leave policy is approved and circulated within the Health Board.	Medium	Discussion around agreeing a Health Board wide policy is still ongoing between the Medical Director and the BMA. This is due to the differences between provision for study leave contained in the previous Cwm Taf and Swansea Bay policies. Agreement needs to be reached between the involved parties, to allow for the new policy to progress and be ratified through the formal UHB policy route.	Medical Director & Director for People	Medical Director	Nov-22	Now December 2022 Now March 2023		Completed	April 2023 Update - The former Cwm Taf policy and the Swansea Bay policy have some key fundamental differences. The BMA have now stated that they do not support the movement of all previous Swansea Bay employees to a Cwm Taf Morgannwg University Health Board policy. As the Transfer of Undertakings Protection of Employment (TUPE) rules apply to this, the UHB are unable to move these staff without agreement. All staff who were previously Swansea Bay employees and were subject to TUPE, will be allowed to remain on the Swansea bay policy if they chose to do so. All new employees start in the UHB, will be employed under a CTM wide policy.	October 2022 Update - On track for completion November 2022. December 2022 update - The MD is in active talks with the BMA to come to solution to the differences in study leave entitlements. The former Cwm Taf policy and the Swansea Bay policy have some fundamental differences that ideally need to be harmonised across the whole of Cwm Taf Morgannwg University Health Board. This is not in the gift of the Health Board to do unilaterally, it needs to be agreed in partnership. February 2023 Update - Further meeting to be scheduled with BMA to discuss approach and confirm agreement
CAMHS Workforce Follow Up Review 2.1	Aug-22	Reasonable	a) The SOP in relation to the set up and use of electronic staff files should be finalised. b) All current electronic files should be fully populated with documentation scanned from hard copy files. c) The roll out of electronic staff files to all other areas of the CSG should commence.	Medium	a) A SOP is being drafted by the Swansea Bay CAMHS locality Senior Nurses on the set up and use of electronic staff files and will be taken to the Quality, Patient Safety and Experience meeting for review and discussion prior to sign off. b) Swansea Bay CAMHS locality Senior Nurses will ensure all current electronic files will be fully populated with the documentation from the hard copy files c) CTM CAMHS locality will commence the roll out of electronic files following sign off of the SOP to approach and any learning from the Swansea Bay CAMHS team	Chief Operating Officer	a) Senior Nurses for Swansea Bay CAMHS locality b) Senior Nurses for Swansea Bay CAMHS locality c) Head of Nursing and Senior Nurses for each locality	a) End of October 2022 b) End of September 2022 c) End of November 2022	Should all be complete by November 2022 Now January 2023 Now March 2023		In progress	April 2023 Update - SOP will be reviewed for sign off in the CAMHS Quality, Safety and Patient Experience meeting at the end of March. In the interim there is an agreed process around where staff files are held and how they can be accessed if staff members are not in work, which addresses the initial concern from the audit.	October 2022 Update - nursing electronic files in Swansea Bay CAMHS have been fully populated with the documentation from the hard copies. A draft SOP has been developed and will be discussed with teams in October prior to sign off. December 2022 Update - All nursing electronic files in SB CAMHS have been fully populated with the documentation from the hard copies. SOP has been developed but requires review in CAMHS Quality, Safety and Patient Experience meeting which was cancelled in October due to limited attendance with next date in January 2023. February 2023 Update - SOP has been drafted and circulated for comment prior to sign off.
Medical Records Management 1.1	Nov-22	Reasonable	The responsibilities of the Health Records departments across the Health Board should be standardised. Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation.	Medium	Accept There are challenges to standardising the operational procedures of the Health Records teams due to the variances between the digital systems used within the Princess of Wales and the rest of the Health Board. It should also be noted that some of the Health Records personnel within the Health Board are not under the direct responsibility and accountability of the Director of Digital. The Health Board has devised a programme of work to standardise the PAS in use across the Health Board. This programme is planned until the Autumn of 2024. Process will be aligned as practically possible prior to the completion of the programme.	Director of Digital	Director of Digital	Qtr. 2 2024/2025			In progress	April 2023 Update - In progress - discussions ongoing regarding a phased approach to standardisation of process - commencing with booking processes and alignment of functions	December 2022 Update - Scoping and implementation work ongoing. 2023 Update: Ongoing - will be aligned to the next iteration of the Care Group structure February

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ICTM Quality Improvement Team 1.1	Dec-22	Reasonable	Procedural guidance should be developed that set out the difference between projects that the QI team are involved in delivering and projects where the team operate in a supportive role.	Medium	As part of the response to this audit we are producing an overarching set of procedures and guidance for the ICTM Improvement Team which will incorporate this recommendation. This will be supported by a documented and recorded approval process for projects we agree to support.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			Completed	April 2023 Update - The QI team have adopted a document published in the BMA that highlights the difference between a QI project and other pieces of work such as research. This document forms part of the criteria used when assessing new projects at the monthly Project group. This group consists of ICTM senior management, our Associate Medical Directorate and representatives from Audit, E&D and OD as well as members of our multidisciplinary faculty. This ensures new projects are subject to a rigorous level of scrutiny	February 2023 Update - Procedural guidance is in draft form for completion in January 2023. Project approval will be incorporated as an agenda item in the monthly project group.
ICTM – Quality Improvement Team 2.1	Dec-22	Reasonable	A comprehensive central record should be maintained of all improvement activity carried out by the QI team. This should include a unique project reference number and the status of each project or programme and the date it was approved.	Medium	We are developing a solution which will be based either on use of the existing LifeQI system or a new centrally held database.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23	Now February 2023		Completed	April 2023 Update - The QI Team is maintaining a log of all projects underway that contains a unique identifier. In addition all new projects will be asked to detail the project on our LIFE QI project management software.	February 2023 Update - All improvement projects will be captured on LifeQI.
ICTM – Quality Improvement Team 2.2	Dec-22	Reasonable	All Improvement projects should be aligned to the organisation's strategic aims and objectives, and this should be captured within project documentation.	Medium	As part of its response to this audit we are producing an overarching set of procedures and guidance for the ICTM Improvement Team which will incorporate this recommendation. Life QI and other software will be adapted to facilitate this.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			Completed	April 2023 Update - The monthly project group will scrutinise how each project aligns with organisation strategy (This group consists of ICTM senior management, our Associate Medical Directorate and representatives from Audit, E&D and OD as well as members of our multidisciplinary faculty. This ensures new projects are subject to a rigorous level of scrutiny). In addition a review of the work of the QI team has been undertaken to ensure it aligns with key priorities.	February 2023 Update - We are aligning all projects either to the goals of CTM 2030 - the LHBs long term strategy, or toward the goals of the national Safe Care Collaborative. In addition, scrutiny at the monthly project group will allow us to ensure projects are aligned to organisation goals.
ICTM – Quality Improvement Team 3.1	Dec-22	Reasonable	The QI Faculty Framework should be reviewed. The review should cover the effectiveness of the operation of the framework since its implementation, and re-alignment to the new Care Group structure currently being implemented across the Health Board.	Medium	As part of its response to this audit we are producing an overarching set of procedures and guidance for the ICTM Improvement Team which will incorporate this recommendation. A review of the Faculty Framework is underway but will be dependent on the roll out of the new organisation structure which is still in progress.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23	Now February 2023		Completed	April 2023 Update - The Faculty Framework has been reviewed and updated and a new structure created. Tenures on the previous iteration for the Faculty have been ended and recruitment into the new structure is underway.	February 2023 Update - Faculty Framework has been reviewed and a new model in development.
ICTM – Quality Improvement Team 4.1	Dec-22	Reasonable	Where possible performance measures and / or indicators should be drawn up and recorded for all improvement projects to allow easier monitoring of success during and at the conclusion of a project.	Medium	The nature of improvement and our approach to nurturing improvement skills as opposed to direct involvement in project may make this difficult to implement for every project. However we will include this in our new procedural guidelines and where possible include it within the scope of improvement projects.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			Completed	April 2023 Update - The QI team is asking for all projects to be included on our LIFE QI project software. This includes a progress assessment tracker that can be used to highlight performance. Projects will be reviewed regularly at our monthly Project group. This group consists of ICTM senior management, our Associate Medical Directorate and representatives from Audit, E&D and OD as well as members of our multidisciplinary faculty. This ensures new projects are subject to a rigorous level of scrutiny	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.

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ICTM – Quality Improvement Team 4.2	Dec-22	Reasonable	To facilitate wider sharing of information and the lessons and good practice arising from improvement projects, the QI team should liaise with Project Leads to remind them of the importance of keeping the Life QI system updated with progress on their projects and against any performance measures and / or indicators on a regular basis.	Medium	As part of its response to this audit we are producing an overarching set of procedures and guidance for the ICTM Improvement Team which will incorporate this recommendation. Clearer guidance on the use of LifeQI and the accountability associated with receiving a license will be part of this guidance.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Jan-23			Completed	April 2023 Update - The QI team is asking for all projects to be included on our LIFE QI project software. This includes a progress assessment tracker that can be used to highlight performance. Projects will be reviewed regularly at our monthly Project group. This group consists of ICTM senior management, our Associate Medical Directorate and representatives from Audit, E&D and OD as well as members of our multidisciplinary faculty. This ensures new projects are subject to a rigorous level of scrutiny	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.
Radiology Service Review 1.1	Dec-22	Reasonable	The Terms of Reference for all groups and committees should be reviewed to ensure they are up to date and relevant, including information such as purpose and remit of the group, attendees and quoracy arrangements, frequency of meetings and arrangements for rescheduling.	Medium	Due to the HB restructure, the previous Radiology Performance Meeting Forum has been stood down and replaced with a weekly Care Group Radiology Performance Review. ToR to be sourced from the Executive Office to reflect attendees, quoracy and frequency of the meetings while the care group structure beds in. A Radiology Quality, Improvement & Governance Structure Meeting has been arranged to update the governance meeting arrangements, reporting structure and review of ToR on 9/11/2022.	Chief Operating Officer	Executive Office Clinical Service Manager Senior Superintendents Clinical Lead for Quality and Governance Health and Safety Leads	31 December 2022 9 November 2022	Now March 2023 Now April 2023		In progress	April 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. Executive department to provide Review to provide ToR. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR for QI&G and the first new meeting took place on 25/01/23, with vice chair appointed.	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR for QI&G and the first new meeting took place on 25/01/23, with vice chair appointed.
Radiology Service Review 2.1	Dec-22	Reasonable	a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	Medium	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancellation the members will review the agenda to assess whether there are any urgent matters that require action and re arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	Chief Operating Officer	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads	30-Nov-22	Now March 2023 Now April 2023		In progress	April 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. Executive department to provide ToR for Performance Review Meetings. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR and the first new meeting took place on 25/01/23. A Vice Chair has been appointed to oversee meetings in absence of Chair. Radiology ToR for QIG completed action.	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR and the first new meeting took place on 25/01/23. A Vice Chair has been appointed to oversee meetings in absence of Chair. March 2023.
Radiology Service Review 2.2	Dec-22	Reasonable	Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	Medium	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	Chief Operating Officer	Clinical Service Manager	Dec-22	Now March 2023 Now May 2023		In progress	April 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups.	February 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups.
Radiology Service Review 4.1	Dec-22	Reasonable	a) Acknowledging that for 2022/23 the Standards of Behaviour Policy has been amended, and less categories of staff will be required to make a return, relevant staff within Radiology should be reminded of the relevance of the policy and the requirement to comply with it and complete an annual return. Where individuals fail to make a return, managers should continue to prompt staff to do so. b) Management should work with the Committee team to identify any gaps in the declaration of interest reporting.	Medium	a) The register of the declaration of interest information is maintained by the Corporate Service Department and submissions are registered and updated through this Department. A request for any outstanding declaration of interest will be made to the Corporate Services Department to identify those individual where these are outstanding and the relevant staff will be prompted to complete. b) A system of review will be agreed with the Corporate Services Department.	Chief Operating Officer	Corporate Services Manager/Clinical Service Manager	31st December 2022			In progress	April 2023 Update - DOI data/info to be provided by Corporate Team.	February 2023 Update - no update provided on this occasion

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Radiology Service Review 13.1	Dec-22	Reasonable	To allow more effective monitoring, improvements should be made to the data and reporting format of information taken to the Performance Review meetings, including: • Having a level of consistency in the data so that management can differentiate between the data of the constituent services within the CSG. Similarly, where necessary the breakdown of data across localities should be in place. • Performance data on areas such as workforce and quality should be presented at every meeting. • Where performance targets are included, it should be clear if the target is an internal CSG one. Any Health Board and Welsh Government targets should also be included and reported against to allow comparisons to other CSGs. • IMTP priority updates and actions should be better articulated to determine what is actually	Medium	A new system of Performance Review across the Care Group has now been established with weekly meetings with the Chief Operating Officer and monthly Business Meetings. The exact format of the Business Meetings has yet to be finalised but it is anticipated that they will: • Have a level of consistency and accuracy in the data so that management can differentiate between the data of the constituent services within the CSG and plan to address gaps. • Report Performance data on areas such as workforce and quality and risks at every meeting. • Include any Health Board and Welsh Government targets and trajectories towards achieving them. • Include any IMTP priorities and actions in the wider health board IMTP.	Chief Operating Officer	Care Group Director	31st December 2022	Now March 2023 Now April 2023		In progress	April 2023 Update - There is no formal agenda for the monthly performance meeting. Following receipt of the ToR, this will enable the department to follow an agenda or inform expectations for reporting consistently. Ongoing.	February 2023 Update - There is no formal agenda for the monthly performance meeting. Following receipt of the ToR, this will enable the department to follow an agenda or inform expectations for reporting consistently. Ongoing.
Radiology Service Review 14.1	Dec-22	Reasonable	A review of the format of the CRES information presented during the Performance Review meetings should be undertaken, to ensure the data is more meaningful and easier to interpret. Details about the CRES schemes that have been identified in the relation to the overall target, and progress and likelihood of achieving each scheme should also be presented.	Medium	A review of the format of the CRES information presented during the Performance Review meetings will be undertaken, to ensure the data is more meaningful and easier to interpret.	Chief Operating Officer	Finance Business Partner Clinical Service Manager	31st December 2022	To be confirmed		Completed	April 2023 Update - The current Performance Meeting does not cover CRES. CRES discussions are held at Care Group level with Director of Finance and Care Group senior team.	February 2023 Update - The current Performance Meeting does not cover CRES. CRES discussions are held at Care Group level with Director of Finance and Care Group senior team.
Health & Safety Management 06	Aug-20	Reasonable	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Director for People	Head of Health, Safety & Fire	01/01/2021 31 May 2022	Now 01/07/2021 Trial Audit on Social Distancing completed August 2021. New completion date for audit package to be suitable for H&S Audits 31/01/2022 Now May 2022 Now September 2022 Now February 2023 Now June 2023		Part Completed	April 2023 Update - Findings from the recent Health and Safety Audit were provided to the Health, Safety and Fire Sub Committee in February 2023. Problems are still present with the use of AMaT to present the data captured and following discussions with the Clinical Audit Team, the Health and Safety Team are having to explore the use of alternative audit packages.	APRIL 2021: An audit tool is being developed, taking learning from the social distancing audit tool developed. The package itself is developed, and by July we will have determined the key areas to be examined via the audit tool. This will be complete and ready to use by the end of July. A revised implementation date has been provided. July 2021 - Audit Package currently undergoing further testing due to some reporting issues on the AMaT system. SEPTEMBER 2021: The above audit findings were presented as a draft to the last Health, Safety and Fire Committee in September 2021. There are still some issues with the audit package producing an Executive summary of the audit undertaken. The Health, Safety and Fire Team are in further discussions with the Clinical Audit Team and AMaT to resolve this. Whilst awaiting this system fix an audit programme is being set up and will be rolled out once the system fixes have been completed. November 2021 - No further update provided. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation. April 2022 Update - Health & Safety Team has been working closely with Clinical Audit colleagues to determine whether the AMaT system could be used to capture audit information. The Team were now working towards a revised target date of end of May 2022 to complete this recommendation. August 2022 Update - Following several other issues which had to be resolved with AMaT the Health and Safety Team will be undertaking a management audit of a selection of wards/departments throughout the month of September. Update October 2022 - First audit commenced in September 2022 and a selection of Wards and Departments have been highlighted to be audited. Audit results will be presented to the next Health, Safety and Fire Sub Committee. December 2022 Update - First audit commenced in September 2022 and a selection of Wards and Departments have been highlighted to be audited (x30). Audit results will be presented to the next Health, Safety and Fire Sub Committee in February 2023. February 2023 Update - The Health Safety and Fire Team have completed their second Organisational Audit and results will be provided to the Health, Safety and Fire Sub Committee in February 2023.
Financial Systems 06	Apr-21	Reasonable	Management may want to consider creating a procedure, as it will help strengthen efficiencies, deliver best practice and more importantly it will provide added support should the department have new staff working in that area.	Low	Agreed. A manual for the fixed asset register will be created.	Director of Finance	Finance Manager	Sep-21	Now September 2022 Now November 2022 Now December 2022		In progress	April 2023 - No update received from the Team on this occasion	July 2021 Update - Action on target to be completed by September 2021. September 2021 - No further update. November 2021 - No further update provided. January 2022 Update - Due to changes in post and the significant pressure on the team as a result of IFRS implementation and preparation for the new quinquennial revaluation this has been unable to be addressed. It is proposed that this is picked up post the year end audit process over the summer of 22/23 post IFRS 16 adoption. April 2022 - No further update to report. August 2022 Update - A user manual for the Fixed Asset register is in progress, we have started working on it but it is not yet complete. October 2022 Update - Implementation date remains November 22. December 2022 Update - A draft version has been completed and is being checked through, this will now be completed during December 2022. February 2023 Update - no update provided on this occasion.
Sunnyside Health & Wellbeing Centre 09	Aug-21	Reasonable	Performance of relevant parties should be monitored appropriately	Low	As above although there will be a delay with the appointment of a new contractor.	Director of Finance	Senior Project Manager	Sep-21	Now January 2022 for Contractor only Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - Once a contractor is in place then agreed KPIs will be used to monitor ongoing performance	September 2021 Update - Complete for advisors but will not be complete for contractor until a new contractor is appointed. November 2021 Update - ongoing, awaiting contractor appointment. January 2022 Update - this has been further delayed as a result of a need to extend the tender period. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.
Sunnyside Health & Wellbeing Centre 17	Aug-21	Reasonable	Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	Low	The Health Board already has in places processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Director of Finance	Senior Project Manager	Nov-21	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	April 2023 Update - Once the contractor is appointed the agreed mechanism for sign off of variations can be put in place	September 2021 Update - Ongoing. November 2021 Update - to be completed this month. January 2022 Update - although technically this has been agreed it can not be fully implemented until the new contractor is back on site and appointed which will be at least March. April 2022 Update - See above - project remains on hold whilst new contractor appointed. June 2022 Update - Still undertaking tender process expected to come to a close and the project to re-commence, as a result this document can commence re-drafting as soon as contractor known and WG have approved a cost uplift. August 22, there are ongoing complications with the appointment of a replacement contractor after the initial contractor went into administration in July 2021. A tender process failed to deliver an acceptable tender and construction frameworks are under consideration. Until this is resolved the project remains on hold. Any procurement will be at least 3 months so it is recommended to review December 2022 to give time to appoint, confirm and implement recommendations as all outstanding recommendations can not be discharged without a new contractor in place. October 2022 Update - This scheme is on hold pending the appointment of a new contractor to undertake the works. Therefore the timeline for addressing the actions will be updated on appointment of a new contractor. At the moment that is not expected to be until December at the earliest. December 2022 Update - no change as there will not be an update until the new contractor is appointed and due to the need for a new tender process this will be March 2023. February 2023 Update - position remains unchanged.

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
Risk Management 2022 05	Aug-22	Reasonable	Management should consider the use of Datix for capturing all risks, this would allow for a consistent approach throughout the Health Board and provide greater effectiveness of monitoring.	Low	The ability to maintain a consistent approach to recording low level risks will be considered with a suggestion to align with the implementation of the new All Wales Risk Module on Datix where low level risks can be added to the system without generating the more detailed steps higher level risks require.	Director of Corporate Governance	Assistant Director of Governance & Risk	Oct-22	Now 31 December 2022 Now 31 March 2023		Completed	April 2023 Update - The revised Risk Assessment Procedure was approved in December 2022 which mandates the use of Datix for all risks irrespective of scoring. This has been promoted through the Staff Newsletter along with the training. On implementing the new OFW Risk Module this will be built into the system.	October 2022 Update - This recommendation has been aligned to the implementation of the Datix Cymru Risk Module the implementation of the new module has been delayed. Progress is monitored via the OFW Risk Module Meetings which is next due to meet in October 2022 where a further update on timescales will be received. Furthermore, the current risk training encourages risk owners to include all risks to the Datix System and this will be reflected in the next iteration of the Risk Management Procedure. December 2022 Update - This recommendation is dependent on the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A meeting has been scheduled in early December with a small cohort of risk leads across NHS Wales and the OFW System Lead to undertake some work on the progress of the module developments. A further update will be available following this meeting with a greater insight into an anticipated implementation date. In the meantime the revised Risk Assessment Procedure which is planned for approval in December 2022 mandates the use of Datix for all risks irrespective of scoring. The Risk Management Training also captures the Health Boards position on mandating the use of Datix for risk. February 2023 Update - A small cohort of the OFW Task and Finish Group met with the OFW Datix Team on the 6th December to receive an update on progress. Suggestions on further improvements were put forward and a further update meeting is scheduled for 2023. In the meantime monthly training continues with sessions booked throughout 2023. The revised Risk Assessment Procedure was approved in December 2022 which mandates the use of Datix for all risks irrespective of scoring. This has been promoted through the Staff Newsletter along with the training.
CSG & ILG Quality Assurance 1.1	Aug-22	Reasonable	The terms of reference for the CSG Service Group Performance Review (SGPR) meetings should be reviewed and updated where necessary, including amending the frequency of meetings if deemed appropriate. CSGs should endeavour to hold their SGPR meetings in line with the frequency agreed in the terms of reference.	Low	The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILG's), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSGs for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023		Completed	April 2023 Update - Recommendation: completed, closed. The operational reporting structure is now in place. As cited above in action 3.0, the Quality and Safety Framework will now be socialised and aligned to the current corporate and care group governance functions.	October 2022 update-The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation, Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. December 2022 Update - Quality & Safety Framework first draft expected December 2022. February 2023 Update - no update provided on this occasion
CSG & ILG Quality Assurance 2.0	Aug-22	Reasonable	Quality governance training should be provided to all relevant staff in the ILGs and their constituent CSGs to ensure a sound understanding of quality assurance principles and practices	Low	The Health Board launched a new Patient Safety Incident Management Framework and Toolkit in June 2022. This describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. In July 2022, the Health Board also launched a rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience. The training also introduces the important concepts of psychological safety, human factor errors and safety thinking. Attendance is recorded on the Health Board's Electronic Record System, which ensures that those undertaking incident investigations are appropriately, and consistently trained to improve standards and performance. Bespoke Datix training has been rolled out by the Datix Management Team following the adoption of the Once for Wales incident module, and is ongoing. The corporate team have initiated good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. Training sessions are supported by the Health Board's Communication channels, Intranet SharePoint system where further information and assistance for colleagues is signposted by the Patient Care and Safety site. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework.	Director of Nursing	Assistant Director Quality & Safety	The nature of this action is ongoing; however, the new structure will provide an opportunity to target CSGs. Quality & Patient Safety Framework December 2022	Now January 2023 Now June 2023		In progress	April 2023 Update - Recommendation: incomplete, open/yellow. The leadership teams are to have understanding and all staff have RCA training for moderate & above moderate reviews as set out within the DoFC-hoFQity and clinical care group. A request via Heads of Quality to respective care groups and the corporate team to: 1. establish an assessment as to the number of current RCA and governance trained senior staff, 2. establish a list of core senior team members to be trained. This will ensure each service group is represented by a core group of trained individuals to fulfil governance and learning requirements as an initial baseline. The initial assessment is to be completed by end of April 2023, and phase 2 is to be completed by end of June 2023. This action can then be considered complete and closed.	October 2022 update-As previously identified the Patient Safety Incident Management Framework and Toolkit describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. The rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience continues on a monthly basis. Bespoke Datix training sessions are being offered CSG's and departments by the Datix Management Team following the adoption of the Once for Wales incident module. The corporate team have continued good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework in December 2022 which will articulate how CSGs provide assurance through standardised frameworks, systems and processes. To date approx. 70 people have been trained to maximise patient safety, understand putting things right legislation and undertake investigations. Sessions will continue to run monthly from November. As the organisational change takes place, the vision is for the all governance teams across the care groups to support with delivering this training. December 2022 Update - As previously identified the Patient Safety Incident Management Framework and Toolkit describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. The rolling programme of patient safety investigation training/ RCA training which includes good governance in relation to quality and patient safety & Datix and patient experience has a rolling training programme every 6- 8 weeks due to room booking availability across all 3 sites. To date approx. 80 people have received training. As the organisational change takes place, the vision is for the all governance teams across the care groups to support with delivering this training. Further training is being scoped with the claims team as feedback from medical colleagues is more training is required around identifying breach of duty. Bespoke Datix training sessions are being offered to CSG's and departments by the Datix Management Team following the adoption of the Once for Wales incident module. The corporate team have continued good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework in December 2022 which will articulate how CSGs provide assurance through standardised frameworks, systems and processes. February 2023 Update - no update provided on this occasion
CSG & ILG Quality Assurance 5.0	Aug-22	Reasonable	For clarity, each CSG should consider mapping out its quality assurance reporting and oversight arrangements from the CSG up to the ILG Quality and Safety Group.	Low	This will be actioned through the new Quality and Patient Safety Framework as detailed in earlier agreed management actions.	Director of Nursing	Assistant Director Quality & Safety	Dec-22	Now January 2023 Now May 2023		In progress	April 2023 Update - Recommendation: incomplete, open/yellow. A program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.	October 2022 update-This has been responded to within earlier updates in relation to the new Quality & Safety Framework. December 2022 Update - Quality & Safety Framework first draft expected December 2022. February 2023 Update - no update provided on this occasion
iCTM – Quality Improvement Team 3.2	Dec-22	Reasonable	The updated faculty framework document should be formally approved with the date of approval and issue recorded on the document.	Low	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	Mar-23	Now April 2023		In progress	April 2023 Update - The Faculty framework has been reviewed but not yet formally approved. This will be done shortly via the Executive Nurse Director with an expectation that the faculty framework will be formally approved by 28th April 2023.	February 2023 Update - Procedural guidance is in draft form for completion in January 2023.
Wellbeing 3.2	Feb-23	Substantial	The 'Inspiring People' Group should provide a return to a formal and regular oversight and monitoring of the Wellbeing Priorities Work plan and the work of the Employee Wellbeing Services as whole. However, arrangements under the new operating model structure for locality based wellbeing groups should be made to ensure localised communication is not lost.	Medium	The Inspiring People Group will provide a mechanism for overseeing and reporting on Health and Wellbeing activity and through its representation provide an opportunity to test new ideas and share learning. The need to maintain good communication to wellbeing groups within the service is recognised	Director for People	Assistant Director of OD & Wellbeing	31.1.2023 (inaugural meeting)	Now April 2023		In progress	April 2023 Update - Inspiring People Programme Board has been set up, an initial meeting has taken place with the Executive and Deputy Sponsor. Our first formal meeting is due to take place 17 April 2023.	
Wellbeing 1.1	Feb-23	Substantial	1.1a The draft Employee Wellbeing policy should be reviewed by the Local Partnership Group at the earliest opportunity, ahead of being presented to the People and Culture committee for approval. 1.1b Once finalised, staff should be made aware of the policy's existence.	Low	1.1a CTM acknowledges the recommendation, the policy has been drafted and commenced the process for approval. It is on the agenda for discussion at the next Local Partnership Forum (LPF) meeting in December. Once approved it will then be taken to People and Culture Committee for chairs action. 1.1b Once ratified, all staff and stakeholders will be informed and it will be made available to all staff via publication on the appropriate SharePoint sites and the Wellbeing website pages.	Director for People	Head of Policy, Compliance and Agenda for Change for LPF Strategic Lead for Employee Experience and Wellbeing, Strategic Lead for Employee Experience and Wellbeing for People and Culture Committee.	31/12/22			Completed	April 2023 Update - Policy approved and actively available to staff TO BE CLOSED - COMPLETE	

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
Wellbeing 2.1	Feb-23	Substantial	For the proactive elements of the Wellbeing service provided we would encourage the use of the forward looking work plan, while acknowledging that it should remain flexible to accommodate the reactive nature of more immediate priorities.	Low	A Wellbeing Service is predominately reactive in nature and responsive to the changing needs of the staff population. To be effective, the service has to react to these changing needs in a flexible and timely manner. To support the proactive element of the service a Wellbeing Priorities Work plan is developed; however, the plan can and will be impacted by reactive priorities that arise which can result in the plan not necessarily recognising the current and accurate position of the work being undertaken. The work plan will continue to evolve and will be developed based on anticipated activity in the following 6-month period. In response to this specific action, the team will revisit the Work plan in December 2022.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	Dec-22			In progress	April 2023 Update - The wellbeing team are developing a detailed action plan informed from the detail gathered from our surveys. The strategic aim and actions of the service are captured and monitored through the 10 Priorities of the People Directorate	
Wellbeing 3.1	Feb-23	Substantial	For future staff surveys, analysis work should be undertaken in relation to where respondents were located and the return rates by Clinical Services Groups / departments, so as to aid identification of those areas where more targeting and awareness work is needed to encourage completion of future surveys.	Low	At the time of running the current 2022 survey the new care group model had only just launched, work to reflect this in organisational hierarchies is still ongoing to include every staff member within the Health Board, the highest context marker in conducting the Wellbeing survey is to make the survey feel as assessable to as many staff as possible. In order to support small departments where staff may feel they could be identifiable, the Team are exploring how it could introduce a free text entry where staff would not need to indicate the area where they work.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	Next survey 31/05/2023			In progress	April 2023 Update - Revised Wellbeing Survey to be live in May/June 2023	
Wellbeing 3.2	Feb-23	Substantial	To help analysis of the data, where relevant, future Wellbeing surveys should incorporate 'drop down' menus for responders to choose pre-set answers as opposed to 'free text' fields.	Low	To further support the action in 3.1, the Team will also explore the introduction of 'Drop Down' menus where location identification at a department level does not present a risk in terms of staff becoming identifiable.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	May-23			In progress	April 2023 Update - Revised Wellbeing Survey to be live in May/June 2023	
Wellbeing 4.1	Feb-23	Substantial	To maximise potential uptake of Wellbeing Activists in the former Merthyr & Cynon ILG locality, awareness and engagement work should be undertaken to build relationships, confidence and trust with staff.	Low	Work is already underway to increase the number of Wellbeing Activists in underrepresented areas, by promoting the work of those already providing this role locally and by informing staff within services of similar work going on in the same service on another site. Activity is also underway to identify the number of activists in the new Care Group Model to be able to reflect this position moving forward.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	Mar-23			In progress	April 2023 Update - work is ongoing with care groups to promote and attract further activists across all our geographical locations	

Red -
Orange -
Yellow -
Green -
Blue - Action

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
R2 Follow Up Outpatient's Not Booked	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 through the Qik 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.	Chief Operating Officer			February 2021 Ongoing August 2021 Now December 2021 Now March 2022 Now June 2022 Now September 2022 Now February 2023		In Progress	April 2023 - nothing further to report this month. Will receive focus for the next meeting. Work is underway across the UHB on FUNB and other patient waiting times.	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 outlined in previous months is continuing and the Elective Recovery Plan is gathering pace and that it is monitored via weekly Board Meetings. 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 the COO - where progress is demonstrated. Harm Reviews are also ongoing. Revised implementation date not provided. September 2021 Update - No change from the last comment. November 2021 Update - There is significant work underway on FUNB and related issues via the Planned Care Board including Follow Up Validations, SOS / PIFU projects, Attend Anywhere, DNA Work, Consultant Connect. There are robust mechanisms in place to monitor progress. Despite the progress and given the passage of time since this audit was completed, changes in management arrangements and the impact of Covid 19, conversation is ongoing with colleagues in Audit to decide on how to answer this recommendation in a meaningful way. A meeting will be held before the next Audit Committee to discuss further. February 2022 Update - further discussion required with ILGs, evidence suggests that this is no longer an issue. To be confirmed at next meeting. April 2022 Update - Confirmation not received from all ILGs - anticipate very likely this will be received by the next meeting. June 2022 Update. Work continues as part of planned care recovery with Follow Up Validations, SOS / PIFU projects, Attend Anywhere, DNA Work, Consultant Connect. Progress has been monitored both through PCR Board and through ILG Performance meetings. However, the focus remains on clinical priority as the services recover. August 2022 - nothing further to report in this update. Date remains September 2022. October 2022 Update - following meeting with Acute Services Managers, issue clarified with AW colleague and meeting planned to decide on final comment. December 2022 Update - following further advice from Audit Wales, a further question has been posed to Acute Services Managers asking for reassurance around the way that processes are working within the UHB. Response not yet received, anticipated by time of next meeting. February 2023 Update - nothing further to add. Verbal update will be sought for meeting of Audit Committee.
Clinical Coding Follow Up Review 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 Health Board. In 2018, NWS 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 Digital		Not specified by the Health Board	October 2020 April 2021 Now March 2022 Now June 2022 Now October 2022 Now October 2023		In progress	February 2023 Update - Action plan now in place for Medical Records - Action Plan in place until October 2023. Propose to close.	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 digitalisation 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 mandate or 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. Digitalisation 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 digitalisation, which have been delayed due to COVID-19 until 2021. 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 case note itself without additional steps being taken prior to digitalisation. 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. Digitalisation 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 has also been delayed until 2021. 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. January 2021 Update In response to internal findings from 2014 in relation to the quality of medical records and the NWS 2018 report looking into the quality of clinical coding documentation, the Clinical Coding department has employed a coding trainer who will implement a coding education and engagement plan. The plan will cover areas such as the training of trainee coders on how to extract clinical information from health records and building/developing working relationships with staff across the UHB to improve on the quality and availability of the case notes. The CTO software planned for implementation in early 2021 will provide clinical coding colleagues with real-time, single-view access to critical patient information on demand. Staff who were initially involved in the project are currently being invited to reconvene and to promote awareness of the project and its benefits among their colleagues. Terms of reference are currently being drafted for a Performance and Clinical Information Strategy Group (PCISG), the group among other functions will provide a forum for stakeholders to collaborate, monitor and address issues relating to clinical data quality. These are actions that the P&I Directorate can take forward, however we are eagerly anticipating any update as to what potential role a Health Records Committee or alternative plan will have on the quality of medical records within the UHB. May 2021 - No further update to report. July 2021. Information on this recommendation has been received and will be escalated to the ILGs for comment next quarter. Revised implementation date not provided. September 2021 Update. All of the processes previously described are still ongoing, including an aspect of training in the Junior Doctor Induction Course. Query has gone to Medical Records Manager as within ILGs at present it seems that this has not received significant management focus. Once the current wave of Covid has passed then the allocation of time will be more possible. November 2021 Update - Processes are still ongoing and the date for completion remains March 2022. February 2022 Update. A response will be available at the next meeting - plan in place to meet the Manager for Medical Records in the next month. Target remains March 2022. April 2022 Update - Nothing further in this month - will be chased again in the coming month. Pressure of work at present is significant. June 2022 - Update Will be available for August 2022. August 2022 - nothing further to report. October 2022 Update: The Digital Patient Notes Programme Board, the Information Governance Group and the Digital & Data Committee. December 2022 Update - It has been proposed that this recommendation remains open pending discussions between Audit Wales and the Director of Digital.
Clinical Coding Follow Up Review 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 NWS 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 Digital		Not specified by the Health Board	October 2020 November 2021 Now June 2022 Now October 2022		In progress	February 2023 Update - Regular audits and reporting of the quality of the medical record are now in place - propose to close.	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 IMPT 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. July 2021. Information on this recommendation has been received and will be escalated to the ILGs for comment next quarter. September 2021 Update. The Clinical Audit Team will be undertaking a documentation audit of both acute and community case notes during October / November 2021 using AMaT (audit management software) to support the data capture. Clinical Audit facilitators will be taking a random sample of case notes to retrospectively conduct the audit and report publication is planned for the end of November. November 2021 Update - nothing further to report at this meeting. February 2022 Update. A response will be available at the next meeting - plan in place to meet the Manager for Medical Records in the next month. April 2022 Update - Nothing further in this month - will be chased again in the coming month. Pressure of work at present is significant. June 2022 - Update Will be available for August 2022. August 2022 - nothing further to report. October 2022 Update: Propose to close - processes are now in place to monitor the quality of the record and this progress is reported to the Digital Patient Notes Programme Board, the Information Governance Group and the Digital & Data Committee. December 2022 Update - It has been proposed that this recommendation remains open pending discussions between Audit Wales and the Director of Digital.
Audit of Accounts Addendum 2020/2021 02	Aug-21	The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	Medium/Low	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	Director for People		Immediate	Now August 2022 Now October 2022 Now December 2022 Now March 2023		In Progress	April 2023 - No update received from the Team on this occasion	September 2021 - No update received. November 2021 - No further update provided. April 2022 - The Health Board has reviewed its governance and procedures in place for the appointment of senior officers. The governance arrangements understands the extent of WG's delegated authority to the Health Board, including the decisions, which WG has not delegated. The Health Board's Retire and Return Policy is currently subject to review and will be discussed at the Workforce Policy Review Group on the 21 April 2022, prior to organisational wide consultation. The Policy will ensure appropriate procedures are in place for the consideration and approval / rejection of business cases. The Policy will be presented to the August 2022 People and Culture Committee for approval. June 2022 Update - The Health Board's Retire and Return Policy is currently subject to review and was discussed at the Workforce Policy Review Group on the 21 April 2022. The policy is now out to organisational wide consultation. The Policy will ensure appropriate procedures are in place for the consideration and approval / rejection of business cases. The Policy will be presented to the August 2022 People and Culture Committee for approval. August 2022 Update - The CTM Retire and Return Policy was not endorsed to be presented to the People and Culture Committee in August 2022 for approval, as the partnership WPRG agreed further work was needed to align to the policy to the additional NHS flexibilities options, which permits employee to access their NHS Pension without retiring. It has been agreed to the LPF will endorse the policy to be approved by the People and Culture Committee via Chair's action in advance of the November 2022 meeting. October 2022 Update - further to partnership discussions with Trade Union Colleagues, it has been agreed that this guidance requires further implication and incorporate clear justified business reasons for approving or rejecting applications based on the employee's retirement plans and the needs of the service. Extensive work has been undertaken to make the guidance fit for purpose. The group will also engage with OD to facilitate the cultural changes required, to ensure managers are aware of the benefits to the organisation of approving such requests. It is anticipated this guidance will go back to the LPF in December 2022 for endorsement and approval will be sought via Chair's action. December 2022 update - This policy work is now being taken forward in partnership with trade unions and OD colleagues to ensure the processes become fully embedded and enable employees and their managers to fully explore all flexible retirement options not just retire and return. It is anticipated that this work will be completed by March 2023. February 2023 Update - Discussions are currently taking place with the Employee Experience Lead and the Head of Nursing Professional Standards and Education, regarding how this policy work can be integrated into the retention / Itchy Feet work which is currently being progressed, to ensure the processes align with the new Flexible Retirement Policy.

Red -
Orange -
Yellow -
Green -
Blue - Action

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
Audit Wales/HI W Quality Governance Follow Up Review R2.3	Aug-21	The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically: a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board c- The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework	High	The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows: • Strengthened focus on quality on strategic planning; • Individuals' voices are better heard; • Shared learning and continuous quality improvement; • Risk better articulated, shared and mitigated; • Strengthened two-way 'point of service delivery' to Board sight; and • Extensive review and improvement of the management of concerns and serious incidents. Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's. The revised framework will provide improved granular detail in respect of ILG governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSG/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded.	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022 Now May 2023	In Progress		April 2023 Update - Recommendation: incomplete, open/yellow. A program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update - As detailed above in R1, a revised Quality & Governance Framework will be presented to the Quality & Safety Committee in March 2022. Update April 2022 - Timescales were agreed for a revised Quality and Safety Governance Framework to be presented to the Quality & Safety Committee in March 2022 - this has been delayed by the proposed new operating model for the organisation to July 22. The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. There is an ongoing internal audit commissioned of governance processes at service group level to inform the new Governance Framework, the audit team are currently undertaking fieldwork within 3 service groups and the results of this work will lead the design of the new framework granularity of ward to board assurance. July 2022 Update - The Quality & Patient Safety Governance Framework will be revised following implementation of the new operating model. Proposed first draft December 2022. Internal Audit Assurance report of our governance function with in the ILGs reviewed as providing reasonable assurance obtained overall and areas with substantial assurance, demonstrating our positive mechanisms for oversight, escalation and risk. We have a number of key matters arising from the audit which need addressing however with the new operating model I'm sure these are elements we can pick up/incorporate into the new operation model to provide assurance on all CSG's. October 2022 update - Quality Strategy update as above ref.R1. Quality goals and objectives within the strategy align with other key Health Board strategies and frameworks. December 2022 Update - The Quality & Safety Framework first draft will be available end of December 2022. Quality Strategy update as in R1. February 2023 Update - no update provided on this occasion
Audit Wales/HI W Quality Governance Follow Up Review R6.1	Aug-21	There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	High	Health Board purchased CIVICA (captures population feedback using a patient insight software platform)	Director of Nursing		Jul-21	Now December 2021 Now July 2022 Now March 2023 Now December 2023	In Progress		April 2023 Update - the team continue to engage with specialties to look at bespoke surveys and to promote training with staff to embed across the HB. Work is ongoing to look at how we can implement SMS messaging for the ED departments. SMS messaging is restricted at present due to IT infrastructure and the capacity to implement across the Health Board. Volunteer patient feedback team continue to support gaining of feedback within POW and volunteer team are working to increase teams available to develop this across to RGH and PCH. VBHC Admin support is also helping to support the input of paper copies of "Have Your Say" into the system and the creation of surveys. VBHC has just recruited a B6 PM who can also provide support for communication and engagement e.g. webpage, leaflets, events etc. Still awaiting the finance issue of Civica to be resolved to enable VBHC team to take over that aspects moving forward.	September 2021 Update - CIVICA PM appointed and produced timeline for roll out within CTM. 'Have your Say' generic people's feedback being placed as a link on the CTMUHS intranet page. Plan for Draft People's Engagement document 'by December 2021. Nov 21 Update - Pilot of Value Based Healthcare PROMs have gone live in Cardiology along with the launch of PREMS and workforce reported experience measures (WREMs). Jan 2022 Update: Problems seen in automating Civica to CTM patients via SMS due to IT resource issues. Business Case is being completed to request additional resource for this. 2x kick start admin support officers to start Feb 2022 to help support the team and gather additional data collection from patients that are not digitally enabled and support in reporting and setting up/ maintenance of surveys within the system. Currently scoping out iPad within CTM to rollout the Civica App onto all service user groups for the Have your say survey and any bespoke surveys requested. Training has been provided to various user groups and set up on the system throughout Oct- Dec. Additional training days will be given from Feb 2022 onwards. Delays have been seen due to COVID-19. April 2022 Update - The Health Board launched the electronic "Have your Say" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KWIIP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. They will be made available to staff that are providing services in patient's homes. Exploration is taking place as to how the posters/cards can be promoted within the wider non-health board community settings. From the 28.02.22, within the Bridgend and Merthyr & Cynon Localities, the PALS team are actively engaging with patients/ service users to promote the completion of the "have your say" cards and generic survey. This is through paper copies being available in areas, which are collated and uploaded on to the system on a monthly basis. Along side this, within Merthyr & Cynon PALS officers are present with Emergency Department at PCH and outpatients at YCC to capture feedback via iPADS. The number of area specific surveys continues to increase, with Staff engaging with patients and service users via links, QR codes and iPADS. June 2022 Update - To date CTM have received 2050 responses, has 18 active surveys, 10 surveys set up and 2 surveys closed on the system. There are 5 automated SMS surveys set up within the system and 33 active discussion with other service user groups within CTM. Work continues to promote the CIVICA system with patients and staff via social media and intranet pages. Number of specialties engaging with the team to develop the use of the system is increasing and from in sections for staff are planned for final/beta across acute sites in September 2021 - No update received. November 2021 - No further update provided. January 2022 Update Quality Plans, Quality Control and Quality Assurance have all now been agreed by Board resulting in the next phase of the maturity framework. Any service changes are now required to have a EQIA and depending on the outcome score of the EQI assessment will determine the sign off process by the Medical/Nurse Director. April 2022 Update Board self assessment of Quality Governance Maturity matrix for 28th April 2022-The Director of Nursing will recommend to the Board the results for Quality Planning, Quality Assessment and Quality Assurance. Quality Safety and Patient Experience forums now feature across all Clinical Service Groups. August 2022 Update - Safe 2 Start' daily meetings are now embedded across the 3 acute hospital sites. Attendance includes, Head of Patient Flow, Head of Nursing, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing position for the day within the hospital, it focuses on Emergency Department demand and key quality and safety metrics relating to patient care. The 2 community hospital sites also undertake a daily Safe 2 Start meeting chaired by the Senior Nurses and this information feeds into the overarching HB daily planning and escalation. From a strategic perspective, in relation to the changes in the organisational operating model this requires a review of the governance framework to confirm arrangements for quality governance and patient safety within the Care Group Structure, there is an anticipated completion date of December 2022. October 2022 Update: The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation. Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. In addition to the comments above in relation to the Quality & Safety Framework and Quality Governance Plans for the CSG's and Care Groups, the Health Board has launched its Listening and Learning Framework in September 2022. This demonstrates how learning will be identified, triangulated, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce.
Audit Wales/HI W Quality Governance Follow Up Review R8.2	Aug-21	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	High	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.	Director of Nursing		Mar-22	Now end of May 2022 Now December 2022 Now January 2023	Completed		April 2023 Update - Recommendation: complete, closed/green. The care group structure is in place, and the Head of Nursing and associated site professionals are aligned and reporting to appropriate care group leadership teams. Further work is underway in substantive plans for supporting teams to strengthen current structures.	September 2021 Update - CIVICA PM appointed and produced timeline for roll out within CTM. 'Have your Say' generic people's feedback being placed as a link on the CTMUHS intranet page. Plan for Draft People's Engagement document 'by December 2021. Nov 21 Update - Pilot of Value Based Healthcare PROMs have gone live in Cardiology along with the launch of PREMS and workforce reported experience measures (WREMs). Jan 2022 Update: Problems seen in automating Civica to CTM patients via SMS due to IT resource issues. Business Case is being completed to request additional resource for this. 2x kick start admin support officers to start Feb 2022 to help support the team and gather additional data collection from patients that are not digitally enabled and support in reporting and setting up/ maintenance of surveys within the system. Currently scoping out iPad within CTM to rollout the Civica App onto all service user groups for the Have your say survey and any bespoke surveys requested. Training has been provided to various user groups and set up on the system throughout Oct- Dec. Additional training days will be given from Feb 2022 onwards. Delays have been seen due to COVID-19. April 2022 Update - The Health Board launched the electronic "Have your Say" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KWIIP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. They will be made available to staff that are providing services in patient's homes. Exploration is taking place as to how the posters/cards can be promoted within the wider non-health board community settings. 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Number of specialties engaging with the team to develop the use of the system is increasing and from in sections for staff are planned for final/beta across acute sites in September 2021 - No update received. November 2021 - No further update provided. January 2022 Update Quality Plans, Quality Control and Quality Assurance have all now been agreed by Board resulting in the next phase of the maturity framework. Any service changes are now required to have a EQIA and depending on the outcome score of the EQI assessment will determine the sign off process by the Medical/Nurse Director. April 2022 Update Board self assessment of Quality Governance Maturity matrix for 28th April 2022-The Director of Nursing will recommend to the Board the results for Quality Planning, Quality Assessment and Quality Assurance. Quality Safety and Patient Experience forums now feature across all Clinical Service Groups. August 2022 Update - Safe 2 Start' daily meetings are now embedded across the 3 acute hospital sites. Attendance includes, Head of Patient Flow, Head of Nursing, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing position for the day within the hospital, it focuses on Emergency Department demand and key quality and safety metrics relating to patient care. The 2 community hospital sites also undertake a daily Safe 2 Start meeting chaired by the Senior Nurses and this information feeds into the overarching HB daily planning and escalation. From a strategic perspective, in relation to the changes in the organisational operating model this requires a review of the governance framework to confirm arrangements for quality governance and patient safety within the Care Group Structure, there is an anticipated completion date of December 2022. October 2022 Update: The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation. Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. In addition to the comments above in relation to the Quality & Safety Framework and Quality Governance Plans for the CSG's and Care Groups, the Health Board has launched its Listening and Learning Framework in September 2022. This demonstrates how learning will be identified, triangulated, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce.
Audit Wales/HI W Quality Governance Follow Up Review R8.6	Aug-21	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	High	Quality Governance Framework to reflect enhanced governance processes	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022 Now January 2023 Now May 2023	In Progress		April 2023 Update - Recommendation: incomplete, open/yellow. A program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update please cross reference with R1 A revised Quality and Safety Governance Framework is to be presented to the Quality & Safety Committee in March 2022. Update April 2022 - Timescales were agreed for a revised Quality and Safety Governance Framework to be presented to the Quality & Safety Committee in March 2022 - this has been delayed by the proposed new operating model for the organisation to July 22. The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. There is an ongoing internal audit commissioned of governance processes at service group level to inform the new Governance Framework, the audit team are currently undertaking fieldwork within 3 service groups and the results of this work will lead the design of the new framework granularity of ward to board assurance. July 2022 Update - The Quality & Patient Safety Governance Framework will be revised following implementation of the new operating model. Proposed first draft December 2022. Internal Audit Assurance report of our governance function with in the ILGs reviewed as providing reasonable assurance obtained overall and areas with substantial assurance, demonstrating our positive mechanisms for oversight, escalation and risk. We have a number of key matters arising from the audit which need addressing however with the new operating model I'm sure these are elements we can pick up/incorporate into the new operation model to provide assurance on all CSG's. October 2022 update: The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation. Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. In addition to the comments above in relation to the Quality & Safety Framework and Quality Governance Plans for the CSG's and Care Groups, the Health Board has launched its Listening and Learning Framework in September 2022. This demonstrates how learning will be identified, triangulated, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce.
Audit Wales/HI W Quality Governance Follow Up Review R10.1	Aug-21	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	High	Risk Training: including the development of a Training Needs Analysis (TNA) in line with All Wales developments, dissemination of the TNA across the Health Board, new risk training programmes which are aligned to the new TNA.	Director of Corporate Governance	Assistant Director of Governance & Risk	Oct-21	Now December 2021 Now April 2022 Now October 2022 Now 31 December 2022 Now 31 March 2023 Now 31st October 2023	In Progress		April 2023 Update - This recommendation remains linked to the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A further meeting with the Task and Finish Group of the OFW Implementation is scheduled for late March 2023. A further update will be reported at the next meeting of the Audit & Risk Committee. The revised implementation is approximate whilst a further programme update is awaited from the Implementation Team of OFW Risk Module. In the meantime monthly risk training is scheduled throughout 2023 which is open to all staff. These sessions are publicised on SharePoint and been included in the Staff Newsletter.	September 2021 Update - No update received. November 2021 - No further update provided. January 2022 update please cross reference with R1 A revised Quality and Safety Governance Framework is to be presented to the Quality & Safety Committee in March 2022. Update April 2022 - Timescales were agreed for a revised Quality and Safety Governance Framework to be presented to the Quality & Safety Committee in March 2022 - this has been delayed by the proposed new operating model for the organisation to July 22. The delivery of the Quality Strategy has been hampered by the delay of the organisational strategy work which is key to ensure alignment of both strategies. A first iteration of a draft Quality Strategy has been completed with work ongoing with a timescale for completion of end May 2022. There is an ongoing internal audit commissioned of governance processes at service group level to inform the new Governance Framework, the audit team are currently undertaking fieldwork within 3 service groups and the results of this work will lead the design of the new framework granularity of ward to board assurance. July 2022 Update - The Quality & Patient Safety Governance Framework will be revised following implementation of the new operating model. Proposed first draft December 2022. Internal Audit Assurance report of our governance function with in the ILGs reviewed as providing reasonable assurance obtained overall and areas with substantial assurance, demonstrating our positive mechanisms for oversight, escalation and risk. We have a number of key matters arising from the audit which need addressing however with the new operating model I'm sure these are elements we can pick up/incorporate into the new operation model to provide assurance on all CSG's. October 2022 update: The health board continues to make changes in respect of its new operating model which includes quality governance and patient safety arrangements for CSG's and the Care Groups they sit within. Each Clinical Service Group will have a standardised assurance framework in place to describe how floor to board assurance is articulated within services, as well as standardised tools for annual work plans, quality assurance of incident management & investigation. Terms of Reference/Agenda for Quality, Patient Safety & Patient Experience Meetings and arrangements to share learning. Upward reporting and monitoring through to the Care Group will be based on agreed quality indicators, informed by work plans and a common reporting framework. These arrangements will be articulated in the revised Quality & Safety Framework due for publication in December 2022. In addition to the comments above in relation to the Quality & Safety Framework and Quality Governance Plans for the CSG's and Care Groups, the Health Board has launched its Listening and Learning Framework in September 2022. This demonstrates how learning will be identified, triangulated, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce. September 2021 Update - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk is working with peers across NHS Wales to develop Level 1 - 3 Risk Training packages available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. An extension to the implementation date is requested to allow for the launch to coincide with the training packages being made available on E-Learning on an All Wales Basis. The Health Board is working with All Wales colleagues to ensure a consistent approach to risk is adopted and transferable across Wales. November 2021 - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk continues to work on an All Wales basis to develop Level 1 - 3 Risk Training packages available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. Update The TNA and development of an All Wales Risk Management Training package has been placed on hold whilst the Once For Wales Risk Management Module is finalised. The rationale for this decision is to ensure that any training developed is aligned to the new module that staff will be expected to use. The Health Board is represented on the Once For Wales Monthly Meetings and the more regular task and finish group meetings. In the meantime, risk management training continues within the Health Board with monthly sessions being held virtually over Teams. April 2022 Update - The implementation of the Once For Wales Risk Module within the Health Board is anticipated circa October 2022, with two pilot sites going live from the 1st April 2022. The All Wales Training Modules are being developed to align with the new approach and timescales. The TNA has been finalised and Module 1 of the training is in draft. Progress is monitored via the OFW Risk Module Meetings and the All Wales Risk Community of Practice for which the Assistant Director of Governance & Risk is a member. June 2022 Update - On track. Risk Training continues to be rolled out to service areas on a monthly basis in partnership with ILG colleagues. August 2022 September 2021 Update - The Assistant Director of Governance Risk represents the Health Board on the All Wales working group for the new risk module and will review the risk management system and processes to align with the new system as it develops. Update November 2021 - No further update provided. January 2022 The Once For Wales Risk Management system is likely to be piloted in two sites prior to implementation across NHS Wales as a whole. As the Health Board is implementing the Incident Module in April 2022 it is anticipated that the OFW Risk Module will be implemented in the Health Board by the end of October 2022. An implementation plan will be developed in conjunction with the Health Board's internal Datix Team. The Health Board is represented on the Once For Wales Monthly Meetings and the more regular task and finish group meetings by the Assistant Director of Governance & Risk. April 2022 Update - The implementation of the Once For Wales Risk Module within the Health Board is anticipated circa October 2022, with two pilot sites going live from the 1st April 2022. The Health Board is represented on the relevant groups by the Assistant Director of Governance & Risk. June 2022 Update - Progressing on an All Wales basis. Implementation dependent on roll-out of risk module in Once for Wales. August 2022 Update - Please refer to the update in R10.1 in relation to the position on the OFW Risk Module Implementation. In the absence of the new module the Health Board continues to mandate the currently risk module available via Datix for the management of Risk as outlined in the Health Boards Risk Management Policy, Strategy and Procedure. Within those documents is the clear process for assessing risk and escalation. October 2022 Update - The recommendation has been aligned to the implementation of the Datix Current Risk Module to ensure that any training module
Audit Wales/HI W Quality Governance Follow Up Review R10.4	Aug-21	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	High	An efficient risk management process which is seen as efficient and not cumbersome - linked to the new Once For Wales Risk Management System.	Director of Corporate Governance	Assistant Director of Governance & Risk	Apr-22	Now October 2021 Now 31 December 2022 Now 31 March 2023 Now 31 October 2023	In Progress		April 2023 Update - This recommendation remains linked to the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. 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Implementation dependent on roll-out of risk module in Once for Wales. August 2022 Update - Please refer to the update in R10.1 in relation to the position on the OFW Risk Module Implementation. In the absence of the new module the Health Board continues to mandate the currently risk module available via Datix for the management of Risk as outlined in the Health Boards Risk Management Policy, Strategy and Procedure. Within those documents is the clear process for assessing risk and escalation. October 2022 Update - The recommendation has been aligned to the implementation of the Datix Current Risk Module to ensure that any training module

CTM
Internal
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Red -
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Yellow -
Green -
Blue - Action

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
Audit Wales/Hi W Quality Governance Follow Up Review R1.6	Aug-21	The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.	High	Review all backlog incidents to eliminate duplicates and ensure correctly identified/categorised.	Director of Nursing		Oct-21	Now 31 August 2022 Now December 2022 Now January 2023 Now May 2023	In Progress		April 2023 Update - recommendation: Incomplete, open/yellow. The exercise to close down all outstanding incidents within the Health Board's Datix Legacy System remains ongoing. All incidents have had an initial review and the investigation being is concluded for the remaining incidents which relate to delays and admission. In relation to Datix Cymru a data validation and audit programme has been drafted, which will be presented to the Datix Management Group for ratification on the 24.04.23. An update report will be presented to Quality & Safety Committee on the 24.05.23 in relation to incident reporting and management within Datix Cymru.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update Patient Safety team have undertaken a review of all of the backlog of incident and risk stratified incidents of a serious nature as a priority for actioning. ILG Head of Quality & Patient Safety are now responsible for ensuring that the backlog of incidents are reduced; monitoring of the backlog of incidents is through the weekly Executive Director led Patient Safety meeting by means of the 'Quality & Safety At A Glance' report. April 22 - the central PS team are undertaking risk stratification, data cleansing, reassignment and housekeeping to closure of historic open serious incidents. This work has been completed within maternity and neonatal services. It is anticipated that the central team will work with the ILG governance teams to establish quality assurance and closure panels to ensure that all SI's are investigated and patients engaged with as well as any learning and PTR considerations are managed appropriately. June 2022 Update - The Datix Team are supporting the ILGs to review and close down outstanding incidents within the Health Boards Legacy system. A batch update exercise was completed on the 07.06.22 based on strict set of criteria and following a robust assessment of risk. Further work is being undertaken to identify areas of high risk that require additional targeted support and those that be included in themed closure. Reports are provided on a weekly basis providing detail on the number of open incidents by Locality, service group and handler. July 2022 Update A further batch updating of incidents within the legacy system was completed 14.07.22 based on a strict risk assessed criteria. Support continues to be provided to all areas in relation to open incidents both in the Health Board's legacy system and Datix Cymru. Weekly reports are provided to all areas in relation to their open incidents. October 2022 update: Incidents identified as requiring data migration are in the process of being migrated across to Datix Cymru. Further assessment will be undertaken on the 01.08.22 to determine the level of risk associated with those open incidents remaining in the system. Assessment undertaken on 01.08.22 and outlined in updated SBAR Report. Batch update undertaken on the 16.08.22 based on criteria outlined in SBAR report agreed by Exec Team 15.08.22. The remaining incidents require individual review. A process is in place for those relating to maternity. December 2022 Update - There are no incidents within the holding area of the Health Board's legacy system. A small number remain
Audit Wales/Hi W Quality Governance Follow Up Review R14.5	Aug-21	The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	High	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Director of Nursing		Sep-21	Now December 2021 No revised date for completion provided - currently in discussion Now March 2023	Part Completed		April 2023 Update-Listening and learning framework developed. The first listening and learning event held in September 2022. The next Listening and Learning event is planned for May 2023. The learning repository is in its infancy, set up and being further developed. The showcasing of the repository will continue as part of the care group engagement program on the quality and safety framework during April 2023. PREMS & CIVICA April 2023-Update the team continue to engage with specialities to look at bespoke surveys and to promote training with staff to embed across the HB. Work is ongoing to look at how we can implement SMS messaging for the ED departments. SMS messaging is constricted at present due to IT infrastructure and the capacity to implement across the Health Board. Volunteer patient feedback team continue to support gaining of feedback within POW and volunteer team are working to increase teams available to develop this across to RGH and PCH. VBHC Admin support is also helping to support the input of paper copies of "Have Your Say" into the system and the creation of surveys. VBHC has just recruited a B6 PM who can also provide support for communication and engagement e.g. webpage, leaflets, events etc. Still awaiting the finance issue of Civica to be resolved to enable VBHC team to take over that aspects moving forward.	September 2021 Update - PREMS fully operational across maternity services. CIVICA PM appointed and produced timeline for roll out within CTM. 'Have your Say' generic people's feedback being placed as a link on the CTMUHB Intranet page. Plan for Draft People's Engagement document by December 2021. November 2021 - No further update provided. Jan 2022 update- Have successfully implemented 7x surveys for maternity, Have your say & patient experience survey across CTMUHB, 1x Heart Failure survey and 2x paediatrics surveys. Currently in the process of implementing surveys for therapies, pathology and frailty nurse services within Feb. Actively scoping out surveys within: Cancer services, community resource team, critical care HDU/ITU, audiology, mental health, primary care, facilities, gynaecology, community dental services, endoscopy, wellness hub and haematology. "Have your say" card has been replicated in electronic format and optional all wales survey attached, qtr. codes and posters on display across HB sites and on social media pages. Further exploration of SMS automation of surveys being explored but limited at present due to IT resource issues to support implementation. Delays have been seen due to COVID-19. April 2022-Update The Health Board launched the electronic "Have your Say" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. They will be made available to staff that are providing services in patient's homes. Exploration is taking place as to how the posters/cards can be promoted within the wider non-health board community settings. From the 28.02.22, within the Bridgend and Merthyr & Cynon Localities, the PALS team are actively engaging with patients/ service users to promote the completion of the "have your say" cards and generic survey. This is through paper copies being available in areas, which are collated and uploaded on to the system on a monthly basis. Along side this, within Merthyr & Cynon PALS Officers are present with Emergency Department at PCH and outpatients at YCC to capture feedback via iPADS. The number of area specific surveys continues to increase, with Staff engaging with patients and service users via links, QR codes and iPADS. June 2022 update- Work continues to promote the CIVICA system with patients and staff via social media and intranet pages. A banner is being developed and will be located around CTM with a link to the "Have your say" survey and QR code. A WREM survey has been developed to evaluate the system with staff and the benefits of the system to the HB. Number of specialities engaging with the team to explore the use of the system is increasing and drop in sessions for staff are planned for June/July
Audit Wales/Hi W Quality Governance Follow Up Review R14.13	Aug-21	The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	High	Work being undertaken with Improvement Cymru to scope work to develop and deploy a model ward and operational best practice guide to improve flow, quality and patient safety.	Director of Nursing		Jul-21	Now October 2021 Now March 2022 Now April 2023	Completed		April 2023 Update, Recommendation, closure. Welsh nursing care records are now rolled out across CTM including POW. Whiteboards and AMAT ward assurance are also in progress. Work is now being undertaken as part of 6 goals work stream. Recommendation this be closed as complete as being captured and advanced through other major work streams	SEPT 2021 UPDATE - Work continuing with IC, action detail reviewed after HIW inspection in Sept 21 requiring review of scope of work and delivery plan. UPDATE Nov 21. Head of Professional Standards leading a project to work with ILG governance leads and ILG Nurse directors to produce a ward/departement assurance framework. This will include ward assurance audits, annual audit cycle, single point of data capture and reporting. Also will scope most appropriate IT programme available. Paper to be presented at Q&S committee March 2022. January 2022 update As part of the PCH Improvement Programme we have implemented a ward assurance framework and tested across all In-Patients wards on PCH. This information is now captured electronically on the AMaT system. Following the successful implementation of the ward assurance framework the same will now be rolled out across the organisation. August 2022 Update - No update received during this period October 2022 update - By way of establishing a baseline, a scoping exercise was undertaken during June 2022 across all clinical areas, which includes Paediatrics, all Adult in patient wards and maternity, where 6 standardised templates were used and the data inputted into AMaT • Agreement to continue the 6 core audits evaluated and input data onto AMAT to provide ongoing assurance. • Continue the CTM Ward Assurance project group to provide a governance framework regarding the development and implementation of new audits, ensuring consistency and validation • Implementation of the Safe care digital platform across CTM September 2021 Update - A baseline assessment against the ACSA standards being undertaken. This will then form the basis of the improvement programmes to develop the service. Completion of process and ACSA accreditation aim July 2024 (usual process 2 years expected from RCOA). Expectation for POW to follow however with theatre changes this will be difficult to complete. November 2021 Update - Theatre improvement programme has been established. April 2022 update - awaiting agreement on a standardised set of HB wide emergency department audits by the nursing unit and identification of a resource to support the Ward and Area module rollout, currently paused. June 2022 Update - on target for completion by July 2024. July 2022 Update - On track for completion July 2024. October 2022 Update - Remains in progress for completion by July 2024. December 2022 Update - On track for July 2024 completion. February 2023 Update - no update received on this project January 2022 update 170 patients have been reviewed using the Nosocomial Framework; Welsh Government (WG) and the Delivery Unit are keen to ensure a level of consistency across Wales in relation to the investigation process of Nosocomial transmissions; several workshops have taken place with attendance including both the Nurse & Medical Directors in order to agree a unified approach; there is a hold on the current process as Welsh Government have agreed to provide health boards with funding to expedite the Nosocomial review investigations; health boards are currently waiting the allocation from WG. Quality & Safety Committee receive regular updates on the health boards position in relation to Nosocomial transmission reviews and the agreed unified approach. April 2022-update - Funding allocation received from WG to support the roll out of the Nosocomial reviews. A Lead Investigator is now in post and several other roles are currently being recruited to. Local Governance forum to be developed to track progress which will be reported into the monthly DU & Strategic Board meetings. The investigation process is likely to take 2 years as there are over 3000 reviews to be undertaken. Quality & Safety Committee will continue to receive regular updates. This work is being led by RTE ILG Nurse Director Carole Tookey and supported by the Patient Care & Safety central team. August 2022 Update - November 2021 Update - The Nosocomial Framework is a Patient Safety project that aims to reduce the risk of hospital-acquired infections (HAIs) and improve patient safety. The project is currently in progress and is expected to be completed by July 2024. October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion. February 2023 Update - Will be implemented at year end
Audit Wales/Hi W Quality Governance Follow Up Review R14.13	Aug-21	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.	High	Undertake audit of compliance against Royal College of Anaesthesia (RCOA) Standards (ACSA process) identify and develop standards to meet with RCOA recommended GPICS (set standards by RCOA for Anaesthetic services) baseline and inform continuous improvement programmes and improve compliance against the standards.	Medical Director		Jul-24		In progress		April 2023 - No update received from the Team on this occasion	
Audit Wales/Hi W Quality Governance Follow Up Review R14.13	Dec-21	The Health Board has undertaken specific work in mortality and harm in relation to COVID-19. However, as with other Health Boards, it has yet to finalise a standard framework to support the assessment of direct and indirect harm associated with COVID-19. The Health Board should produce a framework for assessing both direct and indirect harm from COVID-19 and ensure that the framework and an accompanying report outlining key issues are monitored by appropriate operational, strategic groups and reported the Board or one of its committees.	Medium/Low	The Health Board received an updated version of the NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission on the 16th November 2021. The National Framework contains four options and the Health Board is currently considering the option it will choose to adopt and take forward to assess the harm associated with Covid-19. The chosen option will then be considered at the Strategic Leadership Group in December 2021 and the Quality & Safety Committee in January 2022. Reports will be received and monitored through the Strategic Leadership Group and the Quality & Safety Committee. Reports to the Board will be via the Quality & Safety Committee Highlight Report to Board.	Director of Nursing		31st January 2022	Now March 2022 Now April 2024	Completed		April 2023 Update Directors of nursing need to work with heads of quality to identify a clear process to manage back log and new cases coming forward as we move into care group model from 3rd April 2023. LOOK TO CLOSE THIS REC: AS CASES GOING THROUGH PANEL AND REDRESS	
Audit of Account Addendum 2021/22 R2	Aug-22	The Health Board should ensure that its related-party process is fully and properly applied to support the preparation of the 2022-23 financial statements.	Medium/Low	This was largely due to a transposition error between the reviewed working paper and the final document. We will ensure checks are made in future accounts.	Director of Finance		Apr-23		In Progress		April 2023 Update - Will be updated as part of year end accounts	
Audit of Accounts Addendum 2021/22 R5	Aug-22	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.	Medium/Low	A change in process for the completion of audit working papers caused a delay and a member of the finance team who left at the end of the financial year also caused some issues with submitting working papers. We will ensure that audit deliverables are clearly communicated and deadlines for submission kept.	Director of Finance		Apr-23		In Progress		April 2023 Update - Will be updated as part of year end accounts	October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion. February 2023 Update - Will be implemented at year end
Audit of Accounts Addendum 2021/22 R6	Aug-22	The Health Board should ensure that all financial returns are made available by the Welsh Government deadlines and that the figures in the financial statements agree to those returns.	Medium/Low	This was an oversight on the return. We will ensure checks are made that all returns are fully completed.	Director of Finance		Apr-23		In Progress		April 2023 Update - Will be updated as part of year end accounts	October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion. February 2023 Update - Will be implemented at year end
Audit of Accounts Addendum 2021/22 R10	Aug-22	Wherever possible, the Health Board should ensure that all Excel-based working papers include formulae and cell references which will provide a clearer audit trail.	Medium/Low	We encourage where possible to link working papers to source documentation and not hard code. We will reinforce this for the accounts in 2022/23.	Director of Finance		Apr-23		In Progress		April 2023 Update - Will be updated as part of year end accounts	October 2022 Update - Will be completed when draft accounts prepared in April 2023. December 2022 Update - On track for April 2023 completion. February 2023 Update - Will be implemented at year end
Audit of Accounts Addendum 2021/22 R11	Aug-22	The Health Board should update its Medical Pay Financial Control Procedure to reflect the current process	High	This is being updated in line with other FCPs, it will go to Audit & Risk Committee for approval.	Director of Finance		Oct-22	Now December 2022 Now April 2023	In Progress		April 2023 Update - The Medical Variable Pay has been updated and circulated for comment. We are awaiting confirmation of the agreed rate card to include before finalising and submission to Audit & Risk Committee for approval.	October 2022 Update - A draft FCP has been updated and is currently being circulated for review and comment before being brought to the Audit & Risk Committee for sign off in December. December 2022 Update - Out for comment and review. On track for December 2022 completion. February 2023 Update - Awaiting the completion of an internal audit review of the area prior to updating the FCP. The review has been completed and the report is currently in draft stage, and should be finalised shortly. We will then work with the workforce team to update the FCPs accordingly.

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
Equality Impact Assessments R4	Nov-22	Reviewing public bodies' current approach for conducting EIAs: While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.		CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSED. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	Director for People	EDI Practitioner	Mar-23	Now May 2023		In Progress	April 2023 Update - A draft EQIA form has been shared with IT to build into a digital tool. Once the screening tool is ready, need to test with the key stakeholder group (subject to IT ideally April/May2023). Currently developing a video explaining revised form and supplementary guidance docs.	December 2022 update - A Working Group has been established to inform the review, with representation from key stakeholders. A benchmarking exercise against other NHS organisations is underway to gauge current best practices and whether an integrated assessment is needed. The possibility of a digitised assessment tool is being explored to allow for robust auditing processes. February 2023 Update - The working group met on 12/01/23 to process map the current process and identify slippage and pressure points. The Improvement and Innovation Team are currently mapping a reviewed process and initial conversations are underway to explore the digitisation of EIA forms.
Transformational Leadership Programme Board - Baseline Governance Review R1	Dec-22	Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: a) taking a longer-term approach to its planning beyond five years, b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.		Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners	Director of Strategy & Transformation	Head of Regional Collaborative Unit	31 March 2023			In Progress	April 2023 - No update received from the Team on this occasion	February 2023 - No further update. Ongoing action
Transformational Leadership Programme Board - Baseline Governance Review R1	Dec-22	Performance Management The outcomes and performance framework was still being finalised at the time of our review. The TLPB needs to finalise and implement the framework, ensuring it contains quantitative and qualitative measures that will enable the RPB to demonstrate outcomes and impact.		Agreed. Work is ongoing in relation to the performance framework in support of the new delivery plan and this will also need to reflect changes arising from the population needs assessment	Director of Strategy & Transformation	Head of RCU	30 September 2022			In Progress	April 2023 - No update received from the Team on this occasion	February 2023 Update - the outcomes and performance framework is still being finalised
Transformational Leadership Programme Board - Baseline Governance Review R1	Dec-22	Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated		Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	April 2023 - No update received from the Team on this occasion	February 2023 Update - no update provided on this occasion
Transformational Leadership Programme Board - Baseline Governance Review R1	Dec-22	Regional Commissioning Unit Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team.		Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Director of Strategy & Transformation	Head of RCU	31 December 2022			In Progress	April 2023 - No update received from the Team on this occasion	February 2023 Update - no further update, ongoing action
Transformational Leadership Programme Board - Baseline Governance Review R1	Dec-22	Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core		Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	April 2023 - No update received from the Team on this occasion	February 2023 Update - ongoing action as currently in the planning cycle so this work is being taken forward.
Transformational Leadership Programme Board - Baseline Governance Review R1	Dec-22	Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities		Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	April 2023 - No update received from the Team on this occasion	February 2023 Update - needs to be established as part of agenda/working arrangements under the ILB
YCC MIU R1	Feb-23	Our work has found shortcomings in the managerial oversight arrangements of the MIU at YCC. In order to assure itself that these issues are not widespread across the organisation, the Health Board should review the managerial oversight arrangements of services which are staffed by the Health Board but operate remotely to ensure they are sufficiently robust and effective. The findings of the review should be reported to the Quality and Safety Committee to provide the required assurances.		The Health Board (HB) has now completed the initial phase of operational restructure resulting in a care group model encompassing services delivered across the HB. As a result, services delivered outside of the three acute sites have been incorporated to care groups relevant to the speciality and service being delivered. Structural adjustment to the service reporting lines such as the Minor Injury service across the HB being managed by and reporting to the Unscheduled Care Group. It is through this reporting method; the care groups will seek to monitor and respond to operational and clinical governance matters whilst also providing the organisation and the Board with the appropriate assurances.	Director of Nursing		Completed			Completed		
YCC MIU R2	Feb-23	Our work has highlighted concerns with the Health Board's competency-based training arrangements at the MIU. In order to assure itself that these issues are not widespread across the organisation, the Health Board should undertake a review of its competency based training arrangements (at the MIU and across the wider organisation) to ensure: a) effective policies and procedures are in place to support staff to complete all relevant competency based training in a timely manner; b) competencies requiring assessment are assessed by qualified assessors in a timely manner; and c) evidence of competency-based training completed by staff is recorded appropriately; and d) competency-based training completion rates are monitored and reviewed on a regular basis by the relevant management teams; and e) The findings of the review should be reported to the Quality and Safety Committee to provide the required assurances		a) Competency based training has been established against the national training arrangements for minor injury practitioner utilising the framework provided through Agored Cymru. Current and new practitioners now practice on a rotation basis across the community hospital and acute hospital sites to ensure adequate supervision and maximum training opportunities. This process is being led by the Senior Nurse and Advanced Nurse Practitioner for Professional Development (COMPLETED). b) The HB has now established the appropriate number of appropriately trained assessors across minor injury units and hospital sites. This has been further enabled through the adjustment in the educational leadership model as well as the implementation of the HB wide care group structure (COMPLETED). c) Through the leadership of the Senior Nurse for professional development, the management teams can monitor the progress of training of new trainee practitioners as well as the continued development of established practitioners (COMPLETED). d) With the formation of the Unscheduled Care Group (USCG), urgent care service leaders are currently reviewing a model of assurance and learning on all aspects of emergency care innovation and education across the HB. During this transitional phase, each local leadership team now has dedicated Practice Development Nurses working with the Senior Nurse for Professional Development to ensure local compliance and escalations where required (APRIL 2023). e) As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee in March 2023 (MARCH 2023)	Director of Nursing	Unscheduled Care Director of Nursing/Unscheduled Care Medical Director/	R2d April 2023 R2e March 2023			Completed	April 2023 Update - The staff based learning from the MIU closure has been developed into a robust action plan led by Senior Nurse for professional development which is a recently appointed to post. The appointed post holder is an ENP by background and an agreed assessor which is the recognised training diploma for ENP's - and was recognised as a gap in the Audit Wales report. This information was shared via a spotlight report to Quality and Safety committee on 16th march 2023. There are training plans in place to support the relevant MIU staff to complete the Level 7 Diploma and maintain their ongoing evidence of practice and to support Emergency Medicine Consultants and Advanced Practitioners to become Registered Agored Cymru Assessors. There is established oversight and management arrangements for MIU staff via ED senior nurse, lead nurse, head of nursing and the ED Clinical Director Work is currently ongoing to review MIU staffing arrangements, including the skill mix and ENP development roles - of the 4.8 WTE Audit wales were informed we were recruiting to - we have successfully appointed to all posts. PDR compliance is currently at 100% and a trajectory to achieve 85% compliance with statutory and mandatory training within next 3 months via a supportive approach to learning and development Significant improvements have been implemented since the report was published and since the MIU re-opened they are successfully seeing, treating and discharging up to 50 patients a day. this update was shared at Quality and Safety Committee on Wednesday 16th March 2023.	
YCC MIU R3	Feb-23	Our work has found that staff in the MIU did not have up-to-date performance appraisals. However, there is also a similar picture across the Health Board. The Health Board, therefore, need to agree a range of appropriate actions to improve compliance rates across the organisation. The People and Culture Committee should continue to monitor compliance rates and provide effective challenge when the Health Board is failing to demonstrate ongoing improvement.		The Health Board recognises the importance of PADR and the impact it has on employee development, performance and wellbeing. The Health Board has revised its Appraisal process and through the introduction of 'PDR: Your Conversation' it has placed increased emphasis on the importance of values and Behaviours and staff wellbeing at the heart of the conversation. PADR compliance is included in the suite of metrics that is reported to People and Culture Committee as a regular agenda item and provides an opportunity to scrutinise the trend data and performance. The data is also shared with Care Groups and Corporate Directorates to enable improvement plans to be developed and monitored. A Communications and Engagement plan is being launched in February by the Learning and Development department which will include a mix of written guidance and video presentations to reinvigorate PDR and other core learning and improve performance. Bespoke training is also available for teams. Current and new practitioners now practice on a rotation basis across the community hospital and acute hospital sites to ensure adequate supervision and maximum training opportunities. In reporting to the USCG, each local acute site emergency department leadership team is responsible for the support and development of staff and practitioners across the department and respective unit. The USCG Director of Nursing is to present to the People and Culture Committee this financial year on the current arrangement and feedback as well as future care group plans	Director of Nursing	Director for People/Deputy Director for People/Unscheduled Care Group Directors/Unscheduled Care Group Director of Nursing	February 2023/March 2023			Completed	April 2023 Update - Recommendation: complete, closed/green. Where the action is pertaining to YCC MIU, subsequent data supports compliance and should be considered closed. Information has been reported through both People & Culture committees as well as the Quality and Safety Committee. Risks associated more broadly in regards to mandatory training and appraisal standards are captured to appropriately aligned risks and reporting mechanisms through care group performance.	

Ref	Date added	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Previous Updates
YCC MIU R4	Feb-23	Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm		As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year. Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24.	Director of Nursing	Unscheduled Care Group Director of Nursing/ Unscheduled Care Group Directors	March 2023/May 2023			Completed	April 2023 Update. Recommendation: complete, closed/green. A presentation to the Quality and Safety Committee in March 2023 by USC Nurse Director.	
CTMSB SLA Review R1	Feb-23	We observed good scrutiny by the commissioning and contracting group. However, there was a significant agenda which was challenging to cover in the allotted meeting time and there was a lack of operational and clinical representation. The health boards should: - Review the time allotted to meetings, or review the content of the agenda to ensure that agenda items can receive sufficient discussions; and - Ensure appropriate membership at the group so that issues from operational and clinical staff are raised.		At the time the review was undertaken there was a significant amount of disaggregation's being worked through as well as operational/ contractual issues. The frequency of the meetings was increased from monthly to three weekly in order to accommodate the large agenda. This appears to have stabilised meaning that the agenda is more manageable and at the meeting on 11/10/22 the group considered reverting back to monthly meetings or keep to three weekly but reduce the meeting to 1 hour. Services are invited to attend the C&C meetings to discuss cessations or operational issues. At least 30 minutes of the meeting is dedicated to the service discussion. The last service to attend a C&C meeting was Pathology in August 2022. C&C members also attend the service to service meetings and report back to C&C on the outcomes of the meetings. Due to the significant amount of SLAs in place which covers numerous services, it would be extremely challenging to gain operational/ clinical representation at every C&C meeting and attending the meetings is not a good use of colleague's clinical time. All service to service meetings include both operational and clinical staff and this arrangement appears to be working.	Director of Strategy & Transformation	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)	Nov-22			In Progress	April 2023 - No update received from the Team on this occasion	
CTMSB SLA Review R2	Feb-23	Up until recently, there has been no plan for the disaggregation of services and oversight and scrutiny at Board and Committee level has been lacking. A plan for 2022-23 is now in place but oversight still needs to be improved. The health boards should: - Develop a programme with clear timescales for the future disaggregation of services, where appropriate, that goes beyond 2022-23. The programme needs to be informed by the respective health board clinical service plans and communicated within the health boards, including clinical staff. - Use the plan to facilitate monitoring of delivery and increase the level of oversight of the disaggregation programme through the relevant Board and Committee structures within both health boards.		The disaggregation plan for 2022-23 incorporates a plan into the next financial year as it is recognised that most cessations are still in the planning stage and that cessation dates are still to be agreed once the due diligence has been completed. - Exercise to be undertaken with all services to categories SLAs into the following categories as this will inform work plan over the next few years: - Short term disaggregation before end of March 2024 - Plan to medium term disaggregation between 2 and maximum of 5 years - Long term service and contractual relationships to be maintained between the two Health Boards on a partnership basis with no intent of disaggregating - Revised disaggregation plan to be signed off by Joint Management Group which includes a 5 year work programme. Progress against the work plan to be reported through SBU's Performance & Finance Committee and through CTMUHB's Planning Performance and Finance Committee and Board. This is in place –the PPF committee received a full progress update on 25th October 2022 and will continue to receive reports at 6 monthly intervals	Director of Strategy & Transformation	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)/ Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)	January 2023/March 2023			In Progress	April 2023 - No update received from the Team on this occasion	
CTMSB SLA Review R3	Feb-23	Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.		Changes in patient flows and impact on patients is addressed in the cessation paperwork and is always discussed as part of the disaggregation discussions. Equality Impact Assessments have started to be completed for the cessation of the Clinical Capacity SLAs in NPTH as the changes will impact on patient flow and access to services. However, there is not enough corporate resource to complete a detailed impact assessment for each SLA cessation and in most cases the impact is not necessary as there is no change in patient flow. The Community Health Councils are kept up to date on all cessations and detailed engagement is undertaken where changes will affect patient flow.	Director of Strategy & Transformation	Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)	Nov-22			In Progress	April 2023 - No update received from the Team on this occasion	
CTMSB SLA Review R4	Feb-23	Our work identified that there was no clear link between the risk registers managed by the commissioning and contracting group to the health board risk registers. The health boards should review the risk management process associated with the transition so that risks are linked and reflected in individual health board corporate risk registers.		Clinical risk matrix has been developed and is completed as part of the disaggregation process. The risk score is highlighted to Joint Management Group and Joint Executive Group through the slide deck. However, the risk register for the programme needs to be reviewed and there needs to be a stronger link between the risk register for the programme and the corporate risk registers. Process to be developed outlining how service risks are linked with the CTMU and SBU risk registers.	Director of Strategy & Transformation	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)	Mar-23			In Progress	April 2023 - No update received from the Team on this occasion	



AGENDA ITEM

5.3.1

AUDIT & RISK COMMITTEE

CONSULTANT JOB PLANNING – PROGRESS REPORT

Date of meeting	19/04/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Dr Nerys Conway, Assistant Medical Director for Medical Workforce

Presented by	Dr Dom Hurford, Executive Medical Director

Approving Executive Sponsor	Executive Medical Director

Report purpose	FOR NOTING

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

ACRONYMS	
ABUHB	Aneurin Bevan University Health Board
ADH	Additional duty hours
AMD	Assistant Medical Director



BMA	British Medical Association
CAVUHB	Cardiff and the Vale University Health Board
CTM	Cwm Taf Morgannwg
DCC	Direct Clinical Care
ILG	Integrated Locality Group
LNC	Local Negotiating Committee
NWSSP	NHS Wales Shared Services
PTHB	Powys Teaching Health Board
SAS	Specialty & Associate Specialist
SPA	Supporting Professional Activities
UHB	University Health Board

1. SITUATION/BACKGROUND

- 1.1 The purpose of this paper is to provide the Audit & Risk Committee with an update on the progress around job planning.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING – INTERNAL AUDIT REPORT FINDINGS 1-7

2.1 Job plan completion and sign-off

- Job planning is a contractual requirement that need to be completed and signed off by Consultant and SAS Doctors.
- Signed-off job plans currently stand at 44% for consultants and SAS doctors. (This is an increase from 33% at the last audit and risk committee).
- The Care Group Medical Directors have a responsibility to allocate and ensure that the job planning process is being completed appropriately within their Care Group. The Care Groups are in the process of appointing Clinical Directors who will be instrumental in ensuring that job planning is completed.
- There is a new SPA document guide for Consultants and one in its final stages for SAS Doctors.
- Two job planning workshops took place in January for Consultants and SAS Doctors. This was led by the AMD for Medical Workforce in collaboration with Christopher Saunders from the BMA. The aim was to engage the

workforce around the process of job planning including the benefits to them as individuals and their specialties.

- An automatic job plan sign off reminder is now sent to colleagues who have completed but not signed off their job plans.
- A job plan checklist and proforma is being prepared by the AMD for Medical Workforce to ensure equity and parity with the job planning process.

2.2 Weekly number of sessions, activities and outcomes

- Development of a SPA policy document was required to standardise the approach across the UHB for SPA and DCC split, to ensure fairness and equity. This document has been distributed to Consultants within CTM and a draft SAS version is in its final stages with our LNC.

2.3 Clear personal outcomes within the job plan

- As part of the job planning training, clear personal outcomes will be factored into the process and are now recorded in new job plans. The training that has been rolled out across the UHB has covered this area. The job plans have clear outcomes regarding the site where the activity is to be undertaken, the type and duration of activity, and clarity around whether the activity constitutes a DCC or a SPA.
- However, further work is needed to quantify the specific amount of the clinical activity that is expected from the specified duration of the DCC.
- The new SPA document deals with ways of seeking objective evidence of the activity undertaken as an SPA.

2.4 Additional Duty Hours (ADH)

- There is work currently taking place looking at a regional rate card in collaboration with all other Welsh NHS Organisations. This work is being led by NWSSP.
- Whilst this work is ongoing we are discussing with finance colleagues about a possible in house rate card for non-Consultant CTM staff. This is in its infancy of discussion. A consultant rate card requires further work and analysis.
- Of note there has been a recent rate card released by the BMA in Wales and England for junior Doctors, SAS and Consultants. These rates are not sustainable or affordable by CTM. As a result engagement events have been held by the AMD for Medical Workforce to all junior doctor messes and with the wider Medical Workforce.

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

3.1 None.



4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Correct and current job plans allows for better planning around staff levels and DCC sessions. This has a direct impact on quality, safety and experience.
Related Health and Care standard(s)	Staff and Resources
	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.
Legal implications / impact	Not required
	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are requested to **NOTE** the report and the update provided.



AGENDA ITEM

5.3.2

AUDIT & RISK COMMITTEE

MEDICAL ROSTERING – PROGRESS REPORT

Date of meeting

19/04/2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Paul Harrison Head of Workforce Productivity and eSystems, Nerys Conway Assistant Medical Director Medical Workforce

Presented by

Dom Hurford, Executive Medical Director

Approving Executive Sponsor

Executive Medical Director

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

AMD
BMA
ED
MD

Assistant Medical Director
British Medical Association
Emergency Department
Medical Director

1. SITUATION/BACKGROUND

- 1.1 The purpose of this paper is to give the committee an update on the progress achieved in relation to the audit report on Medical Rostering.

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

2.1 Recommendation 3.1

Responsible person: AMD for Workforce

"The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then be sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff."

Update – In progress

The policy has been updated and amended as recommended. The policy is now being processed through Policy Review Group.

The policy will then be taken to the next Local Negotiating Committee for noting and implementation.

2.2 Recommendation 3.2

Responsible person: Anaesthetics & Emergency Department (ED) roster managers

"For areas where the full roll out of Health Roster is not imminent, separate 'how to' guides on the local system used should be considered. The guides should include the step-by-step process for creating the rosters and also guides for users of the system, allowing consistency during unexpected periods of absence."

Update – In progress

No change.

How to guides are yet to be developed or shared by Anaesthetics or ED colleagues.

2.3 Recommendation 4.1

Responsible person: Executive Medical Director (MD)

"Management should ensure that the Study Leave policy is approved and circulated within the Health Board."

Update – Closed

The former Cwm Taf policy and the Swansea Bay policy have some key fundamental differences. The BMA have now stated that they do

not support the movement of all previous Swansea Bay employees to a Cwm Taf Morgannwg University Health Board policy. As the Transfer of Undertakings Protection of Employment (TUPE) rules apply to this, the UHB are unable to move these staff without agreement.

All staff who were previously Swansea Bay employees and were subject to TUPE, will be allowed to remain on the Swansea bay policy if they chose to do so.

All new employees start in the UHB, will be employed under a CTM wide policy.

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

There are no risks/matters for escalation to the Committee on this occasion.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Staff and Resources
	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.
Legal implications / impact	Not a policy
	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	
	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care



5. RECOMMENDATION

- 5.1 The Committee are requested to **NOTE** the report and the update provided.

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

Date issued: April 2023

Document reference:3313A2023

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About this document

- 1 This document provides the Audit and Risk Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board. We will present an Outline Audit Plan to the committee on 19 April 2023; and present a detailed Audit Plan at the subsequent meeting.
- 2 We also provide additional information on:
 - Other relevant examinations and studies published by the Audit General.
 - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Planned date for consideration
2022-23 Performance Report, Accountability Report and Financial Statements	Executive Director of Finance and Director of Corporate Governance	The statutory audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements, which are prepared and audited in accordance with the Welsh Government's 2022-23 'Manual for Accounts' guidance.	We have commenced audit planning.	To be considered by the Audit and Risk Committee on 26 July 2023 and by the Board on 27 July 2023; with the Auditor General certifying on 28 July.

2022-23 Charity Account.	Executive Director of Finance	The statutory audit of the Health Board's Charitable Funds Accounts.	Audit work not yet started	December 2023 / January 2024

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Review of the commissioning and contracting arrangements post Bridgend boundary change	Executive Director of Strategy and Transformation	This work examined the robustness of the arrangements for overseeing and managing the contractual agreements established following the Bridgend service transition in 2019. The work also considered the programme for service disaggregation (for relevant services), and whether the arrangements support future regional service models currently being explored by the organisations.	Completed	Considered December 2022

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Cwm Taf Morgannwg Health and Social Care Partnership - Transformation Leadership Programme Board	Executive Director of Strategy and Transformation	The review examined how the Transformation Leadership Programme Board arrangements are supporting the four bodies (Cwm Taf Morgannwg University Health Board, Rhondda Cynon Taf County Borough Council, Merthyr Tydfil County Borough Council and Bridgend County Borough Council) to develop effective and sustainable approaches to regional working.	Completed	Considered December 2022
Review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit (Local work 2022)	Executive Director of Nursing, Midwifery, and Patient Care	The high-level review examined the issues surrounding the temporary closure of the Minor Injuries Unit at Ysbyty Cwm Cynon.	Completed	Considered February 2023
Structured Assessment 2022	Executive Director of Corporate Governance	The review assessed the corporate arrangements in place at the Health Board in relation to: • Governance and leadership;	Completed	To be considered in April 2023

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		- Financial management; - Strategic planning; and - Managing the workforce, digital, resources, estates, and other physical assets.		
Orthopaedic services – follow up	Chief Operating Officer	This review examined the progress made in response to our 2015 recommendations. The findings from this work 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. Our findings have been summarised into a single national report with supplementary outputs setting out the local position for each health board.	Completed	To be considered in April 2023
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the	Fieldwork	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.		
Joint Review Follow up (Local work 2022)	Chief Executive	This work will examine the Health Board's progress in implementing the recommendations made in the Joint Review Report from 2019.	Fieldwork	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
All-Wales thematic on workforce planning arrangements	Executive Director of People	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Fieldwork	To be confirmed
Primary Care Services - Follow-up Review (Local Work 2023)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made several recommendations to the Health Board. This work will follow-up progress against these recommendations.	Planning	To be confirmed

Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

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

Title	Publication Date
<u>Digital Inclusion in Wales</u> and <u>Key questions for public bodies</u>	March 2023
<u>Orthopaedics Services in Wales – Tacking the Waiting list backlog</u>	March 2023
<u>Betsi Cadwaladr University Health Board – Review of Board Effectiveness</u>	February 2023
<u>Together we can – Community resilience and self-reliance</u>	January 2023
<u>A picture of Flood Risk Management</u>	December 2022
<u>'A Missed Opportunity' – Social Enterprises</u>	December 2022
<u>Poverty in Wales Data Tool</u>	November 2022
<u>Time for change – Poverty in Wales</u>	November 2022

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.
- 8 There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Audit Wales Annual Plan 2023-24	April 2023
Fee Scheme 2023-24	January 2023



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AGENDA ITEM

5.4.2

AUDIT & RISK COMMITTEE

CTMUHB STRUCTURED ASSESSMENT REPORT

Date of meeting

19th April 2023

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Cally Hamblyn, Assistant Director of Governance & Risk

Presented by

Cally Hamblyn, Assistant Director of Governance & Risk

Sara Utley, Audit Wales

Darren Griffiths, Audit Wales

Approving Executive Sponsor

Paul Mears, Chief Executive

Report purpose

FOR NOTING

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

Committee/Group/Individuals

Date

Outcome

Board Members via email

February 2023

FOR NOTING

Executive Leadership Group

13th March 2023

ENDORSE IN TERMS OF FACTUAL ACCURACY, TONE AND BALANCE

Health Board Meeting

30th March 2023

NOTED THE REPORT

ACRONYMS

CTMUHB

Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

- 1.1 Audit Wales undertake a structured assessment within the Health Board on an annual basis. The structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that the Health Board has made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under Section 61 of the Public Audit (Wales) Act 2004.
- 1.2 The Structured Assessment Report was received at the Board meeting on the 30th March 2023. At the time of presentation, the Organisational Response was not finalised and was therefore not considered by the Board. The Organisational Response is captured within the report presented to this Committee.

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

- 2.1 On receipt of the draft report, the Executive Leadership Team had the opportunity to provide feedback to Audit Wales on the factual accuracy, balance and tone of the Structured Assessment Report and any amendments were finalised under mutual agreement.
- 2.2 The report at Appendix 1 sets out the findings from the Auditor General's 2022 structured assessment work at CTMUHB. The Organisational Response highlights the Health Boards response to the findings and the improvement action it plans to take to address the recommendations.
- 2.3 Audit Wales have not reviewed the Health Board's quality governance arrangements as part of this work as this is subject to a separate review during 2023 of CTMUHB's progress in addressing the recommendations of the 2019 Joint Review of Quality Governance Arrangements, in conjunction with Healthcare Inspectorate Wales.

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

- 3.1 The 'Key Messages' and 'Recommendations' are captured on pages 4-8 of the report.
- 3.2 The recommendations will also be added to the Audit Tracker, which is routinely monitored by the Audit & Risk Committee through to closure.



4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Health Board can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.
Legal implications / impact	No
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

- 5.1 The Audit & Risk Committee are asked to **NOTE** CTMUHB's Structured Assessment Report 2022 and the Organisational Response to the recommendations.

Structured Assessment 2022 – Cwm Taf Morgannwg University Health Board

Audit year: 2022

Date issued: February 2023

Document reference: 3313A2023

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

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2022 structured assessment work at Cwm Taf Morgannwg University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.
- 2 Our 2022 Structured Assessment work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to the public and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.
- 3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. We have also provided updates on progress against recommendations identified in previous structured assessment reports.
- 4 The approach we adopted to deliver our work is detailed in **Appendix 1**.
- 5 We have not reviewed the Health Board's quality governance arrangements as part of this work. Instead, we will be undertaking a separate review during 2023 of the Health Board's progress in addressing the recommendations of our 2019 [Joint Review of Quality Governance Arrangements, jointly with Healthcare Inspectorate Wales](#).

Key messages

- 6 Overall, we found **that while the Health Board's corporate governance arrangements continue to develop and improve, it needs to strengthen its performance and financial management arrangements to fully address the challenges facing the organisation.**
- 7 The Health Board's arrangements support the effective conduct of Board and committee business. The Board remains committed to openness, but opportunities exist to improve the Health Board's administrative arrangements for ensuring public transparency of Board business. The Health Board is led by a relatively

stable Executive Team, and positive changes have been made to the role of the Director of Corporate Governance to allow them to focus exclusively on the Health Board's governance arrangements. Extensive work has been undertaken to develop and agree a new operating model for the organisation. However, it will take time for the new structures to embed and deliver the intended benefits and improvements. Overall, the Health Board's systems of assurance are improving. The Health Board has made positive progress in developing a new Board Assurance Framework, which it must now use to shape Board and committee business. Although the Health Board has effective arrangements for reporting performance to the Board, its performance remains the worst in Wales in a number of areas. The Health Board, therefore, needs to ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces, especially where performance in those areas is comparatively worse than other Health Boards in Wales.

- 8 The Health Board has made good progress in developing a long-term strategy for the organisation, which provides a clear framework for preparing its clinical strategy. Preparing a financially balanced and approvable Integrated Medium-Term Plan for 2023-26 is also a priority for the Health Board, as it failed to prepare a balanced and approvable three-year plan this year. The Board maintains effective oversight of the Health Board's approach to strategic planning, and there is good evidence of stakeholder engagement and involvement in the development of corporate plans and strategies. However, corporate plans and strategies generally lack measurable outcomes and clear summaries of key actions / deliverables, timescales, and measures which limits effective monitoring and reporting.
- 9 The Health Board has clear arrangements for financial planning and achieved its financial duties for 2021-22. However, the Health Board is unlikely to achieve its financial duties in 2022-23 due to growing cost pressures and challenges around delivering recurrent savings and containing expenditure. The Health Board, therefore, needs to review its financial management arrangements to fully address the risks to achieving financial sustainability in the short- and medium-term. The Health Board also needs to strengthen certain financial control procedures. Financial reports prepared for the Board are clear, comprehensive, and support effective monitoring and scrutiny. However, opportunities exist to enhance these reports further.
- 10 Supporting staff well-being is a clear priority for the Health Board. Whilst the Health Board's staff well-being offer is comprehensive, the organisation needs to provide greater assurances to the Board that the support provided is having a positive impact. The Health Board has a clear Digital Strategy in place, which it intends to refresh in the context of the new long-term strategy. In doing so, it must seek to address the staffing and funding challenges in this area to maximise the benefits of digital technologies and solutions. The Health Board does not currently have an Estates Strategy. Furthermore, Board-level arrangements for overseeing the condition of the estate and scrutinising capital programmes and projects require strengthening.

Recommendations

- 11 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's organisational response to these recommendations is summarised in **Appendix 2**.

Exhibit 1: 2022 recommendations

Improving administrative governance arrangements

- R1 We found opportunities for the Health Board to improve its administrative governance arrangements to enhance public transparency and support Board and committee effectiveness. The Health Board, therefore, should:
- a) publish the agendas of private Board and committee meetings;
 - b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner;
 - c) update report cover sheets to enable authors to better link their reports to the requirements of the Well-being of Future Generations (Wales) Act 2015; and
 - d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.

Using the Board Assurance Framework (BAF) to shape Board business

- R2 Although the Health Board has made positive progress in developing a BAF, it is not yet currently being used to shape Board and committee business. The Health Board, therefore, should actively use the BAF on an ongoing basis to shape and inform Board and committee work programmes.

Strengthening performance management arrangements

- R3 The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.

Establishing measurable outcomes for strategic priorities

- R4 The Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation. However, the new strategy (CTM 2030) currently lacks clear and measurable outcomes. The Health Board, therefore, should seek to accelerate the work of the CTM 2030 Steering Group and Strategy Groups in developing outcomes for each strategic priority, setting out what success would look like, and identifying how to measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.

Enhancing arrangements for monitoring delivery of corporate plans and strategies and reporting progress to the Board

- R5 We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring:
- a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting;
 - b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and
 - c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.

Strengthening financial management arrangements

- R6 We identified the need for the Health Board to improve its arrangements for containing expenditure and delivering savings. The Health Board, therefore, should review its arrangements to ensure there is sufficient grip and challenge at all levels of organisation on expenditure and savings delivery.

Strengthening financial controls

- R7 Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should:
- a) review the delegated upper financial limit for the Chief Executive;

- b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and
- c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions.

Enhancing financial reports to the Board

- R8 Whilst the Health Board has effective arrangements for reporting financial performance to the Board, we identified opportunities to enhance these reports further. The Health Board should:
- a) provide greater assurances that mitigating actions are in place to address key financial risks highlighted in the reports; and
 - b) report the financial performance of the new Care Groups at the earliest possibility.

Maximising the benefits of digital technologies and solutions

- R9 There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.

Strengthening Board-level oversight of estates issues and risks

- R10 There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should:
- a) ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee;
 - b) update the committee's Terms of Reference to reflect these responsibilities; and
 - c) establish a clear process for ensuring appropriate cross-referral of issues with the Quality and Safety Committee, which oversees health and safety matters.

Detailed report

Governance arrangements

- 12 In this section of the report, we provide our views on the Health Board's governance arrangements, with a particular focus on:
- Board and committee effectiveness;
 - the extent to which organisational design supports good governance; and
 - key systems of assurance.
- 13 Details of progress made on previous year recommendations relating to the Health Board's governance arrangements are provided in Exhibit 2.
- 14 We found that **the Health Board's governance and leadership arrangements are improving, and organisational structures are being refreshed to support further improvements. However, the Health Board needs to further strengthen its systems of assurance to fully address the performance challenges facing the organisation.**

Board and committee effectiveness

- 15 We considered the extent to which the Board and its committees conduct their business effectively and support good governance. In examining this, we have looked at whether:
- the Board and its committees demonstrate appropriate levels of public transparency;
 - meetings are conducted appropriately supported by clear Schemes of Delegation, Standing Orders, Standing Financial Instructions, and Registers of Interest;
 - there is an appropriate and well-functioning committee structure below the Board;
 - the Board and its committees receive the right information, including views from staff and service users; and
 - there is evidence of sufficient self-review by the Board and its committees.
- 16 We found that **the Board and its committee are generally effective, with evidence of good scrutiny, challenge, and self-reflection. However, opportunities exist to improve the Health Board's administrative arrangements for ensuring public transparency of Board business.**
- 17 The Board is committed to conducting its business in an open manner; however, opportunities exist to improve the Health Board's administrative arrangements for ensuring public transparency of Board business. All public Board meetings are live streamed to allow the public to observe virtually, with recordings made available on the Health Board's website. The Health Board, however, does not live-stream or record its committee meetings. Private Board and committee sessions are kept to a minimum, and reserved for confidential and sensitive matters only. However, the

agendas for private Board and committee meetings are not published with the public papers for meetings (**Recommendation 1a**). The Health Board circulates Board and committee papers to attendees in advance of meetings. However, our review of the website found that the Health Board:

- has not published the papers for some meetings. For example, there are no papers available for the Stakeholder Reference Group since December 2019, and the papers of the Audit and Risk Committee meeting held on 14 June 2022 are missing.
- has published incomplete sets papers for some meetings. For example, there are several papers missing for the Audit and Risk Committee meetings held in 2022, such as the routine updates provided by internal and external audit.

The Health Board should take action to address this to enable full transparency (**Recommendation 1b**).

- 18 The Health Board's governance arrangements support the effective conduct of Board and committee business. The Health Board appropriately reviews its Standing Orders, Schemes of Reservation and Delegation, Standards of Behaviour Policy, and Standing Financial Instructions on a frequent basis. However, opportunities exist to strengthen certain controls further (we discuss this further in **paragraph 68**). The Health Board has also prepared an assurance framework to help clarify its role and responsibilities in relation to the organisations it hosts¹. The Audit and Risk Committee regularly receives the Declarations of Interest, Gifts, Hospitality, and Sponsorship Register, which it last reviewed in December 2022. The Board Member Declarations of Interest Register is available on the Health Board's website.
- 19 The Health Board has a stable, skilled, and experienced cadre of Independent Members. We found that Independent and Executive Board members have a healthy relationship, which in turn facilitates informal and formal flows of information. We have also observed Independent Members offering a good balance of challenge and support in Board and committee meetings. At the time of our review, the Health Board was seeking to appoint a substantive Chair to replace the interim Chair in March 2023.
- 20 The Health Board has a stable committee structure, which is well embedded. Each committee has clear terms of reference, which appropriately reflect the majority of Health Board business. However, there is a gap in the Planning, Performance, and Finance Committee's terms of reference in relation to overseeing matters relating to the Health Board's estate (we discuss this further in **paragraph 88**). Committee chairs are actively involved in agenda setting and clear work programmes are set out. But opportunities exist to make greater use the new Board Assurance

¹ The Health Board hosts the Welsh Health Specialised Services Committee (WHSSC), the Emergency Ambulance Services Committee (EASC), and the National Imaging Academy Wales (NIAW).

Framework to shape committee business (we discuss this further in **paragraph 31**). Meetings are well chaired and run to time. Committee chairs meet regularly, and there is good cross-referral of issues between committees and escalation up to Board.

- 21 The Health Board prepares good quality papers for Board and committee meetings, which provide sufficient detail to enable scrutiny and decision making. Whilst report cover sheets are generally good, they could be more explicit on the links to the requirements of the Well-being of Future Generations (Wales) Act 2015 (**Recommendation 1c**). Also, whilst the Health Board has prepared a cover sheet to accompany presentations, it does not currently enable presenters to summarise information sufficiently or capture the relevant risks and issues (**Recommendation 1d**).
- 22 The Board demonstrates a good commitment to hearing from staff and patients. The Board and the Quality and Safety Committee receive a patient story at each meeting, which also includes feedback from staff. Walkarounds have also restarted, which provide good opportunities for Independent Members to engage directly with staff across primary, community, and acute services. The Health Board has also undertaken bespoke staff engagement work in specific areas, such as maternity services, with the results actively being used to shape the organisation's culture and leadership work programmes. The Board has also ensured that staff have been actively engaged in the development of the Health Board's new long-term strategy.
- 23 The Health Board has effective arrangements for Board and committee self-review and improvement. The Board and its committees assess their effectiveness on an annual basis and prepare action plans to address training needs and matters requiring improvement. The Health Board has made effective use of development sessions to support Board learning and development. These sessions have also been used during 2021-22 to support the development of the Board Assurance Framework and shape the long-term vision, strategic goals, and priorities for the organisation. The interim Chair has conducted Personal Development Reviews with all Independent Members and there is a buddying system in place to enable Independent Members to learn from each other.

Organisational leadership and design

- 24 We considered the extent to which the Health Board's organisational structure supports effective governance. In examining this, we have looked at whether:
 - the responsibilities of Executive Directors are clear, and that they have balanced and equitable portfolios of work;
 - there is clarity on the role of the Director of Corporate Governance (Board Secretary), and there are adequate resources in place to support the work of the Board and its committees; and

- the organisational structure supports effective governance and facilitates whole system working.

- 25 We found that **the Health Board is led by a relatively stable Executive Team, and positive changes have to the role of the Director of Corporate Governance to allow them to focus exclusively on the Health Board's governance arrangements. Whilst a new operating model has been agreed, it will take time for the new structures to embed and deliver the intended benefits and improvements.**
- 26 The Health Board has taken positive steps to strengthen and stabilise its Executive Team as well as to ensure that Executive Directors have clear responsibilities and balanced and equitable portfolios of work. A substantive Medical Director was appointed in July 2022, and a full time Director of Therapies and Health Sciences was appointed in April 2022 following the end of the fixed term joint appointment with Cardiff and Vale University Health Board. Appropriate interim arrangements have been put in place following the departures of the Director of Public Health and Director of Corporate Governance in November 2022. Recruitment to these posts was underway at the time of our review.
- 27 The Corporate Governance Team provides good support to the Board and its committees, despite not having a full complement of staff. The Health Board has revised the Director of Corporate Governance role following the departure of the previous postholder. As a result, operational responsibility for clinical audit and "Putting Things Right" (the management of concerns, redress, claims, and litigation) has been transferred to the Executive Director of Nursing. Positively, this will allow the new Director of Corporate Governance to focus exclusively on the Health Board's governance arrangements.
- 28 The Board approved the creation of a new operating model in March 2022 with the aim of:
- supporting post-pandemic recovery;
 - improving service quality;
 - streamlining management arrangements; and
 - facilitating joint-working across the Health Board.
- Under the new model, the Integrated Locality Groups have been replaced by new Health Board wide Care Groups². The new model retains locality working, but management and oversight will be undertaken at a Health Board level. The Health Board also plans to reorganise and realign its corporate functions to support the new operating model. The Board has maintained good oversight of the development and implementation of the new operating model. However, it will take

² There are six Care Groups in total: Planned Care Group; Unscheduled Care Group; Children and Families Care Group; Diagnostics, Therapies and Specialities Care Group; Mental Health and Learning Disabilities Care Group; and Primary and Community Care Group.

time for the new structures to embed and deliver the intended benefits and improvements.

Systems of assurance

- 29 We considered the extent to which the Board and its committees oversee, scrutinise, and challenge organisational risks, performance, and quality of services. In examining this, we have looked at whether:
- there is an effective Board Assurance Framework (BAF) in place, which is actively reviewed and owned by the Board;
 - the BAF is underpinned by appropriate systems for managing risks and performance, and handling information in a secure manner; and
 - effective action is taken to address audit and review findings and recommendations.
- 30 We found that **whilst the Health Board's systems of assurance are generally effective, it needs to strengthen its performance management arrangements to address current operational challenges.**
- 31 The Health Board has made positive progress in developing a Board Assurance Framework (BAF). The Board was actively involved in developing the BAF, before formally approving it in March 2022 (see **Exhibit 2, 2021 (Phase 2) R4**). The BAF appropriately reflects the Health Board's strategic goals and provides good information on gaps in controls and assurance, as well as mitigating actions. The Board receives and reviews the BAF at each public meeting. Whilst this is a positive development, the Health Board now needs to use the BAF to actively shape and inform Board and committee business (**Recommendation 2**).
- 32 The Health Board's risk management arrangements continue to evolve. The Board approved an updated Risk Management Strategy in March 2022, which is supported by comprehensive and up-to-date policies and procedures. The Health Board has continued to strengthen its organisational (corporate) risk register, and there is good evidence of risks being actively managed. However, there is scope to strengthen the risk mitigating actions. The Health Board has also taken positive steps to strengthen operational risk registers by including all risks on DATIX³, rather than risks scoring eight and above as was previously the case. The Executive Team has also realigned organisational risks to the new operating model, and work is underway to amalgamate and improve the content of operational risk registers. The Health Board has provided risk management training to over 360 members of staff, and will continue to offer this training throughout 2023 and beyond. The training commenced prior to the roll-out of the new operating model. Although it supports those staff changing roles and attending the

³ Datix is a web-based incident reporting and risk management system used by healthcare organisations.

training in their new structure, the training will continue beyond implementation of the model. It is also open to corporate / central teams.

- 33 Although the Health Board has effective arrangements for reporting performance to the Board, its performance remains the worst in Wales in a number of areas. The Board receives comprehensive reports on the Health Board's performance against the Welsh Government Performance Framework and other priority areas for the organisation. The reports are detailed and provide a good overview of the Health Board's position against a range of finance, quality, performance, and workforce indicators. Reports also highlight risks and areas of concern, and outline the actions being taken to improve operational performance. There is also good evidence of appropriate scrutiny and challenge by the Board. Operationally, the Health Board has also established new arrangements for holding teams to account for performance in line with the new operating model. However, the Health Board's plans for improvement have not yet been realised, and its performance in a number of areas remains the worst in Wales. As a result, the Health Board has been escalated from routine arrangements to enhanced monitoring for performance under Welsh Government's Escalation and Intervention Arrangements ⁴ (**Recommendation 3**).
- 34 The Health Board has appropriate arrangements for overseeing information governance at a committee-level, but some operational arrangements require improvement. The Digital and Data Committee receives regular reports on the Health Board's activities and improvement plans in relation to data protection and information security, and provides good scrutiny and challenge. Operationally, the Health Board's cyber resilience arrangements require strengthening. In December 2022, the NHS Wales Cyber Resilience Unit assessed the Health Board's arrangements and found that compliance was less than 50% in 5 of the 28 domains reviewed. As a result, the Unit gave the Health Board 134 recommendations to address in total. However, a lack of resources in this area are likely to impede the Health Board's ability to address these recommendations in full.
- 35 The Health Board has taken a number of positive steps to improve its arrangements for tracking internal and external recommendations, but further enhancements are required. The Health Board has reviewed progress against all longstanding recommendations, and a number of recommendations were either closed or assigned revised implementation dates following this exercise. As of December 2022, there were 75 Internal Audit recommendations still outstanding where the implementation date had passed, and 8 for Audit Wales. Whilst progress reports to the Audit and Risk Committee are generally good, there is scope to improve the summary report to provide a more formal update to the committee on the closure of recommendations and their subsequent removal from the tracker.

⁴ There are four escalation levels: routine arrangements, enhanced monitoring, targeted intervention, and special measures.

The Health Board is yet to establish arrangements for tracking recommendations made by external inspection and regulatory bodies in line with the recommendation we made in our 2018 structured assessment report (see **Exhibit 1, 2018 R6**). The Health Board should address this recommendation without further delay to enable the Quality and Safety Committee to monitor, scrutinise, and challenge progress effectively.

Exhibit 2: progress made on previous year recommendations

Recommendation	Description of progress
Audit Recommendations 2018 R6 The audit recommendation tracker should be expanded to include the recommendations of other external agencies e.g., Healthcare Inspectorate Wales and the Delivery Unit	No Progress Arrangements are yet to established.
Direct and Indirect Harm from COVID-19 2021 (Phase 2) R5 The Health Board has undertaken specific work in mortality and harm in relation to COVID-19. However, as with other Health Boards, it has yet to finalise a standard framework to support the assessment of direct and indirect harm associated with COVID-19. The Health Board should produce a framework for assessing both direct and indirect harm from COVID-19 and ensure that the framework and an accompanying report outlining key issues are monitored by appropriate operational, strategic groups and reported the Board or one of its committees.	In Progress A Nosocomial COVID-19 Incident Management Team has been established. Internal governance mechanisms are also in place, including an oversight group that reports to the Quality and Safety Committee. Investigatory work has commenced in line with the agreed national framework. Since April 2022, there has been monthly progress reporting to the Delivery Unit. There are over 3200 reviews to undertake that occurred prior to end of April 2022. As of end of July 2022, a further 408 cases have also been reported. In August 2022, the Delivery Unit reviewed the Health Board's self-assessment of programme progress.

Recommendation	Description of progress
	All programme workstreams received a 'reasonable assurance' rating or above.
Clarity on the status of deferred Board business 2021 (Phase 2) R1 Our review found that not all committees provide clarity on the status of deferred items of Board business. The Health Board should ensure that all committees are clear about the current status of deferred items of business, and an indicative timescale for when they will be brought back into active management.	Complete All committees are clear on the current status of deferred business.
Integrated Locality Group Review 2021 (Phase 2) R2 Significant transformation and improvement activity is delegated to the Health Board's Integrated Locality Groups. As part of its review of its operating model the Health Board should evaluate the capacity and capability of each Integrated Locality Group to deliver the scale of change required.	Complete In 2021, the Health Board established a new directorate - Improvement CTM (ICTM) – led by a new Director of Improvement and Innovation. There is a clearer focus on what this team will do and how it will support operational staff, with items for delivery detailed in its 2022-25 Business Plan.
Strategic Risks 2021 (Phase 2) R4 The Board has approved six risks to achieving strategic priorities which are aligned to the four strategic wellbeing and future generation objectives set out in the Health Board's Annual Plan 2021-22. Currently, with only six strategic risks, they may be too high level to allow meaningful scrutiny. The Board needs to ensure that its strategic risks also reflect the risks to achieving priorities	Complete The Health Board has developed and implemented a revised Board Assurance Framework (BAF) that captures nine strategic / principal risks aligned to the Health Board's strategy. In March 2022, the Health Board agreed a revised BAF, and the Board formally received it for the first time at its May 2022 meeting.

Recommendation	Description of progress
set out in its Annual Plan, the Planned Care Recovery Plan, actions to address its special measures and targeted intervention status and the direction of travel to be set out in the emerging long-term strategy.	

Strategic planning arrangements

- 36 In this section of the report, we provide our views on the Health Board's strategic planning arrangements, with a particular focus on the organisation's:
- vision and strategic objectives;
 - Integrated Medium-term Plan;
 - planning arrangements; and
 - arrangements for implementing and monitoring the delivery of corporate strategies and plans.
- 37 Details of progress made on previous year recommendations relating to the Health Board's strategic planning arrangements are provided in **Exhibit 3**.
- 38 We found that **the Health Board's strategic planning arrangements continue to improve, and positive progress has been made in developing a clear long-term vision and strategy for the organisation. Preparing a Clinical Strategy and an approvable IMTP, and enhancing reporting arrangements, must remain key priorities for the Health Board.**

Vision and strategic objectives

- 39 We considered the extent to which there is a clear vision and long-term strategy in place for the organisation. In examining this, we have looked at whether:
- the vision and strategic objectives are future-focussed, and rooted in a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
 - the vision and strategic objectives have been developed and adopted by the Board; and
 - the long-term strategy is underpinned by an appropriate long-term clinical strategy.
- 40 We found that **the Health Board has clear strategic long-term goals and priorities that provide a framework for developing its clinical strategy.**

- 41 The Health Board has made good progress in developing its long-term strategy for the organisation, 'CTM 2030 - Our Health, Our Future'. In July 2021, the Board approved a clear vision for the Health Board, underpinned by four strategic goals - Creating Health, Improving Care, Sustaining Our Future, and Inspiring People. The strategic goals each have four clear priorities for action and will be met through implementing a public health 'life course' across five strategic areas - Starting Well, Growing Well, Living Well, Ageing Well, and Dying Well.
- 42 The Board formally adopted the vision, strategic goals, and priorities in March 2022. This was done following extensive engagement with staff, residents, partners, and other stakeholders on population needs as well as the challenges and opportunities facing healthcare services in the region over the next ten years. The Health Board is currently developing a Clinical Strategy for the organisation in the context of CTM 2030. The Health Board aims to have its agreed Clinical Strategy, 'CTM 2030 – Future Clinical Services', in place by July 2023.

Integrated Medium Term Plan

- 43 We considered the extent to which the Health Board has been able to produce an approvable Integrated Medium-Term Plan (IMTP) for 2022-2025. In examining this, we have looked at whether:
- the IMTP was submitted within the required timeframes in line with Welsh Government guidance;
 - the draft and final versions of the IMTP were discussed, challenged, and agreed by the Board prior to submission; and
 - the IMTP received approval from the Minister for Health and Social Services.
- 44 We found that **the Health Board has been unable to produce a financially balanced, Welsh Government approved IMTP for 2022-25.**
- 45 The Health Board has been unable to produce a financially balanced and Welsh Government approved Integrated Medium Term Plan for 2022-25 due to its challenging financial position. Instead, the Health Board prepared a high level three-year plan, with a particular focus on the actions it felt it could achieve in 2022-23. The Board discussed, approved, and submitted the high-level plan to Welsh Government in March 2022.
- 46 Following discussions with Welsh Government, the Health Board updated the plan to become an Annual Plan for 2022-23, which includes greater detail on plans for unscheduled care and planned care recovery. The 2022-23 Annual Plan was submitted to Welsh Government in April 2022, and retrospectively approved by the Board in May 2022.
- 47 The Health Board's inability to produce an approvable IMTP has resulted in it being escalated from routine arrangements to enhanced monitoring for planning and finance under Welsh Government's Escalation and Intervention Arrangements.

Wider planning arrangements

- 48 We considered the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans. In examining this, we have looked at whether:
- prudent and value-based healthcare principles are considered and reflected in corporate strategies and plans;
 - corporate strategies and plans have been developed in liaison with relevant internal and external stakeholders; and
- 49 We found that **the Health Board's approach to strategic planning is improving, with evidence of good stakeholder engagement and Board-level oversight.**
- 50 The Board has maintained effective oversight of the organisation's arrangements for developing corporate strategies and plans, particularly CTM 2030. The Board has actively been involved in shaping the long-term vision, strategic goals, and priorities for CTM 2030 through workshops, development sessions, and regular discussions in public Board meetings. Reports presented to the Board provide a good overview of strategy development and clearly indicate where formal Board input is required. The Planning, Performance, and Finance Committee also provides effective oversight of the arrangements for developing CTM 2030 and preparing the 2023-26 IMTP. The Health Board has created additional capacity to prepare the 2023-26 IMTP and develop enabling strategies and plans relating to the workforce, estate, and digital services within the context of CTM 2030.
- 51 Value-Based Healthcare (VBH) principles are clearly reflected in CTM 2030 and the Health Board's 2022-23 Annual Plan. The Health Board's VBH Strategic Delivery Plan forms part of the Improvement and Innovation Directorate's Business Plan and contains clear plans for progressing VBH across the organisation, with a particular focus on heart failure, palliative care, diabetes, and wider programmes areas including lymphoedema, cellulitis, and alcohol liaison services. The Health Board has a clear funding delivery plan in place which is aligned to national VBH priorities and guidelines. The Health Board intends to establish consistent programme management and reporting arrangements to support project progression and oversight.
- 52 The Health Board has a positive approach to stakeholder engagement. It has demonstrated strong engagement with a diverse range of the stakeholders in developing CTM 2030, using a range of approaches to engage residents, staff, and external partners. The Health Board has also involved the Stakeholder Reference Group in strategy development. However, as mentioned in **paragraph 17**, the Health Board has not published papers for Stakeholder Reference Group meetings on its website since December 2019. The Health Board actively engages with other Health Boards to explore, identify, and implement regional solutions to shared issues and challenge, such as increasing pathology capacity. The Health Board also engages effectively with the Community Health Council, particularly around service changes.

Implementation and monitoring arrangements

- 53 We considered the extent to which the Board oversees, scrutinises, and challenges the implementation and delivery of corporate strategies and plans. In examining this, we have looked at whether:
- corporate strategies and plans contain clear milestones, targets, and outcomes that aid monitoring and reporting; and
 - the Board receives regular reports on progress to deliver corporate strategies and plans.
- 54 We found that **corporate strategies and plans generally lack clear outcomes, milestones, and targets which inhibits effective progress monitoring and reporting.**
- 55 Whilst CTM 2030 sets a clear direction of travel for the Health Board, it currently lacks clear and measurable outcomes. The CTM 2030 Steering Group and Strategy Groups are currently developing outcomes for each strategic priority, setting out what success would look like, and identifying how to measure and report progress. However, there is scope to accelerate the pace of this work. Furthermore, although the 2022-23 Annual Plan references the goals of the Health Board's Population Health Strategy, it is unclear how they relate to the wider strategic goals and public health 'life course' approach set out in CTM 2030 **(Recommendation 4).**
- 56 The 2022-23 Annual Plan includes a range of different actions / deliverables, timescales, and measures, some of which relate to the strategic goals and priorities set out in CTM 2030. However, peer review feedback on the 2022-23 Annual Plan noted a lack of clarity on what is an ambition and what is a deliverable. Our review of the 2022-23 Annual Plan also found that actions / deliverables, timescales, and measures are not summarised or presented in a way that allows progress to be monitored and reported effectively on a quarterly basis **(Recommendation 5a).** Furthermore, the 2022-23 Annual Plan lacks detail on which Executive Directors are responsible for ensuring the delivery of key actions / deliverables, thus limiting opportunities for ensuring appropriate accountability **(Recommendation 5b).**
- 57 The Health Board provides routine updates on the delivery of corporate strategies and plans to the Planning, Performance, and Finance Committee. The Board also receives a quarterly update on delivery of the 2022-23 Annual Plan (see **Exhibit 3 2001 (Phase 2) R2**). However, the reports are very high-level in nature and do not provide sufficient information to enable full scrutiny, challenge, and assurance. Furthermore, reports are not aligned to the performance reports presented to the Board. As a result, the Board is unable to assess the extent to which progress is on track, and the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance **(Recommendation 5c).**

Exhibit 3: progress made on previous-year recommendations

Recommendation	Description of progress
Targets and Milestones 2021 (Phase 1) 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.	Superseded This recommendation is superseded by a new recommendation (see Exhibit 1 – R6a)
Independent Member scrutiny of delivery of operational plans 2021 (Phase 1) 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.	Complete The Health Board produces and presents quarterly progress updates on delivery of the Annual Plan to Board and the Planning, Performance, and Finance Committee.
Planned Care Recovery Programme 2021 (Phase 2) R3 The Health Board's Planned Care Recovery Plan sets out how the Health Board intends to increase activity, reduce waiting times, and improve access to services. We found that although summary information is provided to the Planning, Performance and Finance Committee, it was not sufficiently explicit. The Health Board needs to provide more detail on the current progress against delivery of the Planned Care Recovery Plan against the set targets and expected activity.	Complete Updates on the Planned Care Recovery Programme are provided to the Quality and Safety Committee, and the Planning, Performance, and Finance Committee. Updates are well written and well presented, and provide performance against trajectory.

Managing financial resources

- 58 In this section of the report, we provide our views on the Health Board's arrangements for managing its financial resources, with a particular focus on the organisation's:
- arrangements for meeting key financial objectives.
 - financial controls; and
 - arrangements for reporting and monitoring financial performance.
- 59 We found that **the Health Board has clear arrangements for financial planning, and its finances are well scrutinised. Whilst the Health Board met its financial duties for 2021-22, it faces several risks to achieving financial balance and sustainability in the short- and medium-term.**

Financial objectives

- 60 We considered the extent to which the Health Board has effective arrangements in place to meet its key financial objectives. In examining this, we have looked at whether the Health Board:
- met its financial objectives for 2021-22, and is on course to meet its financial duties in 2022-23; and
 - has a clear and robust financial plan in place, which includes realistic and sustainable savings and cost improvement plans.
- 61 We found that **the Health Board achieved its financial duties for 2021-22. However, growing cost pressures, as well as the underlying deficit, create risks for financial balance and sustainability in the short- and medium-term.**
- 62 At the end of 2021-22, the Health Board met both its financial duty to operate within its annual revenue resource limit and within its cumulative resource limit for the three-year rolling period 2019-20 to 2021-22, achieving surpluses of £172,000 and £1.143m respectively. The Health Board also met its 2021-22 financial duty to break-even against its annual and three-year rolling capital resource limit, achieving surpluses of £42,000 and £113,000 respectively. However, as it failed to meet its 2021-22 savings target by £11.1m, it started the 2022-23 financial year with an accumulated underlying deficit of £44.5m.
- 63 The Health Board's financial plan is clearly set out in the 2022-23 Annual Plan. The plan is based on a clear series of assumptions regarding the Health Board's expected income, Welsh Government funding to support COVID-19 recovery, exceptional cost pressures, and the cost saving potential of services. However, the plan lacks detail on financial risks and mitigating actions. The Health Board is seeking to manage its financial challenges by improving forecasts, identifying remedial actions, and delivering cost savings. However, these arrangements do not appear to be sufficiently robust. In Month 9 2022-23, the Health Board was reporting a shortfall of £7.2m in recurrent savings, and overspends of £5.8m and

£11m in Primary Care Prescribing and Planned Care Groups / Directorates respectively (**Recommendation 6**).

- 64 The Health Board is not on course to meet all of its financial duties in 2022-23. As the Health Board has not been able to produce a financially balanced IMTP for 2022-25, it has failed its statutory duty to prepare an approvable three-year plan. At month 9 2022-23, the Health Board reported a £21.3m year-to-date deficit against its core revenue plan, which was £1.4m worse than plan. However, the Health Board was forecasting that the deficit would remain at £26.5m as per the core plan submitted to Welsh Government⁵. The Health Board is on course to remain within its capital resource limit for 2022-23, spending £50.1m of its capital budget at Month 9 2022-23.

Financial controls

- 65 We considered the extent to which the Health Board has appropriate and effective arrangements in place for allocating, authorising, recording, and managing the use of its financial resources. In examining this, we have looked at whether:
- there are effective controls in place to ensure compliance with Standing Financial Instructions and Schemes of Delegation.
 - the Audit Committee maintains appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud.
 - there are effective financial management arrangements in place; and
 - financial statements were submitted on time, contained no material misstatements, and received a clean audit opinion.
- 66 We found that **while some financial controls appear robust, others require strengthening.**
- 67 The Health Board has adequate arrangements to ensure compliance with its with Standing Financial Instructions and Scheme of Reservation and Delegation. In June 2022, Internal Audit issued a reasonable assurance rating on the adequacy of the Health Board's financial systems for budgetary control and the requisition of goods and services. We did not identify any significant control weaknesses from our review of the Health Board's 2021-22 financial statements. However, we made fourteen recommendations for improvement, which included a need for the Health Board to seek timely approval for any senior officer appointment that would exceed the relevant pay band authorised by Welsh Government.
- 68 The Audit and Risk Committee maintains effective oversight of the Health Board's arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud. The reports prepared by the Health Board are clear and

⁵ The forecast excludes COVID-19 response costs and other exceptional cost pressures.

support effective oversight, scrutiny, and challenge. The Audit and Risk Committee also reviews any changes made to financial control procedures. Whilst the Health Board's Financial Control Procedures are generally effective, we identified opportunities to strengthen controls further by reviewing the delegated upper financial limit for the Chief Executive (**Recommendation 7a**), and ensuring there is a clear process in place for the Board to review and approve capital programmes and projects (**Recommendation 7b**). We also found that some of the financial control procedures published on the Health Board's website were out-of-date, such as the procedures for private patients, and patients' property (**Recommendation 7c**).

- 69 The Health Board submitted draft financial statements for audit by the Welsh Government imposed deadline of 29 April 2022. The Audit and Risk Committee considered these on 14 June 2022. Our audit identified no material misstatements, and we issued an unqualified audit opinion, except for the regularity opinion, for which we issued a qualified opinion⁶.

Monitoring and reporting arrangements

- 70 We considered the extent to which the Board oversees, scrutinises, and challenges the organisation's financial performance. In examining this, we have looked at whether:
- reports to the Board provide a clear picture of the organisation's financial position, as well as the key financial challenges, risks, and mitigating actions taken; and
 - Board members sufficiently challenge ongoing assessments of the financial position.
- 71 We found that **the Health Board's financial reports are generally clear and comprehensive and support effective monitoring and scrutiny.**
- 72 The Health Board has effective arrangements for reporting financial performance to the Board and the Planning, Performance, and Finance Committee. Reports provide timely and good quality information, and contain a good mixture of text and exhibits to convey key messages. The reports clearly set out the Health Board's revenue, capital, and savings position. Whilst reports also clearly highlight key financial risks, opportunities, and assumptions, they do not provide sufficient assurances that mitigating actions are in place to address them (**Recommendation 8a**). Furthermore, the Health Board stopped reporting the financial performance of the Integrated Locality Groups from Month 5 2022-23 following the approval of the new operating model. The Health Board, therefore, should report the financial performance of the new Care Groups to the Board at the earliest possibility (**Recommendation 8b**). We have observed good scrutiny and

⁶ We issued a qualified regularity opinion to all Health Boards due to clinicians' pension tax liabilities.

challenge around the organisation's financial position at both Board and Planning, Performance, and Finance Committee meetings.

Managing the workforce, digital resources, the estate, and other physical assets

- 73 In this section of the report, we provide our high-level views on the Health Board's arrangements for managing its wider resources, with a particular focus on the organisation's:
- arrangements for supporting staff wellbeing (please note we will be undertaking a separate review of the organisation's wider workforce planning arrangements);
 - arrangements for managing its digital resources; and
 - arrangements for managing its estate and other physical assets.
- 74 We found **that staff well-being remains a clear priority for the Health Board. However, capacity and funding challenges need to be addressed to enable the Health Board to maximise the benefits of digital, and Board-level oversight of matters relating to the estate require strengthening.**

Supporting staff well-being

- 75 We considered the extent to which the Health Board has appropriate and effective arrangements in place for supporting staff well-being. In examining this, we have looked at whether:
- mechanisms to seek staff views about their well-being needs are effective, and appropriate action is taken to respond to findings; and
 - actions to support and improve staff wellbeing are actively monitored by the Board, including actions taken in response to our report on how NHS bodies supported staff well-being during the COVID-19 pandemic⁷.
- 76 We found that **the Health Board has effective arrangements for seeking staff views about their well-being needs, but its arrangements for providing assurances to Board on the effectiveness of its well-being offer requires strengthening.**
- 77 The Health Board has effective arrangements for seeking staff views about their well-being needs, such as the annual well-being survey. There is good evidence of the Health Board using staff feedback to shape its well-being offer. For example, the Health Board increased the financial element of its well-being provision following staff feedback.

⁷ Taking care of the carers? How NHS bodies supported staff wellbeing during the COVID-19 pandemic.

- 78 The Health Board routinely provides updates on its well-being activities and performance against workforce metrics to the People and Culture Committee. Whilst reports provide a good overview of activity, they do not provide sufficient assurance that well-being interventions are having a positive impact on staff well-being.
- 79 The Audit and Risk Committee received the management response to our Taking Care of the Carers report recommendations in December 2021. In December 2022, the Health Board reported to the Audit and Risk Committee that all six recommendations had been completed.

Managing digital resources

- 80 We considered the extent to which the Health Board has appropriate and effective arrangements in place for managing its digital resources. In examining this, we have looked at whether:
- there is a Board approved digital strategy in place which seeks to harness and exploit digital technology to improve the quality, safety, and efficiency of services, as well as to support new models of care and new ways of working; and
 - benefits arising from investments in digital technology are actively monitored by the Board.
- 81 We found that **whilst the Health Board has a clear Digital Strategy in place, it must seek to address staffing and funding challenges to maximise the benefits of digital technologies and solutions.**
- 82 The Health Board's strategic digital intentions are clearly set out in its Digital Strategy, which has been in place since 2017. In April 2022, Internal Audit reviewed the Digital Strategy and issued a reasonable assurance rating. It found that the Digital Strategy's eight themes remained valid, and supported the organisation's overall strategy. The Health Board intends to review the Digital Strategy as part of its arrangements for developing the organisation's Clinical Strategy.
- 83 The Digital and Data Committee routinely monitors the Health Board's progress in delivering the twenty-eight major digital schemes set out in the 2022-23 Annual Plan. However, there is limited capacity within the Health Board to fully deliver the digital transformation agenda. The limited availability of capital funding is also a barrier to delivery. Whilst these risks are appropriately reflected in the BAF, the Health Board should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions (**Recommendation 9**).

Managing the estate and other physical assets

84 We considered the extent to which the Health Board has appropriate and effective arrangements in place for managing its estate and other physical assets. In examining this, we have looked at whether:

- there are Board-approved strategies and plans in place for managing the organisation's estates and its wider physical assets;
- there are appropriate arrangements in place for the Board to review, scrutinise, challenge, and approve significant capital projects and programmes; and
- there are appropriate arrangements in place for the Board to maintain appropriate oversight of the condition of the estate and other physical assets.

85 We found that **the Health Board currently has no estates strategy, and Board-level arrangements for overseeing the condition of the estate and scrutinising capital programmes and projects require strengthening.**

86 The Health Board does not currently have an Estates Strategy, but is aiming to develop one during 2023. In the absence of an estate strategy, the 2022-23 Annual Plan sets out the Health Board's capital schemes for 2022-23. The risks associated with the limited availability of capital funding are appropriately reflected in the plan.

87 The Board appears to have a limited role in reviewing, scrutinising, challenging, and approving significant capital projects and programmes. At an operational level, capital bids are scrutinised by the Executive Capital Management Group (ECMG). In May 2022, the ECMG approved the Health Board's statutory and backlog maintenance programme of works. The backlog maintenance allocation for 2022-23 is £1.8m against a risk adjusted backlog totalling £62.9m. In June 2022, the Health Board provided an update on the capital programme to the Planning, Performance, and Finance Committee. The report outlined the scale of the challenge, provided backlog maintenance figures, and set out the prioritisation criteria for discretionary capital.

88 The Health Board's arrangements for ensuring appropriate Board-level oversight of the condition of the estate and other physical assets require strengthening. Although the Board Assurance Framework references the intent to introduce regular reporting on estates-related key performance indicators to the Planning, Performance, and Finance Committee from June 2022, we have not seen evidence of this yet. Furthermore, whilst the Health Board's Capital and Estates Governance Board maintains operational oversight, it does not provide assurance reports to the Planning, Performance, and Finance Committee. The Health Board, therefore, should ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee **(Recommendation 10a)**. It should also update the committee's Terms of Reference to reflect these responsibilities **(Recommendation 10b)**, and establish a clear process for ensuring appropriate cross-referral of issues with the Quality

and Safety Committee, which oversees health and safety matters
(Recommendation 10c).

Appendix 1

Audit approach

Exhibit 4 sets out the approach we adopted for delivering our structured assessment work at the Health Board

Exhibit 4: audit approach

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Audit and Risk Committee; • Digital and Data Committee; • People and Culture Committee; • Planning, Performance, and Finance Committee; • Population Health and Partnerships Committee; and • Quality and Safety Committee.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • Key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interests, and Registers of Gifts and Hospitality; • Key organisational strategies and plans, including the IMTP; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • Relevant policies and procedures; and • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews

We interviewed the following Senior Officers and Independent Members:

- Chair of the Board;
- Chair, Audit and Risk Committee;
- Chair, Digital and Data Committee;
- Chair, People and Culture Committee;
- Chair, Quality and Safety Committee;
- Chief Executive;
- Chief Operating Officer;
- Director of Corporate Governance;
- Director of Digital;
- Director of Finance;
- Director of Strategy and Transformation;
- Medical Director; and
- Assistant Director of Governance and Risk.

Appendix 2

Organisational response to audit recommendations

[Appendix 2 will be completed once the report and organisational response have been considered by the relevant committee.]

Exhibit 5: organisational response

Recommendation	Organisational response	Completion date	Responsible officer
R1 AP recommendation text - AP recommendation bullet - AP recommendation sub-bullet	Table text bold Table text - Table bullet - Table sub-bullet	Table text	Table text
Insert/delete table rows as required			



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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.

Organisational response

Report title: Structured Assessment 2022 – Cwm Taf Morgannwg University Health Board

Completion date: February 2023

Document reference: 3313A2023

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	Improving administrative governance arrangements We found opportunities for the Health Board to improve its administrative governance arrangements to enhance public transparency and support Board and committee effectiveness. The Health Board, therefore, should: a) publish the agendas of private Board and committee meetings; b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner; c) update report cover sheets to enable authors to better link their reports to the requirements of the Well-being of Future Generations (Wales) Act 2015; and d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.	a) In the exceptional circumstances where the Health Board is required to hold a Private Board meeting or Board Committee it will endeavour to highlight the agenda items covered on the Public Agenda for transparency. b) Due to capacity constraints within the Corporate Governance Function it is accepted that the timely publishing of papers maybe impacted. Discussions are underway with the Web Development Team to consider if they can provide interim support over the next 3-6 months. c) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act. d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues.	a) 30th April 2023 b) 31st August 2023 c) 30th June 2023 d) 30th June 2023	Assistant Director of Governance & Risk
R2	Using the Board Assurance Framework (BAF) to shape Board business Although the Health Board has made positive progress in developing a BAF, it is	The Health Board will continue to include the BAF Report in its agenda setting meetings and align the Board and Committee Cycles of Business to ensure that the business of the meetings are	31 st August 2023	Assistant Director of Governance & Risk

	not yet currently being used to shape Board and committee business. The Health Board, therefore, should actively use the BAF on an ongoing basis to shape and inform Board and committee work programmes.	shaped by the principal risks facing the organisation. The BAF will also help shape Board and Committee Cycles of Business at the beginning of each financial year. Each Committee will receive the principal risk assigned to it as the 'assuring Committee' within the cover paper of the Organisational Risk Register, which is received at all regular Committee meetings as appropriate.		
R3	Strengthening performance management arrangements The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable	30th September 2023 The workshop with Board Members is scheduled for Quarter 1 – 2023-2024.	Executive Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)

		the Board to align measures to strategic priorities etc, the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.		
R4	Establishing measurable outcomes for strategic priorities Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.	We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter". In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible.	30th June 2023	Executive Director of Strategy & Transformation
R5	Enhancing arrangements for monitoring delivery of corporate plans and strategies and reporting progress to the Board We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring:	a) All plans and strategies will contain an executive summary setting out this information. As set out above, work is ongoing around outcome measures. b) Executive Directors are clear on their responsibilities for delivery so we will ensure this is more visible. c) Reports will be reviewed to ensure they provide the Board with sufficient information to	30th June 2023	Executive Director of Strategy & Transformation

	a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	assess the impact of implementation of key actions and deliverables on the Health Board's Performance.		
R6	Strengthening financial management arrangements We identified the need for the Health Board to improve its arrangements for containing expenditure and delivering savings. The Health Board, therefore, should review its arrangements to ensure there is sufficient grip and challenge at all levels of organisation on expenditure and savings delivery.	Finance review meetings are held with all of the Care Groups on a monthly basis and with other functions on a bi-monthly basis. These meetings cover savings delivery, expenditure variances plus action plans to improve the overall control environment. These processes will be reviewed to ensure that they are sufficiently robust in terms of containing Health Board expenditure and delivering planned savings. Within the draft, Internal Audit Plan for 2023-2024 it is proposed that Internal Audit will undertake a review of budgetary control at a localised level.	30 th September 2023	Executive Director of Finance

R7	Strengthening financial controls Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions.	a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance. b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is Chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas. c) A review of all the outdated Financial Control Procedures is underway.	a) 30th September 2023 b) 30th June 2023 c) 31st December 2023 (Qtr 3)	Executive Director of Finance
R8	Enhancing financial reports to the Board Whilst the Health Board has effective arrangements for reporting financial	The monthly finance reports to the Board and the Planning, Performance and Finance (PPF) Committee summarise the key risk and opportunities facing the Health Board. These	31st July 2023	Executive Director of Finance

	performance to the Board, we identified opportunities to enhance these reports further. The Health Board should: a) provide greater assurances that mitigating actions are in place to address key financial risks highlighted in the reports; and b) report the financial performance of the new Care Groups at the earliest possibility.	reports will be reviewed to ensure they provide assurance to the Board that mitigating actions and plans are in place and that the PPF Committee has confidence the risks are being appropriately managed. These reports will capture financial performance of the the new Care Group Model.		
R9	Maximising the benefits of digital technologies and solutions There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	The themes identified in the existing Digital Strategy continue to be aligned to the NHS Wales Digital Strategy and are embedded and will continue to evolve with the CTM2030 strategy in relation to digital activity. The Health Board has performed an analysis and identified a minimum set of resources (staff and capital/revenue) required over the next 3 years. Aligned to this work, during 2022 the Health Board completed a functional map of services required from a Digital and Data perspective. The next stage in the process is to align staffing resources to the functions, which will be achieved by following organisational change process. For significant Digital and Data changes (i.e. projects/programmes) the Health Board has developed a process of creating business cases to support service transformation. These business cases indicate the resources (staffing & Infrastructure) required to implement service	31st December 2023 (Qtr 3) Qtr 1 – Business Case for Patient Centred Contact. Qtr 2 – Business Case for e-prescribing.	Director of Digital

		change and ensure ongoing provision of support services to sustain change. The Health Board is committed to adopting all National Digital developments, where appropriate, and has invested heavily in the deployment of these products across the Health Board. The current strategy is to continue to operate in this manner and ensure it maximises resources efficiently and effectively.	Ongoing as National Digital Developments are released.	
R10	Strengthening Board-level oversight of estates issues and risks There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should: a) ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee; b) update the committee's Terms of Reference to reflect these responsibilities; and c) establish a clear process for ensuring appropriate cross-referral of issues with the Quality and Safety Committee, which oversees health and safety matters.	On publication of Welsh Government's annual Estates, Facilities Performance Management System data, the findings are reported to the Planning, Performance and Finance (PPF) Committee. The report includes the Health Board's performance measured against the national estates key performance indicators which are Physical Condition, Statutory and Safety compliance, fire safety, functional suitability and space utilisation. In addition the report includes the estates operational planned and reactive performance data for statutory and mandatory jobs and also captures helpdesk request data, the reported data is compared against previous years so that trends can be analysed. The report also includes the organisations energy performance and Carbon Dioxide (CO2) emissions which is measured and reported against the Welsh Government performance targets At all of the Health Board's Health, Safety and Fire Sub Committees there is a standard agenda item for an Estates Safety and Compliance report and a fire safety report. These reports cover the	In accordance with the Committee Cycle of Business for the PPF Committee and Health, Safety and Fire Sub Committee – Circa April / May 2023.	Executive Director of Finance

critical infrastructure systems such as high and low voltage electricity, medical gases, ventilation and water.

The Estates and Capital Directorate has its own risk register which is reported quarterly to the Estates / Capital Governance Board, the risks identified with a score above 15 are subsequently reported to Corporate Governance for inclusion on the Health Board's Organisational Risk register.

The Health Board is also considering its approach to developing an Estates Strategy within the Health Board and how this will align with other key strategic documents and plans.

The Planning, Performance & Finance Committee Terms of Reference will be reviewed to reflect the responsibility to receive Board level oversight of estates issues.

The Health Board has a defined Committee Referral process which will be used if there are matters considered at either the PPF Committee or HS&F Sub Committee that require consideration at the Quality & Safety Committee. The HS&F Committee will also ensure any estates issues will be notified to the Q&S Committee through the Committee Highlight Report.

Cwm Taf Morgannwg University Health Board

Outline Audit Plan 2023

Audit year: 2022-2023

Date issued: April 2023

This document is a draft version pending further discussions with the audited and inspected body. Information may not yet have been fully verified and should not be widely distributed.



This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our [Statement of Responsibilities](#).

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

About Audit Wales

Our aims:

Assure



the people of Wales
that public money is
well managed

Explain



how public money
is being used to
meet people's
needs

Inspire



and empower the
Welsh public sector
to improve

Our ambitions:



Fully exploit our
unique perspective,
expertise and
depth of insight



Strengthen our
position as an
authoritative,
trusted and
independent voice



Increase our
visibility,
influence and
relevance



Be a model
organisation for the
public sector in
Wales and beyond

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Audit timeline	7
Audit quality	8
Appendix 1 – key ISA315 changes and impact	9

Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend sharing a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends undertaking to address the audit risks identified and other key areas of audit focus during 2023.

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure, and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our [Statement of Responsibilities](#).

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.



Adrian Crompton
Auditor General for
Wales

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the UK’s Whole of Government Accounts.

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2023 I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates and also highlights the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**.

I will provide an estimate of your fee in my Detailed Audit Plan in May 2023, following completion of my detailed risk assessment.

Your engagement team:

Dave Thomas	Engagement Director & Audit Director Performance Audit
Anthony Veale	Audit Director Financial Audit
Mark Jones	Audit Manager Financial Audit
Darren Griffiths	Audit Manager Performance Audit
Steve Stark	Audit Lead Financial Audit
Sara Utley	Audit Lead Performance Audit

We confirm that our audit team members are all independent of the Health Board and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	March 2023	March 2023
2023 Detailed Audit Plan	February – May 2023	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May - July 2023	July 2023
Performance audit work: • Structured Assessment, incorporating a deep dive into a specific thematic area which will be confirmed in the detailed plan in May 2023. • All-Wales thematic review of planned care, following on from my previous work in this area in 2022. • Local project work to be confirmed in detailed plan in May 2023.	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	
2023 Annual Audit Report	Throughout 2023	January 2024

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD¹ and our Chair acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2022](#).



Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review



Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support



Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

¹ QAD is the Quality Assurance Department of ICAEW

Appendix 1 – the key changes to ISA315 and the potential impact on your organisation

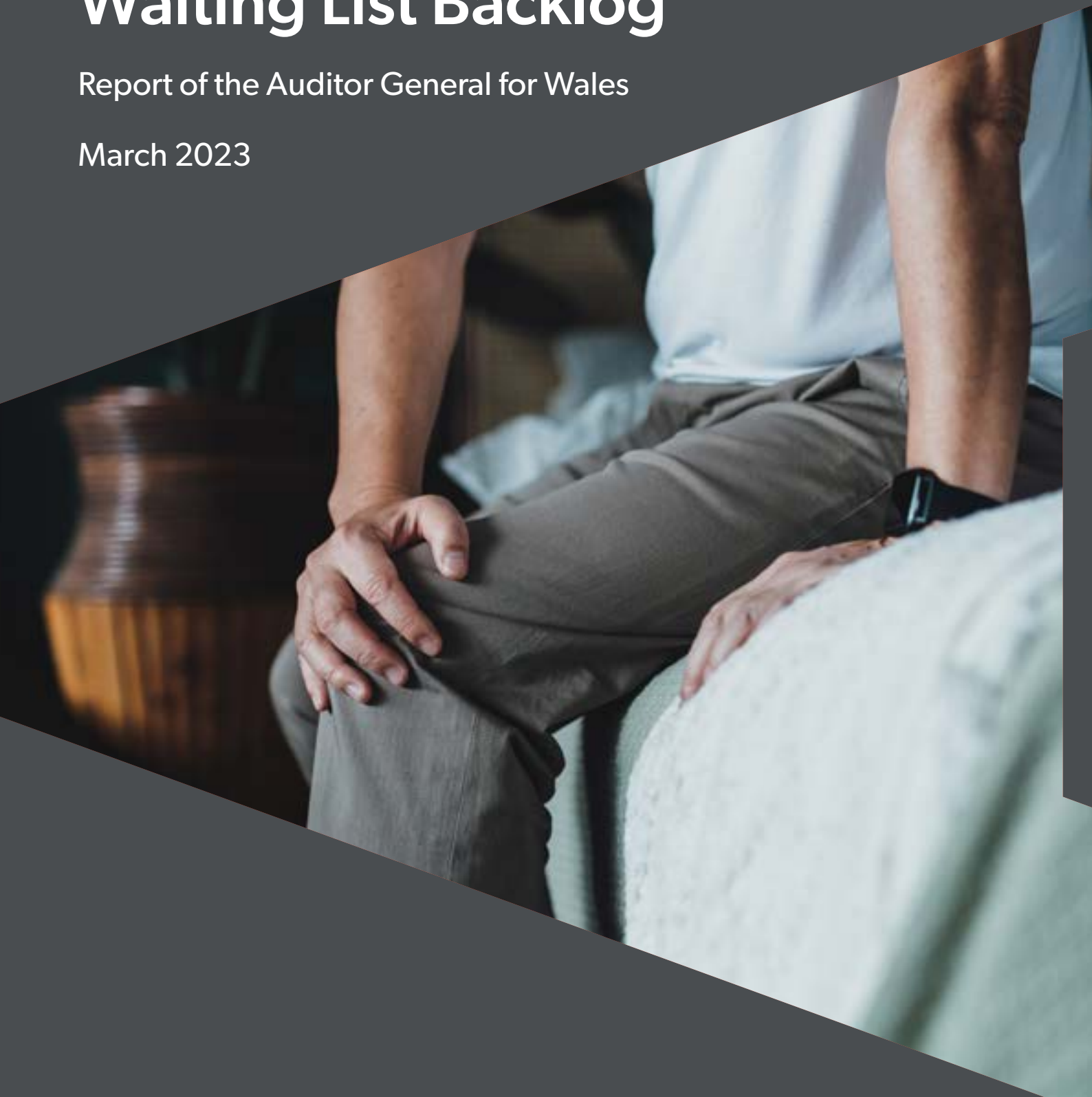
Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes.

Key change	Potential impact on your organisation
	Audit teams may need to test the general IT controls, and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Report of the Auditor General for Wales

March 2023



This report has been prepared for presentation to the Senedd under the Government of Wales Acts 1998 and 2006.

The Auditor General is independent of the National Assembly and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the National Assembly on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Summary report

Context

- 1 Orthopaedics is the branch of surgery that relates to musculoskeletal conditions. Common surgical procedures include hip and knee joint replacement, and diagnostic intervention such as arthroscopy. Orthopaedic surgeons tend to sub-specialise focussing on areas such as major joints, or foot and ankle, shoulder, or wrist.
- 2 NHS Wales orthopaedic spend had grown year on year to 2019-20 peaking at nearly £396 million. The pandemic saw reduction in activity and spend the following year. But even with the increases in spend pre-pandemic, the size of orthopaedic waiting lists was one of the biggest challenges facing the NHS in Wales. This challenging pre-pandemic position has further deteriorated because of the impact of COVID-19 on planned care activity. In November 2022, of the 748,271 people on the NHS waiting list in Wales, 101,014 were waiting for orthopaedic services.
- 3 At the time the UK went into lockdown in March 2020, we were concluding our work to follow up progress against our 2015 reports on waiting times for elective care and orthopaedic services. Across both reviews we had found the same story: many patients still face long waiting times. Some progress has been made in specific areas, but we had not seen the sorts of whole system change that is needed to make the planned care system sustainable.
- 4 In September 2020, we published a report setting out Ten Opportunities for Resetting and Restarting the NHS Planned Care System. We then prepared a broader commentary on Tackling the Planned Care Backlog in May 2022.
- 5 This report provides a commentary on orthopaedic services. It describes the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the recent nationally coordinated work to modernise services. The report also sets out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services. In some instances, we use long term trends to help illustrate change over time.

Key messages

A note on patients and pathways

Throughout this report we talk about patients waiting for treatment. Our figures are based on NHS Wales's 'open' referral to treatment measure. The measure counts the number of pathways which have started but not yet completed treatment, rather than people. Each pathway represents a patient waiting but patients may have more than one health condition and therefore be on the waiting list more than once. As a result, the total number of people waiting for treatment will be lower than the total number of pathways.



- 6 Meeting demand for planned orthopaedic services has been a significant challenge for the NHS in Wales over the last 20 years. The impact of COVID-19 has elongated what was already a lengthy waiting list, such that patients are now facing exceptionally long waits to be seen and treated. For many people this means living in pain and discomfort, with a life-limiting condition.
- 7 Proportionately, there are more than twice as many people waiting in Wales for orthopaedic services as there are in England. In fact, proportionately, there are more people waiting over 36 weeks in Wales than are waiting in England in total¹. Month on month, the orthopaedic waiting list has been increasing, peaking with 102,699 patients on the waiting list in September 2022. Referral rates dropped during the pandemic, and we estimate that there are around 135,000 potentially 'missing' referrals that could come back into the system, putting further pressure on the waiting list.

¹ [Statement by the British Orthopaedic Association](#), on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022. Direct comparisons are not available with Northern Ireland and Scotland due to differences in the way in which waiting lists are reported.

- 8 Services have been slow to restart as the immediate impact of the pandemic has lessened, operating on average at around 60% of pre-pandemic activity levels. There is unexplained variation of orthopaedic waits across Wales depending on where you live and the type of procedure you are having. Necessary infection control regimes will continue to have an impact on patient throughput in settings such as operating theatres, but there is scope for current capacity to be used more efficiently by making appropriate use of day case procedures and looking to safely reduce lengths of stay.
- 9 In the past, the Welsh Government has allocated temporary additional monies to health boards to try and fill the gap between capacity and demand. Whilst this resulted in short term improvements, it did not achieve the sustainable changes to services that were necessary and referral to treatment time waiting list targets² for orthopaedics have never been met since the targets were first established in 2009. There needs to be a realistic assessment of capacity. Funding for orthopaedic services has not reflected growing demand and with a predicted 27% growth in over 75s between now and 2030, services need to be sustainably designed to meet that need.
- 10 We have repeated the wider modelling exercise presented in our Tackling the Planned Care Backlog report in May 2022 for orthopaedic services in order to estimate how long it will take to recover these services. Our optimistic scenario modelling suggests that it could take three years to return orthopaedic waits to pre-pandemic levels. This is based on both a significant drive on community-based prevention, which has shown to have a positive impact on demand, and a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels, noting that current activity is below pre-pandemic levels. Our more realistic scenario indicates that it could be nearer to five years, and our pessimistic scenario indicates that services may never return to pre-pandemic waiting list levels. The scenarios highlight the scale of the challenge facing orthopaedic services in respect of managing demand and building additional capacity.
- 11 There is some hope, however. NHS Wales has commissioned an in-depth review of orthopaedic services with the Getting It Right First Time team³ outlining numerous service efficiency, effectiveness, and productivity improvements for acute orthopaedic services. They set out a comprehensive suite of recommendations in their national report and have also provided reports and recommendations to each of the health boards in Wales. Their work sets out the immediacy and urgency needed.

2 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks.

3 Getting It Right First Time is a national programme designed to improve the treatment and care of patients through review and benchmarking.

- 12 Aligned to this, the Welsh Government commissioned the Welsh National Orthopaedic Society to prepare a National Clinical Strategy for Orthopaedics. This thorough and honest appraisal of the current position and service options for the future sets out in the strongest terms the perilous state of services and gives a clear clinical voice on what needs to be done. It will require brave and bold leadership at a ministerial level all the way through to operational and clinical leaders in hospitals to deliver it.
- 13 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.
- 14 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively, including primary, community and diagnostic services. New technology and improved estate need to be prioritised and health boards must work together to develop regional solutions to help tackle the backlog. In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.



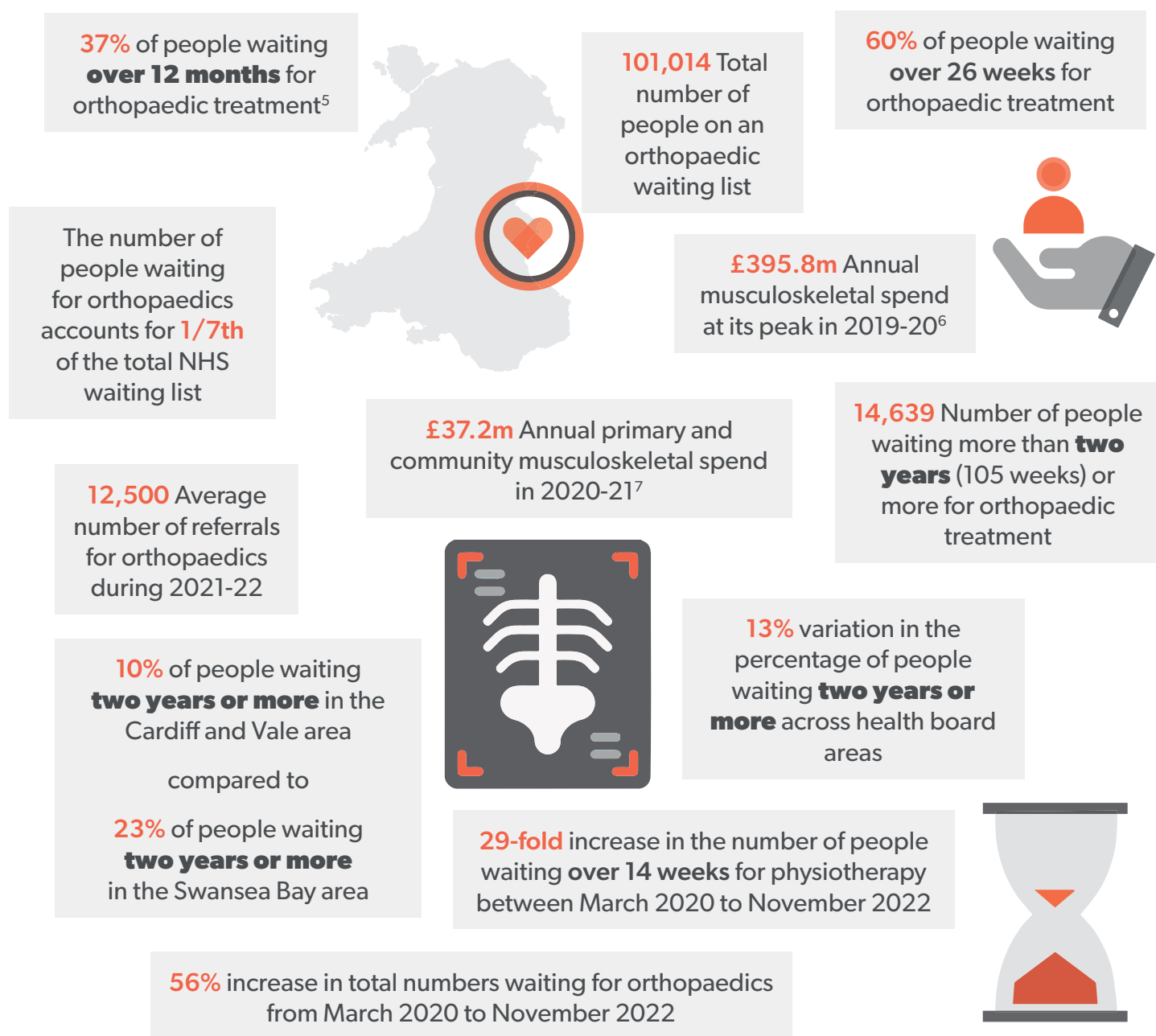
Securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with COVID-19 making this significantly worse. It is positive to see that there is a clear commitment to improve orthopaedic services, but urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

Adrian Crompton

Auditor General for Wales



Key facts⁴



⁴ Data as of November 2022 unless otherwise stated. Data is all-Wales.

⁵ Welsh Government data used is over 53-week data. The true 12-month position will be marginally higher.

⁶ The following year (2020-21) spend decreased to £308.2 million. The reduction in expenditure is a direct consequence of reduction in orthopaedic activity during the pandemic. Source: Stats Wales NHS Programme Budget for Musculoskeletal system problems (excluding Trauma)

⁷ Primary and community musculoskeletal spend forms part of the total annual musculoskeletal spend.

Recommendations

- 15 The box below sets out recommendations that we think are needed to strengthen the delivery of orthopaedic services. These recommendations are meant to complement those already made in the Getting It Right First Time reports and the new National Clinical Orthopaedics Strategy.

Recommendations

For the Welsh Government

- R1 Actions previously taken to tackle orthopaedic performance have had a short-term focus, not delivered sustainable services, and lacked 'buy-in' from local clinical teams. The new national clinical strategy for orthopaedics sets out clinical solutions to deliver sustainable services. We recommend that the Welsh Government now needs to:
- a prepare a clear national delivery plan which sets out the priority actions to be taken over the next three to five years to achieve the clinical strategy. The plan needs to include key deliverables and milestones, and clearly defined roles and responsibilities at a local and national level.
 - b ensure that the national delivery plan includes a clear direction for regional models to recognise the opportunities that exist to maximise available capacity and provide centres of excellence that deliver better outcomes.
 - c ensure that the national delivery plan encompasses the wider service input needed to deliver effective orthopaedic services. This should include but not be limited to primary and community care capacity, diagnostic capacity, capital and estates, and digital services.
 - d ensure that the national delivery plan is reflected in NHS planning guidance and health boards are held to account for implementation through routine performance management arrangements.

Recommendations

- R2 The Getting It Right First Time reports at a national and health board level set out clearly a range of recommendations which will help drive improvements in the hospital element of the orthopaedic pathway across Wales, but many of the areas of focus are not new. We recommend that the Welsh Government needs to:
- a ensure mechanisms are in place to obtain assurance from health boards that the Getting It Right First Time recommendations are being implemented.
 - b place a significant and constant focus on improving efficiencies and productivity in orthopaedics through its challenge and scrutiny of health boards. This needs to be supported by regular benchmark reporting, and an agreed set of orthopaedic procedures that have been shown to have limited clinical value.

For Health Boards

- R3 The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to:
- a ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and
 - b ensure that clear action plans are in place to address the things that get in the way of improvement.

Recommendations

- R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to:
- a ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and
 - b ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.
- R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to:
- a ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level;
 - b ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and
 - c put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.



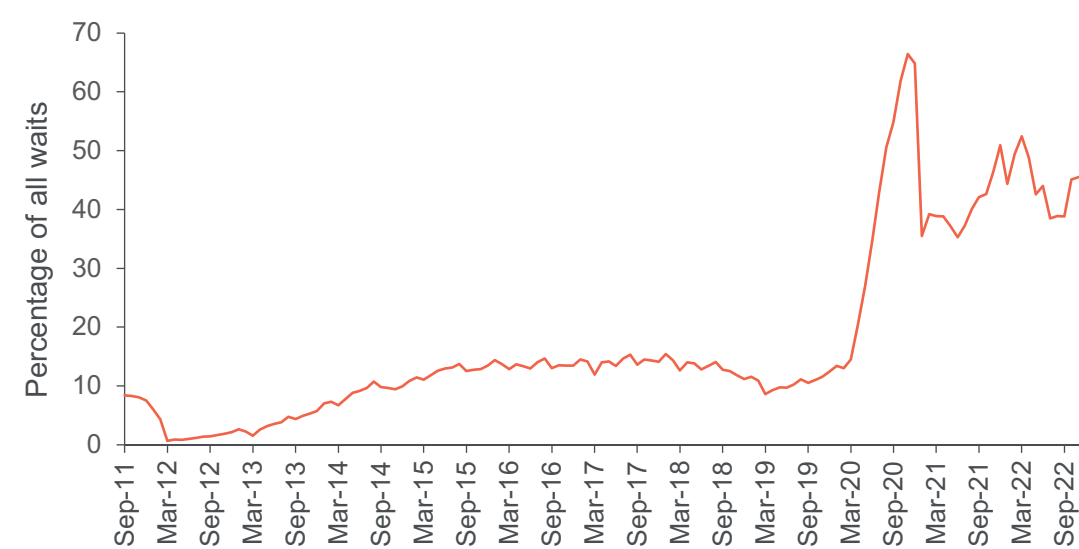
**What is the scale
of the challenge?**

01

Orthopaedic waits have dramatically deteriorated from an already poor position prior to the pandemic

- 16 Orthopaedic services have not been in a position where they have been able to see and treat people within target timescales since well before the onset of the pandemic. National data show a long-term trend in deteriorating performance against waiting time targets. Since 2011, the national targets of 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks have never been met. At its best, in 2012, 88% of orthopaedic patients were waiting no more than 26 weeks, and 11% waiting over 36 weeks across Wales⁸.
- 17 Immediately before the pandemic, in March 2020, 14% of patients were waiting over 36 weeks. But the pandemic has made a bad position worse. The latest (November 2022) data shows that for those waiting to receive orthopaedic treatment, 46% were waiting over 36 weeks (**Exhibit 2**). This position peaked at 66% in November 2020.

Exhibit 2: Percentage of patients waiting over 36 weeks for orthopaedic treatment by month across Wales, September 2011 – November 2022

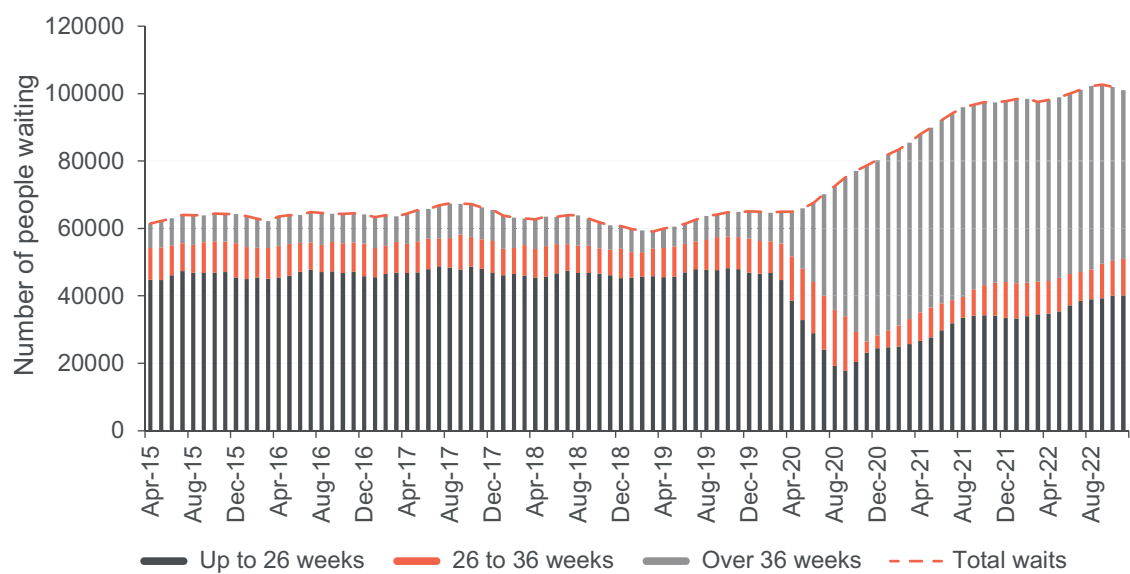


Source: Audit Wales analysis of StatsWales data

8 Data source: Stats Wales, Referral to treatment open pathway data for Trauma and Orthopaedics

- 18 In March 2020, there were 64,942 people on the orthopaedic waiting list. By September 2022, this had increased to 102,699 people (**Exhibit 3**). This position had slightly improved to 101,014 patients in November 2022. Of those, 50,024 (45.5%) have been waiting more than 36 weeks. More concerning is that of those waiting more than 36 weeks, 37,396 have been waiting over 12 months, and 14,639 have been waiting two years or more.

Exhibit 3: Number of patients waiting for orthopaedic treatment across Wales, April 2015 – November 2022



Source: Audit Wales analysis of StatsWales data

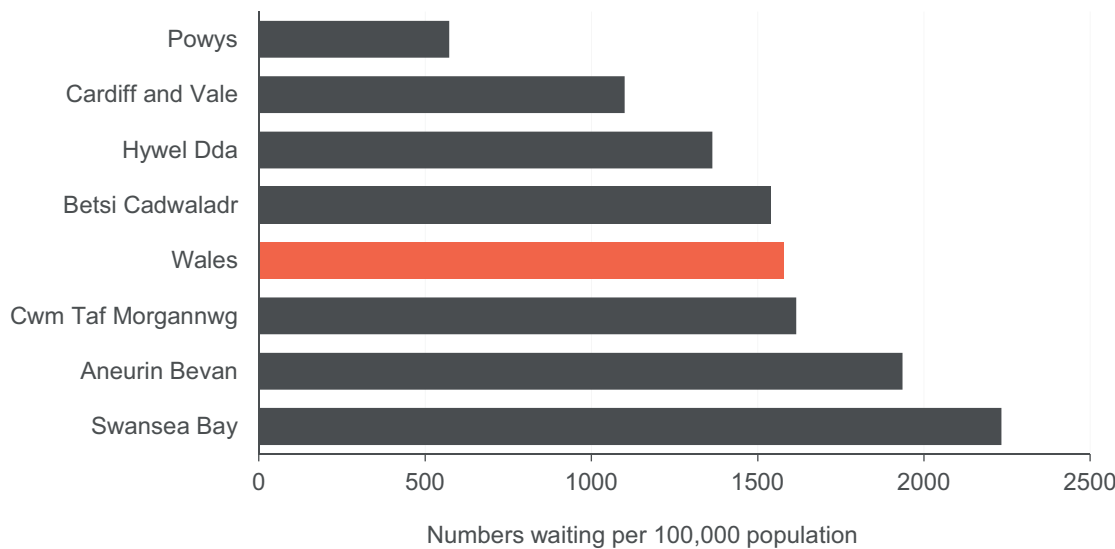
- 19 To give a broader perspective of the extent of the challenge, in March 2022, 1.3% of the population in England were on an orthopaedic waiting list. In Wales, 3% of the population were on an orthopaedic waiting list⁹. In November 2022 proportionately, there were more people waiting for orthopaedic treatment in Wales over 36 weeks (1.6% of the population) than there were waiting in total in England. These figures do however not take account for the health and age of the respective populations, with the Welsh population generally older and sicker than those in England.

⁹ Statement by the British Orthopaedic Association, on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022

The extent of the orthopaedic waiting list shows significant geographical variation across Wales

20 A comparison across health board areas of the total numbers of patients waiting over 36 weeks per 100,000 population shows some stark geographical variations (**Exhibit 4**).

Exhibit 4: Number of patients waiting over 36 weeks for orthopaedic treatment per 100,000 population, by Health Board of residence (November 2022)



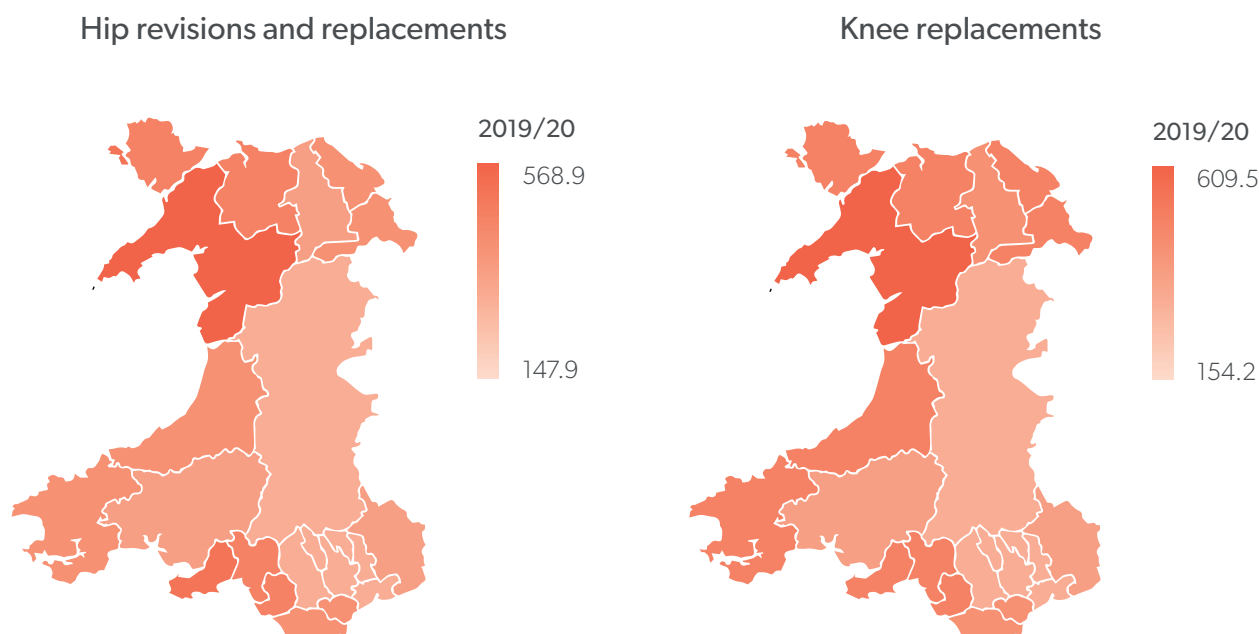
Source: Audit Wales analysis of StatsWales data

21 This geographical variation is equally as noticeable when considering specific orthopaedic procedures such as hip or knee replacement surgery. **Exhibit 5** shows average waits in Wales for hip replacement in 2019-20¹⁰ varied from around 148 days for Powys residents¹¹ to almost 567 days for Gwynedd residents. A similar, though slightly worse position is observed for patients receiving knee replacement procedures with waits varying from 154 days for Powys residents to almost 610 days for Isle of Anglesey residents in 2019-20.

10 2020-21 procedure level wait data is currently incomplete. We have therefore used the most recent pre-pandemic dataset.

11 Note that some Powys residents will receive treatment from English providers where waiting times are shorter than in Wales.

Exhibit 5: Mean waiting times in days for hip revisions and replacements, and knee replacements for 2019-20, by local authority area



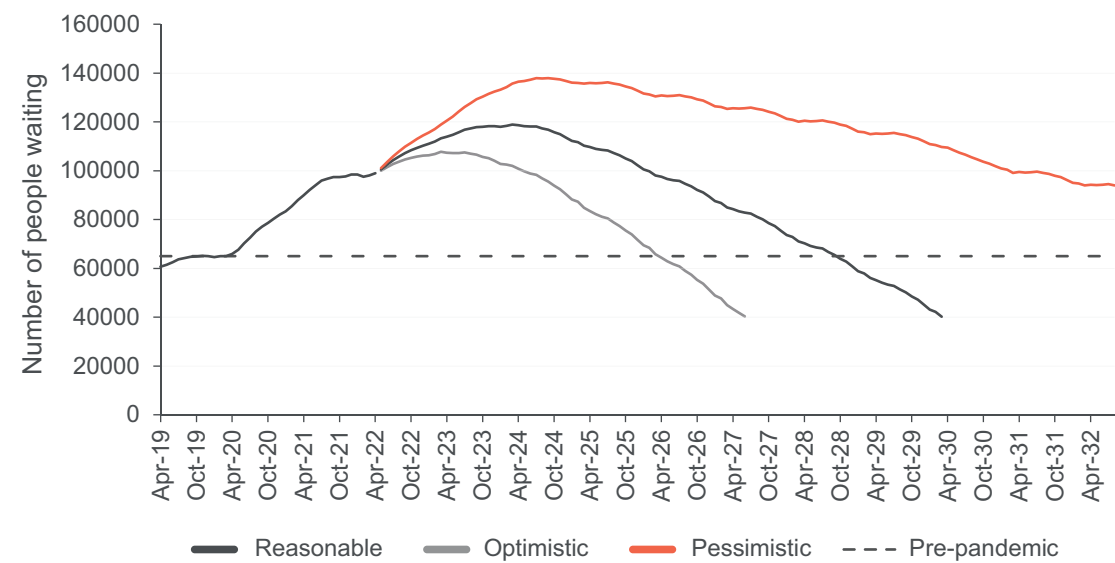
Source: Health Maps Wales, Common Procedure dataset

- 22 Health Boards are using all possible means to try to reduce the waiting lists. This includes outsourcing, where Health Boards are seeking third-party organisations to provide services on their behalf, such as private healthcare providers or NHS Trusts in England. Outsourcing provides a short-term solution, but this potentially could further widen inequalities of access to care. People living in deprived communities may not be able to travel further to receive their care and those with complex comorbidities may require their procedure in a hospital with intensive care facilities. This may mean those groups of patients face potentially longer waits for their treatment.

Without significant intervention, orthopaedic waits may never return to pre-pandemic levels

23 We have used national data to work out how long it could take NHS Wales to get orthopaedic waiting lists back to March 2020 levels¹². We developed three illustrative scenarios: **reasonable**, **pessimistic**, and **optimistic**. The modelling (**Exhibit 6**) for our optimistic scenario suggests that the orthopaedic waiting list could peak in 2023 but return to pre-pandemic levels by 2026. The reasonable model would see waiting lists return to pre-pandemic levels by 2028, noting that pre-pandemic performance was itself not meeting Welsh Government targets. The pessimistic scenario may never see a return to pre-pandemic waiting list levels.

Exhibit 6: Illustrative scenarios of waiting list numbers for orthopaedic services across Wales



Source: Audit Wales analysis of StatsWales data

¹² Appendix 1 sets out how we modelled the scenarios.

- 24 The key variables in our modelling cover the rate at which patients are added to the orthopaedic waiting list over time, the rate at which patients are removed from the list, the potential growth in demand, and the extent to which potentially ‘missing’ referrals or latent demand returns (discussed later in this report). Our optimistic modelling is also based on assumptions around increasing current activity through increased capacity by 25% by 2025 and reducing the referral demand through prevention and early treatment (such as increased use of CMATS). Our modelling does not consider possible new or more complex demand because of changes in population health.

Long waits for treatment are affecting many people’s physical and mental health

- 25 While orthopaedic and musculoskeletal problems are not, in themselves, life threatening, they can be debilitating and can significantly affect people’s quality of life. Many patients waiting for treatment will be experiencing discomfort and pain daily which can lead to a loss in mobility and independence, which in turn can cause wider deterioration in physical and mental health. For some patients this can impact on their ability to work and for many patients there will be an increased need for ongoing support from GPs to help manage their condition. Prolonged waits for joint related problems can also result in further deterioration which could make the required surgery more problematic and potentially less effective.
- 26 In its submission to the Senedd’s Health and Social Care Committee inquiry into the impact of the waiting list backlogs on people in Wales, the Board of Community Health Council’s (CHCs)¹³ highlighted that orthopaedic services were one of the most common services that the local CHCs were hearing about. In a report by the Swansea Bay Community Health Council on the [lived experiences of people waiting for elective orthopaedic surgery](#), 92% of patients reported a deterioration in their condition. Nearly three-quarters agreed the length of time they had been waiting for surgery had affected their mental health and wellbeing.

¹³ [Inquiry into the impact of the waiting times backlog on people who are waiting for diagnosis or treatment in Wales: Board of Community Health Councils](#)



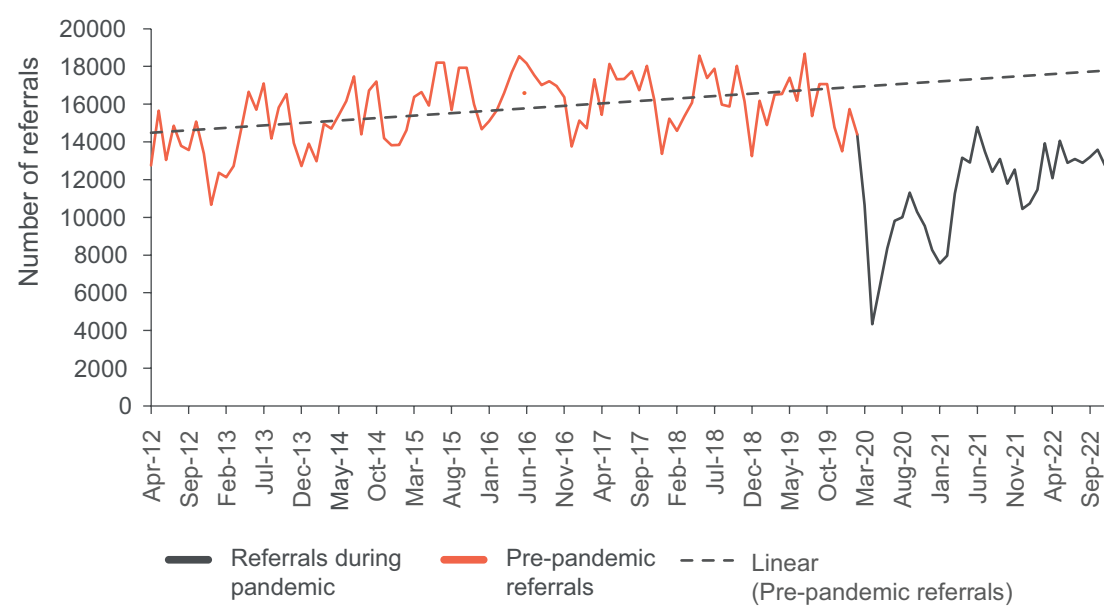
What is impacting the recovery of orthopaedic services?

02

Referral rates are not yet back to pre-pandemic levels

27 The change in the pattern of orthopaedic referrals during the pandemic is like that experienced across planned care services more generally, with a sharp decline in referrals at the onset of the pandemic¹⁴ (**Exhibit 7**). Referrals have not yet returned to pre-pandemic levels. When comparing the level of referrals between March 2020 and March 2022, against 2019-20 referral levels, around 135,000 referrals are ‘potentially missing’.

Exhibit 7: Number of orthopaedic referrals across Wales, April 2012 – November 2022



Source: Audit Wales analysis of StatsWales data

28 NHS Wales is currently benefitting from rates of orthopaedic referrals continuing to be lower than pre-pandemic levels. The waiting list position would otherwise be substantially worse. Some of the missing referrals or latent demand may never appear due to, for example, people choosing to seek private treatment, but it is expected that a proportion of the unmet demand will appear and further exacerbate the challenges being faced by orthopaedic services.

14 Note that referral patterns vary significantly by Health Board.

Although radiology and physiotherapy services are recovering, increased demand is adding to delays in orthopaedic pathways

- 29 Timeliness of orthopaedic treatment is dependent on the timeliness of each stage of the orthopaedic pathway¹⁵ which will include other services such as radiology services and physiotherapy. Since the beginning of the pandemic, the total number of patients across Wales waiting for a consultant referred radiology test increased from 23,979 in March 2020 to 33,121 in November 2022. The total number of people across Wales waiting for a GP referred radiology test increased from 18,703 in March 2020 to 30,175 in November 2022.
- 30 Of particular interest to orthopaedic services are waits for diagnostic magnetic resonance imaging (MRI) and ultrasound scans. While the number of people waiting has increased, positively the number of people waiting less than the target wait of eight weeks is now at, or marginally better, than levels experienced pre-pandemic, suggesting good progress had been made to recover services. The number and proportion of people waiting over 14 weeks however has grown substantially across both diagnostic tests due to the increased demand (**Exhibit 8**).

15 A pathway is an agreed common approach for a course of care. For orthopaedic patients, this would typically include some or all the following: GP referral, first outpatient appointment, diagnostic test and/or therapy intervention, preoperative assessment, MRSA and COVID-19 screening, consenting, surgery and follow-up outpatient appointment.

Exhibit 8: Number and proportion of patients waiting over 14 weeks for diagnostic tests across Wales in March 2020 and November 2022

	March 2020		November 2022	
	Number	%	Number	%
MRI – Consultant referred	34	3.6%	1,344	10.4%
MRI – GP referred	1	0.04%	478	14.6%
Ultrasound Scan – Consultant referred	55	0.7%	2,361	19.5%
Ultrasound Scan – GP referred	18	0.1%	6,611	26.7%

Source: Audit Wales analysis of StatsWales data

31 Access to physiotherapy presents a similar but more concerning picture. The number of adults waiting for physiotherapy increased from 16,253 in March 2020 to over 32,269 in November 2022. Although more patients are now being seen by a physiotherapist within eight weeks compared to pre-pandemic levels, the number of patients waiting over 14 weeks for physiotherapy has increased 29-fold from 148 in March 2020 to 4,202 in November 2022. Numbers waiting however are gradually reducing. Long therapy waits will not only have an impact on the timeliness of orthopaedic pathways but can also undermine preventative efforts to reduce people’s need for surgery.

Capacity and efficiency were already problematic prior to the pandemic, and a slow restart of orthopaedic services has exacerbated the backlog

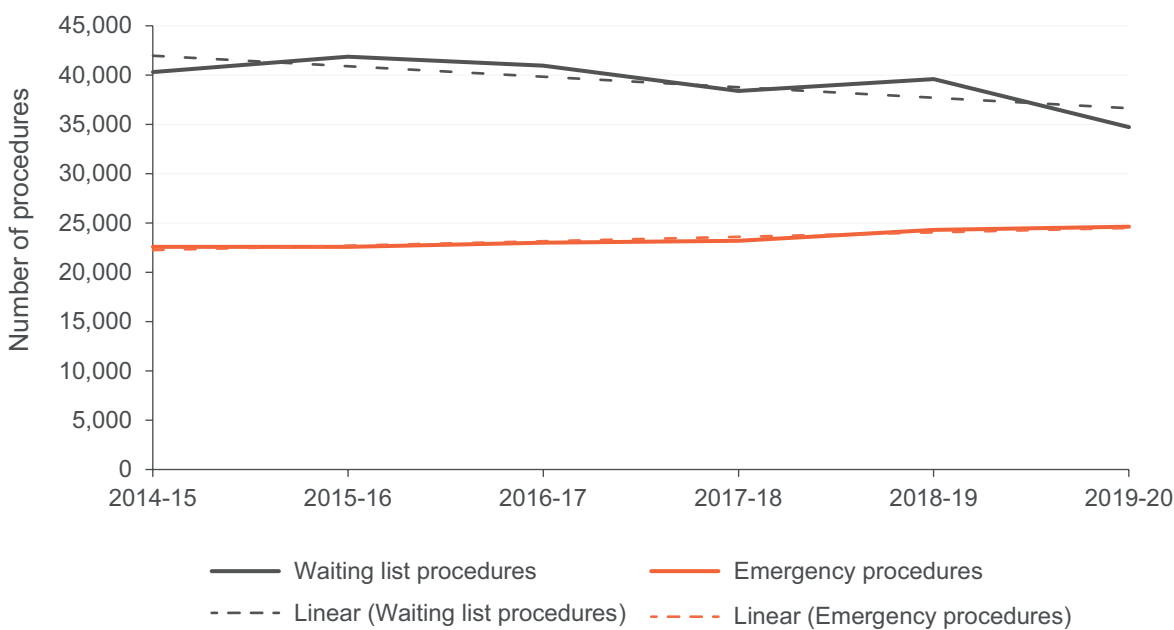
32 For several years there has been insufficient NHS orthopaedic capacity to meet demand. Prior to the pandemic, NHS Wales typically commissioned around 45,000 procedures for the Welsh population, with around 40,000 procedures provided though ‘core’ activity and waiting list initiatives¹⁶. The remainder was commissioned from other non-NHS Wales providers¹⁷. Outsourcing and waiting list initiatives have been short-term measures to improve waiting lists and provide capacity but had done nothing to ensure the sustainability of orthopaedic services.

16 Waiting list initiatives are used by NHS bodies to tackle waiting lists and meet national targets. They involve a short-term increase in capacity such as extra clinics at nights and at weekends, and the use of private healthcare provision.

17 Audit Wales analysis of Patient Episode Data Wales orthopaedic waiting list procedure data, NHS Wales provider versus total commissioned.

33 Over the six years leading up to the onset of the pandemic, the deployment of trauma and orthopaedic capacity changed. National data shows a 10% increase in emergency trauma activity between 2014-15 and 2019-20 which has placed pressure on capacity for planned care. For the same period, there was a 14% decrease in orthopaedic waiting list activity¹⁸ (**Exhibit 9**). The shift between orthopaedic waiting list activity to trauma may not have been readily noticed over such a long period of time but will have had an impact on the capacity to tackle the already existing waiting list backlog. Changes to pension rules for NHS consultants have also impacted on waiting list activity due to a reduction in the willingness of consultants to take on waiting list initiatives.

Exhibit 9: Trend in emergency trauma and orthopaedic waiting list activity, based on the number of procedures, 2014-15 and 2019-20



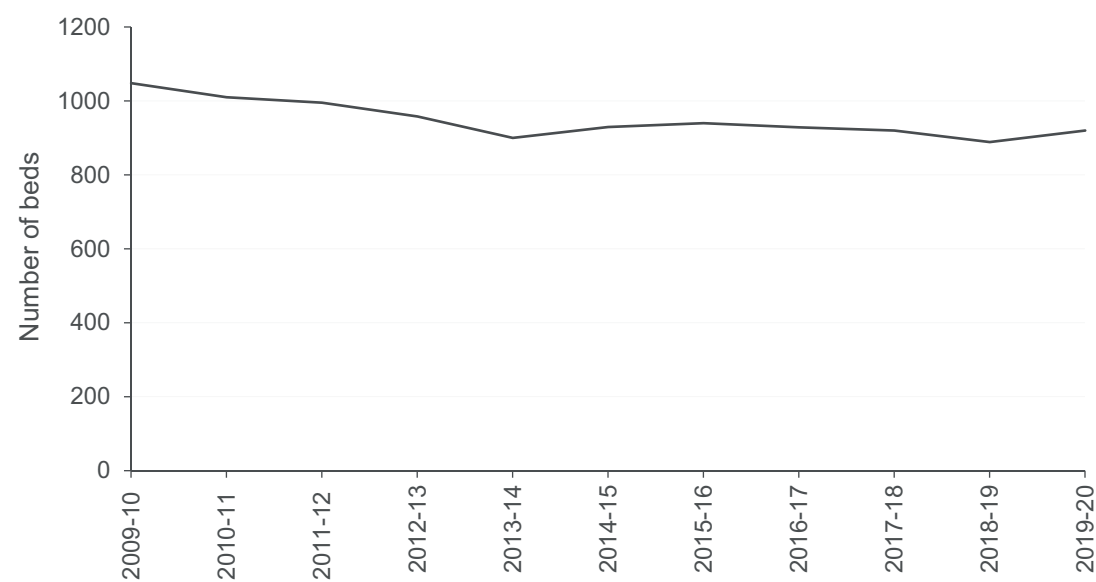
Source: Audit Wales analysis of Patient Episode Database for Wales

34 Capacity constraints also occurred because of a reduction of beds and wider urgent and emergency care pressures resulting in cancellations of orthopaedic activity. **Exhibit 10** shows the total number of orthopaedic beds declined by 12% from 1,048 in 2009-10 to 920 in 2019-20¹⁹.

18 The numbers of waiting list procedures reduced disproportionately in 2019-20. We have assumed this is because of the onset of the pandemic.

19 2020-21 Bed data cannot be compared to previous years because it is based on a different source, definitions, and hospital types.

Exhibit 10: Trend in number of trauma and orthopaedic beds, 2009-10 to 2019-20



Source: Audit Wales analysis of StatsWales data

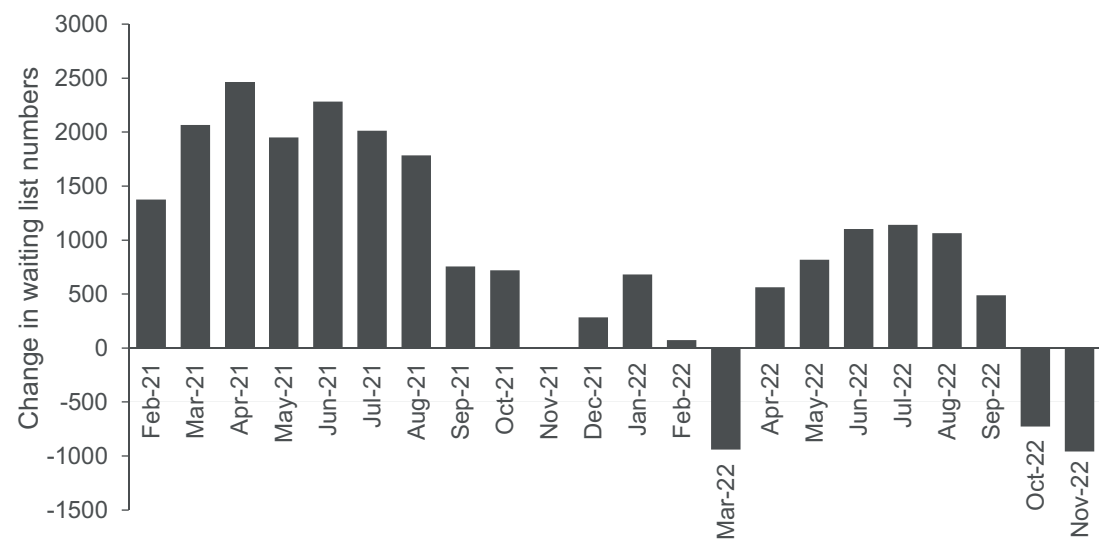
- 35 Bed capacity has also further reduced over the last two years with the continual need for health boards to respond to COVID-19 cases and retain infection control measures.
- 36 Orthopaedic services can operate models with fewer beds if the surgical element of the pathway is well planned, patients are prepared and educated, and processes enable effective and timely discharge. Enhanced recovery approaches also help to reduce length of stay. However, our data analysis indicates lengths of stay have not reduced for many years. Average combined trauma and orthopaedic lengths of stay have stayed at around seven days between 2014-15 and 2019-20²⁰, with substantial variability in lengths of stay by health board. Our data analysis also indicates around a 25% reduction in day case activity between 2014-15 and 2019-20.

20 Audit Wales analysis of Patient Episode Database for Wales

- 37 Orthopaedic services have been slow to restart since the lessening in the impact of the pandemic in 2021 and since the last major (omicron) COVID-19 wave in early 2022. Services are currently still far off the levels of activity seen prior to the pandemic. Current inpatient and day case orthopaedic activity across Wales is around 60% of pre-pandemic levels²¹. Most health boards are also only achieving around 20% to 30% of their orthopaedic procedures as day cases. NHS Wales is targeting around 60% in future. Day case (and very short stay) provides a significant opportunity for utilising existing capacity better.
- 38 Based on changes to waiting lists on a month-by-month basis, orthopaedic capacity is currently not meeting demand, resulting in monthly increases in the number of patients waiting (**Exhibit 11**). In 2021-22, the Welsh Government provided extra funding to health boards to buy additional short and medium-term capacity to support the recovery of planned care services, including orthopaedics. Historically NHS Wales would have looked to NHS England for additional capacity, but they too are struggling to recover their own waiting lists. Consequently, requests for additional capacity through private providers have been greater than the supply available and the ability of health boards to secure the additional capacity needed has been limited. This is particularly the case for orthopaedics. Some medium-term additional capacity has been secured using temporary expansions to health boards' existing clinical estate, such as using demountable units to create operating theatres.
- 39 Funding has also supported administrative and clinical validation of waiting lists to ensure that only those who need treatment are waiting. However, these have tended to be undertaken as one-off exercises to cleanse waiting lists at year end, resulting in a temporary reduction in waiting lists in March. Funding to support the ongoing recovery of planned care has continued and will be available to health bodies for a further three years.

21 Audit Wales analysis of Welsh Government, unvalidated orthopaedic statistics

Exhibit 11: Month-by-month change in waiting lists numbers across Wales, February 2021 – November 2022



Source: Audit Wales analysis of StatsWales data

Orthopaedic services have not kept up with demand and previous national funding initiatives have failed to secure sustainable service improvements

40 Basic analysis of trend data indicates that demand for orthopaedic services is growing. Furthermore, forecasts by the Office of National Statistics indicate a 27% growth of over 75-year-olds (from around 307,000 to 390,000) living in Wales between 2020 and 2032. While positive, this will likely drive further growth in demand for orthopaedic services as more people will be living with age-related orthopaedic and musculoskeletal conditions. This additional demand needs to be planned for and funded.

- 41 Given that orthopaedic waiting lists pre-COVID-19 were deteriorating, it is unrealistic to think that without significant changes, current capacity will ever result in sustainable service recovery. Indeed our ‘optimistic’ scenario modelling (**Exhibit 6**) is based on a gradual increase of commissioned orthopaedic capacity (whether provided by NHS Wales or externally commissioned) and/or productivity levels to 5% above pre-pandemic levels noting that services are currently only running at about 80% of pre-pandemic levels. Our model also assumes that services can curtail any growing demand.
- 42 There has been a history of short-term funded national initiatives for orthopaedic services in Wales. In June 2001, the then Minister for Health and Social Services announced a £12 million package to reduce orthopaedic waits to 36 weeks. Much of this was non-recurrent and consequently had limited ongoing impact. In 2005, the Welsh Government launched its orthopaedic plan for Wales. This initially brought down waits but again did not result in sustainable service improvements. In 2011, the national orthopaedic programme began its aim to eliminate over-36-week waits. At the same time, the then Minister for Health and Social Services announced £65 million over three years to make orthopaedics best in class. Our 2015 report²² considered the £65 million investment. We reported that orthopaedic services have become more efficient in the past decade, but NHS Wales was not well placed to meet future demand. Whilst there had been a focus on securing immediate reductions in waiting times, less attention had been paid to developing more sustainable, long-term solutions to meet demand. Since then, NHS Wales has struggled to meet its orthopaedic waiting list targets.
- 43 Planning for elective orthopaedic services needs to have a clear focus on the short, medium, and longer term, and be supported by realistic assessments of capacity and demand. The short-term focus must be on speeding up recovery of services and addressing existing inefficiencies in the system, the medium-term on building sustainable service models which will start to tackle the backlog; whilst the longer-term view needs to take account of population demographics in forecasting future demand on services, and what is needed to meet that demand.
- 44 While NHS Wales needs to focus on getting services back up and running to meet the demands being placed on them, there is also a duty on health boards to be maintaining a focus on keeping people safe while they are waiting for treatment. Lack of communication from health boards whilst waiting was identified as an issue in the CHC reports. Very few health boards have put arrangements in place to monitor patients on waiting lists and provide the contact needed to reassure patients and provide advice and support as necessary.

22 [Audit Wales Review of Orthopaedic Services, 2015](#)



**What action is
being taken?**

03

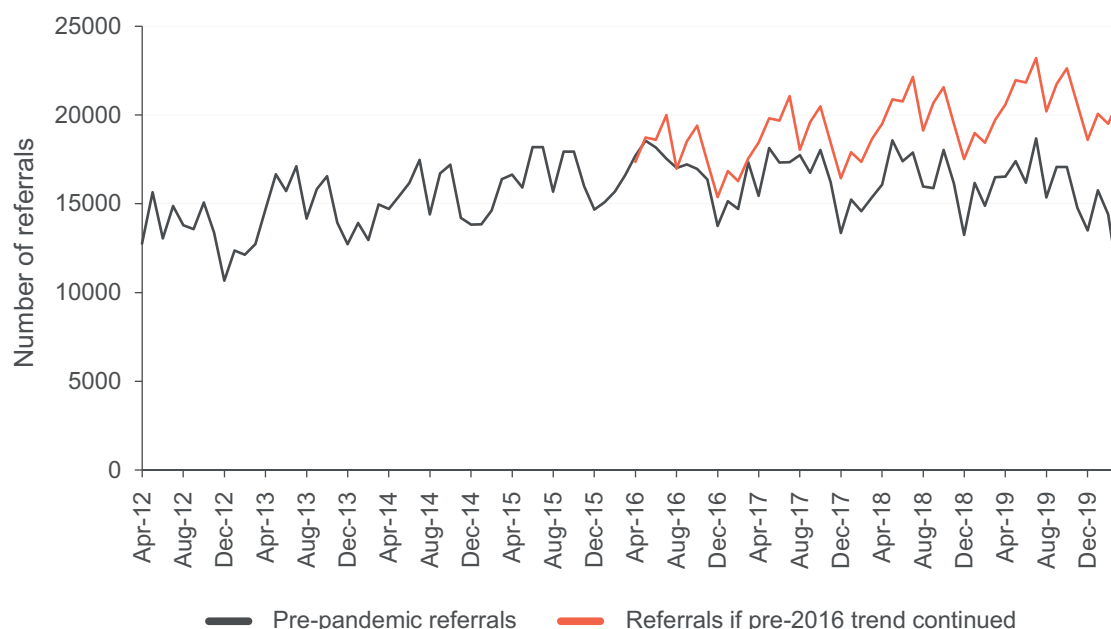
Community-based prevention and treatment are having a positive impact on reducing demand, but capacity is an issue

- 45 For several years, the Welsh Orthopaedic Board has helped to influence developments in orthopaedic services. The Board has overseen the rolling out of preventative approaches such as Community Musculoskeletal Assessment and Treatment Services (CMATS)²³, and more recently First Contact Practitioners (FCPs)²⁴. While community-based musculoskeletal services began far earlier in some health boards, for most they started to be rolled out more comprehensively from 2016.
- 46 While it is difficult to attribute cause and effect directly to the achievements of the community-based prevention, national data suggests that efforts between 2016 and 2020 helped stem the growth in referrals. **Exhibit 12** shows referral trends, and a change in the referral trajectory had community-based prevention not been in place. We have applied a forecast trendline to highlight how the referrals may have increased if the pattern of demand seen between 2012-2016 continued into 2016-2020. With an aging population over this time, we would have expected to see a continued growth in referrals. But this has not been the case.

23 CMATS were developed to provide a community-based service for the assessment and treatment of musculoskeletal-related pain and conditions.

24 First contact practitioner is a new model evolving across the UK which involves placing physiotherapists directly into GP practices to see and treat patients who come into the practice with musculoskeletal problems.

Exhibit 12: Actual orthopaedic referrals compared with predicted referrals from 2016 onwards had community-based schemes not been in place, April 2012- December 2019



Source: Audit Wales analysis of StatsWales data

- 47 But capacity for CMATS has been an issue. Although waits for CMATS are not included as part of the standard waiting times, our recent work on orthopaedic services identified that CMATS waits could be up to four months. All referrals for orthopaedic services are made via CMATS, and only at the point in which it is considered that CMATS intervention is not appropriate, are referrals passed on to orthopaedic services. For many patients, this will be at the point the referral is triaged by the CMATS which can typically take up to a week. But for some, onward referral to orthopaedic services may not happen until they have waited and been seen by the CMATS.
- 48 Our recent work also identified inconsistencies in the CMATS model across Wales, with differences in the range of multidisciplinary professionals that make up the team, and differences in the ability for CMATS to refer directly for diagnostic tests. We also found potential duplication of effort between CMATS which include physiotherapists and FCPs and a risk that overall waits for treatment are elongated because of the need to access both FCPs and CMATS before onward referral to orthopaedic services.

- 49 One scheme to support people is the National Exercise Referral Scheme (NERS). Funded by the Welsh Government and run by the 22 local authorities, the scheme provides opportunities for people with long term conditions to make and maintain healthier lifestyle choices. This is provided through physical activity and behaviour change with the aim to improve health and wellbeing. One intervention is focused on low back pain²⁵, with another focused on weight management. Although numbers are small, the shift to virtual working in response to the pandemic has provided an opportunity to increase capacity and support people on waiting lists. In its latest report²⁶, over 25,000 participants attended one of the virtual, outdoor, or indoor activities put in place to support the wider NERS programme. However, due to the pandemic, the NERS was unable to take new referrals. This has now been changed, but services are heavily reliant on the short-term funding available from the Welsh Government and the support of local authority facilities such as leisure centres to run activities.

There is a clear commitment to improve and transform orthopaedic services nationally, although this may take time to achieve

- 50 Service efficiency, clinical productivity and effectiveness of hospital based orthopaedic services has been an aim in Wales for a long time. NHS Wales has developed clinical pathways based on best practice. But in the past, these clinical pathways have not always been well implemented and there continues to be variation in approaches across health boards.

²⁵ [NERS Low Back Pain Intervention](#)

²⁶ [All Wales NERS Infographic Quarter Two, 2021-22](#)

- 51 More recently NHS Wales has commissioned the Getting It Right First Time (GIRFT) team to review acute orthopaedic services. The reviews started in early 2022 and covered all seven health boards and 21 hospital sites that provide orthopaedic services in Wales, comparing clinical practice with England. Recommendations to health boards focussed on:
- strengthening leadership, through health board specific orthopaedic steering groups;
 - reducing unwarranted and inappropriate variation in clinical practice, performance, and efficiency;
 - engaging staff in change and improvements to orthopaedics and understanding the drivers that are affecting morale;
 - implementing waiting list recovery at pace;
 - better arrangements to support patients prior to admission, and better discharge planning;
 - improving the consistency of collection and use of patient reported outcome measures;
 - improving surgical site infection data recording and reducing deep infection rates to 0.5% or lower;
 - creating short, medium, and long-term multi-disciplinary workforce plans; and
 - building elective orthopaedic recovery plans, including capacity and demand planning on a health board and broader regional footing, multi-disciplinary workforce planning, ring-fencing elective capacity and boosting short-term theatre capacity.
- 52 The GIRFT team's national report to the Welsh Government includes 28 recommendations spanning but not limited to leadership, safety, workforce, efficiency and clinical practice. The recommendations from both the national and local reports need implementing swiftly and effectively.
- 53 At the same time as the GIRFT work, the Welsh Government, through the Welsh Orthopaedic Board, commissioned the Welsh Orthopaedic Society to prepare a clinical strategy for Wales. This strategy provides a thorough and honest appraisal of the current position of orthopaedic services. It sets out the need for new leadership through a Welsh Orthopaedic Network and a requirement for the development of orthopaedic hub sites to better protect waiting list activity from unscheduled care pressures, and to enable efficient high volume low complexity centres of excellence.
- 54 Regional treatment centre hubs offer a good solution to provide protected orthopaedic capacity and deliver best in class levels of efficiency in the medium and longer term. But these will take time, investment, and cooperation across health boards to implement. As an immediate action, some health boards are creating additional operating theatre capacity in the short term, as mentioned in **paragraph 38**.



**What else needs
to be done?**

04

Several challenges need to be addressed if services are not just going to tackle the orthopaedic backlog, but be sustainable for the future

- 55 This report sets out the huge scale of challenge that is faced in Wales. The extent of the numbers of patients waiting, limited capacity available and potential for further growth in demand provide a concerning landscape not just in the short term but also the medium term. All that can be done must be done within the current operating environment, but there remain several risks to longer-term improvement.
- 56 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.
- 57 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively. New technology and improved estate need to be prioritised and regional solutions need to be much more at the core of delivery plans.
- 58 In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.
- 59 These key actions are explored further in the exhibit below.

Exhibit 13: Key actions for NHS Wales to tackle the challenges in orthopaedic services

Lessons must be learnt from previous initiatives which have failed to secure service transformation



Together the new clinical strategy and the GIRFT reports provide the most comprehensive assessment on the position of orthopaedic services in Wales. It is positive that the Welsh Government and NHS Wales are recognising the scale of the challenge. But the response to these cannot be the same as we have seen in response to previous orthopaedics plans; fundamental embedded change is needed.

National plans must be accompanied by buy-in from local clinical teams



Our recent work in orthopaedics, whilst recognising good intent from the Welsh Orthopaedics Board to improve and transform services, highlighted the variability in which that intent translated into practice across health boards. Where national directives to implement service changes have been set in the past, implementation has often been slow, inconsistent, and without the ‘buy-in’ of local clinical teams. The strategy needs to be underpinned by clear and defined programmes of activity and bold leadership will be needed at all levels to ensure that the new clinical strategy delivers a consistent service across Wales.

A renewed focus on efficiencies is needed



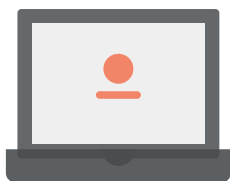
The GIRFT reports have a clear focus on improving efficiency and productivity in orthopaedics, and ultimately delivering better outcomes for the people of Wales. But this focus is not new. NHS Wales has been focusing on reducing length of stay, improving theatre productivity, reducing follow-up rates, and minimising cancellations for some time, but inefficiencies still exist. There needs to be a significant and constant focus in this area. Regular benchmarking reporting needs to be in place to enable challenge and scrutiny to happen locally and nationally, supported by clear action plans to address the things that get in the way of improvement.

A whole system and wider patient pathway focus is needed



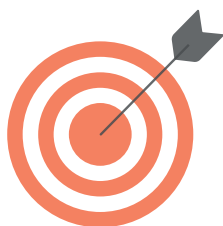
The GIRFT reports and clinical strategy quite rightly focus on orthopaedic services, but effective delivery is reliant on wider services across the NHS. Capacity of enabling clinical services such as diagnostics and therapies to support timely diagnosis, prevention and treatment in the community and effective discharge needs to be available.

Investment in new technologies and improved estate needs to be prioritised



Digital solutions offer further opportunities for efficiencies but need to be effectively piloted and evaluated to ensure wider investment delivers value. Capital and revenue investment needs to be carefully prioritised to get most impact, considering where opportunities exist to make better use of digital initiatives and estate development.

Regional solutions to meet current and future demand need to be pursued with much more rigour



Developing regional service models has been notoriously difficult in the past but regional working provides opportunity to maximise available capacity and provide centres of excellence that deliver better outcomes. Some health boards are starting to work together to look at regional solutions, but these are limited and often as a reactive response to short-term capacity issues. Regional models need to be at the core of orthopaedic delivery plans, and not around the margins with small scale low impact initiatives, which has been the case previously.

Information on patient experience and outcomes must be used extensively to shape clinical decisions and advice to patients



A greater focus needs to be given to patient experience and outcomes. The roll out of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) for orthopaedic services is still variable across Wales. These have been an ambition for a long time but are not well used to inform future investment and more importantly dis-investment and value-based decisions. At a patient level, outcomes should inform choice and 'what matters' discussions. More also needs to be done to support consistent clinical decision making. For example, establishing a common list of procedures not normally undertaken and setting criteria such as BMI thresholds, if surgery for some patient groups would not result in positive outcomes. Our earlier audit work found health boards were working to different lists of procedures considered ineffective.



Appendices

1 Our approach

Our approach

The evidence base for our work comes from reviews of documents on orthopaedic and musculoskeletal services, data analysis, observation of the Welsh Orthopaedic Board and more recently the Orthopaedic Summit in August 2022, and interviews with Welsh Government and NHS officials. We also build on evidence captured prior to the pandemic from health boards.

Our data analysis is based on Welsh Government data on StatsWales, Health Maps Wales, Patient Episode Dataset Wales, and bespoke data requests to NHS officials.

Our scenario modelling in **Exhibit 6** draws on some initial modelling work carried out by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit, was:

- removals are calculated by taking the number of patients waiting over four weeks (ie they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- additions are the people reported in the monthly figures who have been waiting less than four weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their 'clock' reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 6**). We accounted for the possible pent-up demand (see **paragraph 26**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario, with the optimistic scenario assuming that no pent-up demand returns. **Exhibit 14** sets out our modelling assumptions.

Exhibit 14: Waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90.0%	85.0%
Annual increase in additions 2025 onwards	-0.1%	0.0%	-0.2%
Latent ‘missing’ referral demand presenting	5.0%	10.0%	0.0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80.0%	80.0%	80.0%
2023-24	90.0%	85.0%	95.0%
2024-25	100.0%	95.0%	105.0%
2025 onwards	102.5%	100.0%	105.0%

Source: Audit Wales

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.



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Orthopaedic Services in Wales – Tackling the Waiting List Backlog

A comparative picture for Cwm Taf Morgannwg University Health Board

Audit year: 2018

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary

Introduction

- 1 This report supplements our [national report on orthopaedics services](#) and provides additional analysis of the orthopaedic waiting list position at Cwm Taf Morgannwg University Health Board (the Health Board). The report presents a range of data to inform discussion and oversight of the current challenges associated with the recovery of orthopaedic services at the Health Board. It includes several prompts and questions for board members to inform debate and obtain assurance that improvement actions are having the desired effect.
- 2 **A note on the data:** In some instances, the most up to date data available is prior to the pandemic. In others, the data available since the onset of the pandemic is not comparable because of service changes over this period. Therefore, we have:
 - selected data and indicators to help stimulate board member and senior manager discussion and scrutiny on specific aspects of orthopaedic service delivery.
 - used long-term trends and calculations to help present a perspective on orthopaedic services both in relation to the current position and taking a more strategic longer-term outlook.
- 3 In May 2022, the Getting It Right First-Time (GIRFT) team¹ issued its [national report on orthopaedic services in Wales](#) and provided additional local feedback to each health board. The local report for the Health Board was finalised in April 2022. The findings presented here seek to complement rather than duplicate the GIRFT reviews. We have recommended that relevant health board committees receive a progress update against the GIRFT recommendations alongside the Audit Wales national report and the locally tailored data briefing.
- 4 We have presented the findings in this report under the following headings:
 - The scale of the waiting list
 - Referrals and demand
 - Resources and capacity
 - Outpatient models

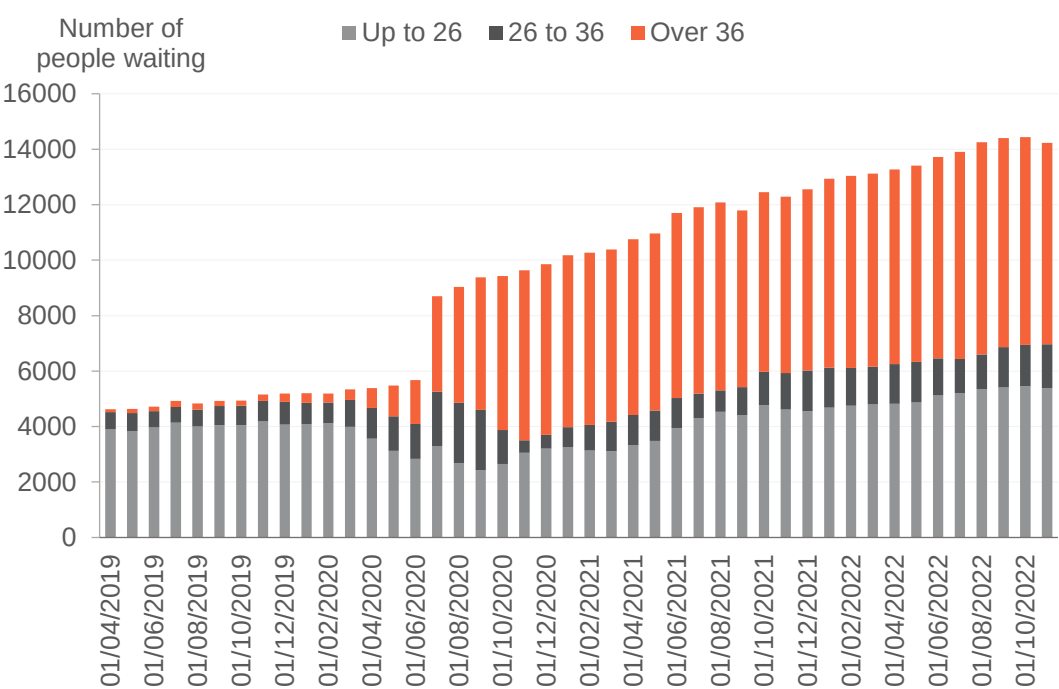
¹ [Getting It Right First-Time](#) is a national programme designed to improve the treatment and care of patients through review and benchmarking.

Detailed report

The scale of the waiting list

5 **Exhibit 1** shows the overall trend in orthopaedic waits at the Health Board since 2016. It shows a picture common to most health boards with a sharp increase in the numbers waiting since the start of the pandemic and within those figures, a significant increase in the numbers facing longer waits.

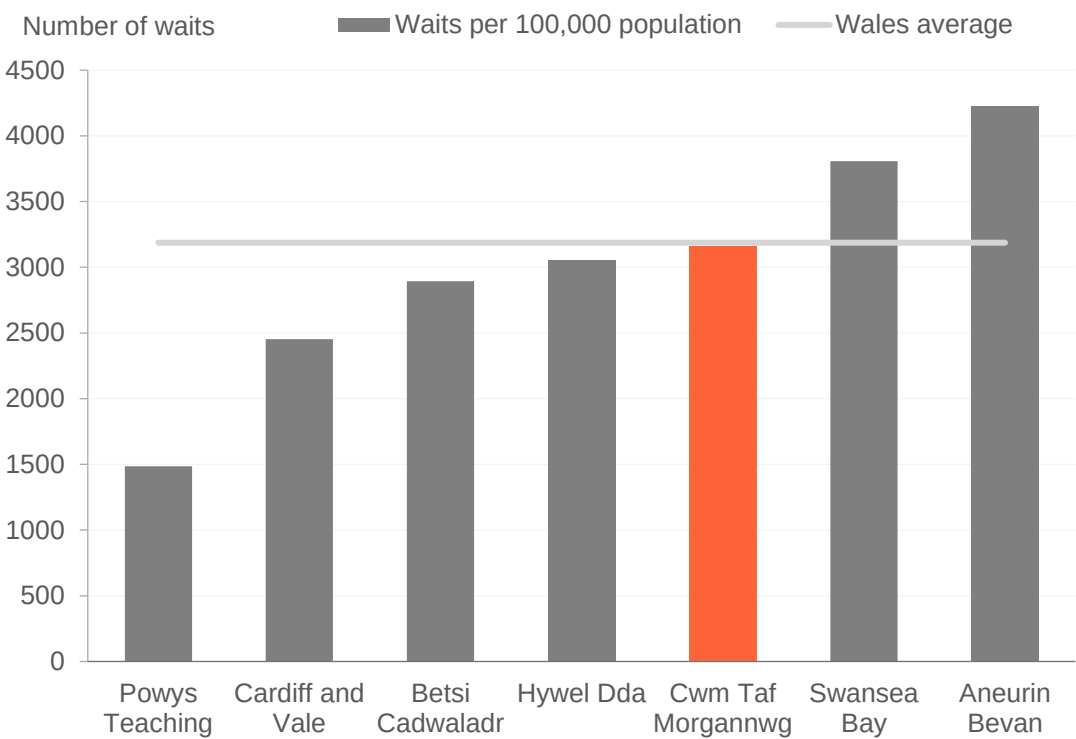
Exhibit 1: total orthopaedic waits, by weeks waiting – Cwm Taf Morgannwg University Health Board (April 2019 – November 2022)



Source: Audit Wales analysis of Stats Wales

6 Comparatively the number of patients on orthopaedic waiting lists relative to population varies across Wales. **Exhibit 2** shows the number of orthopaedic open pathways (waits) per 100,000 population as of November 2022, with the Health Board rate just below the Wales average. This variance may occur because of demographic differences, such as age and deprivation, different primary care referral approaches, different community-based approaches for prevention, treatment, and onward referral. But it is also likely to show that some health boards have been able to secure a better match between capacity and demand than others.

Exhibit 2: total number of orthopaedic waits per 100,000 population, November 2022



Source: Audit Wales analysis of Stats Wales

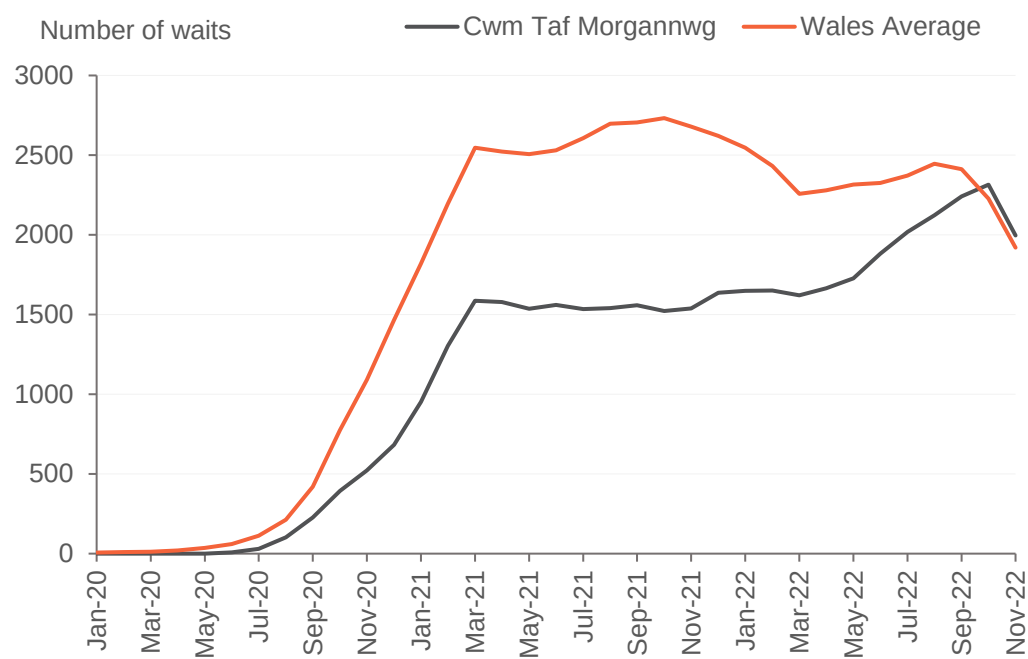
Suggested board member questions



- What factors are contributing to the Health Board's comparative performance on overall orthopaedic waits relative to population?

7 In April 2022, Welsh Government published its programme for transforming and modernising planned care and reducing waiting lists in Wales. This sets out five ambitions to reduce waiting times in Wales. The first one being 'No one should be waiting longer than a year for their first outpatient appointment by the end of 2022'. **Exhibit 3** shows the number of orthopaedic waits for first outpatient appointment longer than a year. As of November 2022, there were 1,919 patient pathways in the Health Board which were waiting longer than a year.

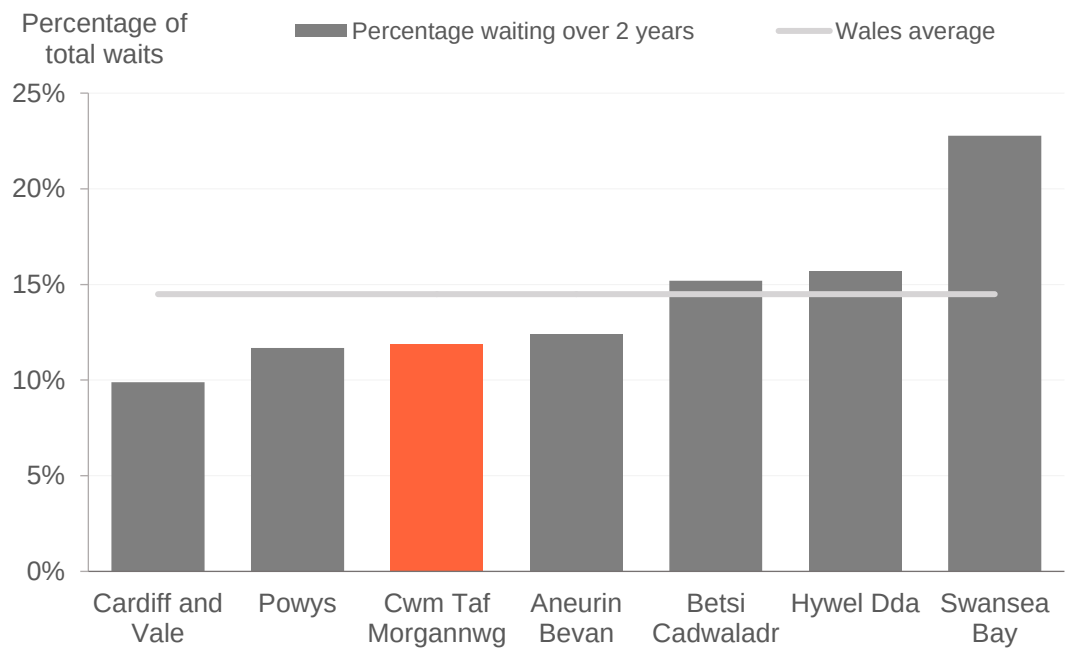
Exhibit 3: total number of orthopaedic waits over a year, waiting for a first outpatient appointment – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales

8 The second key ambition set out in the Welsh Government’s planned care programme is to eliminate the number of people waiting longer than two years in most specialities by March 2023. As at the end of November 2022, there were around 1,689 patient pathways waiting over two years for orthopaedic services in the Health Board. This number is the third lowest in Wales. From our wider analysis, the trends across Wales indicate that health boards are now starting to focus on the growth in extremely long waits. But there is clearly more to do and a finite capacity. **Exhibit 4** shows a comparative picture of long waits. As a proportion of total waits, the proportion waiting over two years in the Health Board is below the Wales average. Exhibit 4 indicates that there is inequality for long waits depending on where people live.

Exhibit 4: percentage of orthopaedic waits over 2 years, by residence, November 2022



Source: Audit Wales analysis of Stats Wales



Suggested board member questions

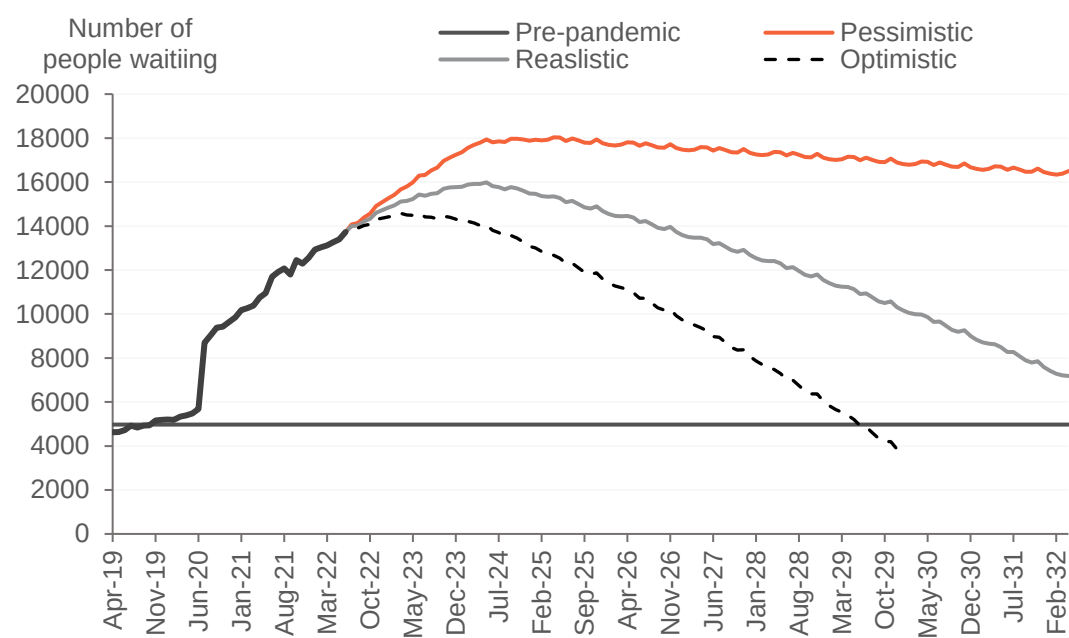
- Is the Health Board likely to meet the targets set out in the Welsh Government’s national recovery plan for planned care? If not, when does it anticipate achieving the key milestones set out in the plan?
- How is the Health Board communicating with patients to tell them how long their wait is likely to be and what to do if their condition deteriorates?
- What is the Health Board doing to prioritise those most at risk of coming to harm because of a delay?
- Does the Health Board have information to indicate whether orthopaedic patients are coming to harm because of delays in their diagnosis and treatment? If so, what does this show and what action is being done to minimise the harm?

9 **Exhibit 5** provides an illustrative scenario (optimistic, realistic, and pessimistic) for the possible length of time that it could take to return orthopaedic waits to pre-

pandemic levels². Our scenario model is based on pre-pandemic levels of capacity, new demand (additions) and activity (removals), future growth in referral demand, and future growth in capacity and/or activity levels.

- 10
- The scenario model also assumes the levels of pent-up demand hitting the system. Pent-up demand being caused by lower-than-expected referrals since the onset of the pandemic. The model does not assume growth in referral demand due to population changes. The scenarios we have presented are based on assumptions which may alter over the coming years.
- 11
- Even in the most optimistic model scenario, the Health Board's orthopaedic waits would not return to pre-pandemic levels for many years. This is based on a move towards a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels. Clearly the timeframe for recovery will reduce if the pent-up demand does not materialise, demand does not grow year-on-year, the Health Board increases internal capacity or productivity, or if there are opportunities for outsourcing. The realistic and more pessimistic modelling scenarios would not see waiting list number return to pre-pandemic for many years, if at all.

Exhibit 5: illustrative scenarios of orthopaedic waiting list numbers – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales data

² Appendix 1 sets out how we modelled the scenarios.

- 12 **Exhibit 6** shows the extent of the variation in waits for hip and knee replacement surgery across Wales prior to the pandemic when this data was last available in 2020. At that time, waits for knee and hip replacements in the Health Board were some of the shortest in Wales, except for the Bridgend area. Variation shows differences between service capacity and waiting list management. As health boards across Wales try to reduce waiting lists through outsourcing, there is potential for further widening of inequalities of access to care.

Exhibit 6: mean waiting times (in days) for knee and hip replacement and revision surgery, 2019-20³

Health Board	County	Knee	Hip
Betsi Cadwaladr	Isle of Anglesey	609.5	363.9
	Gwynedd	604.4	568.9
	Conwy	409.3	344.3
	Denbighshire	266	212.7
	Flintshire	232.4	221
	Wrexham	236.1	226.6
Hywel Dda	Ceredigion	252.4	213.1
	Pembrokeshire	246.4	238
	Carmarthenshire	221.1	180.9
Swansea Bay	Swansea	362.7	373.2
	Neath Port Talbot	323.1	331.8
Cardiff and Vale	Vale of Glamorgan	229	216.3
	Cardiff	241.9	210.1
Powys	Powys	154.2	147.9
Aneurin Bevan	Caerphilly	185.8	165.2
	Blaenau Gwent	200.2	157.1
	Torfaen	182.1	164.7
	Monmouthshire	180.2	160.2
	Newport	196.6	164.1
Cwm Taf Morgannwg	Rhondda Cynon Taf	177.8	150.8
	Bridgend	317.6	294.9
	Merthyr Tydfil	175.3	161.1

Source: Audit Wales analysis of Health Maps Wales

³ Table Key: Under 36 weeks 26-36 weeks Over 36 weeks

Suggested board member questions

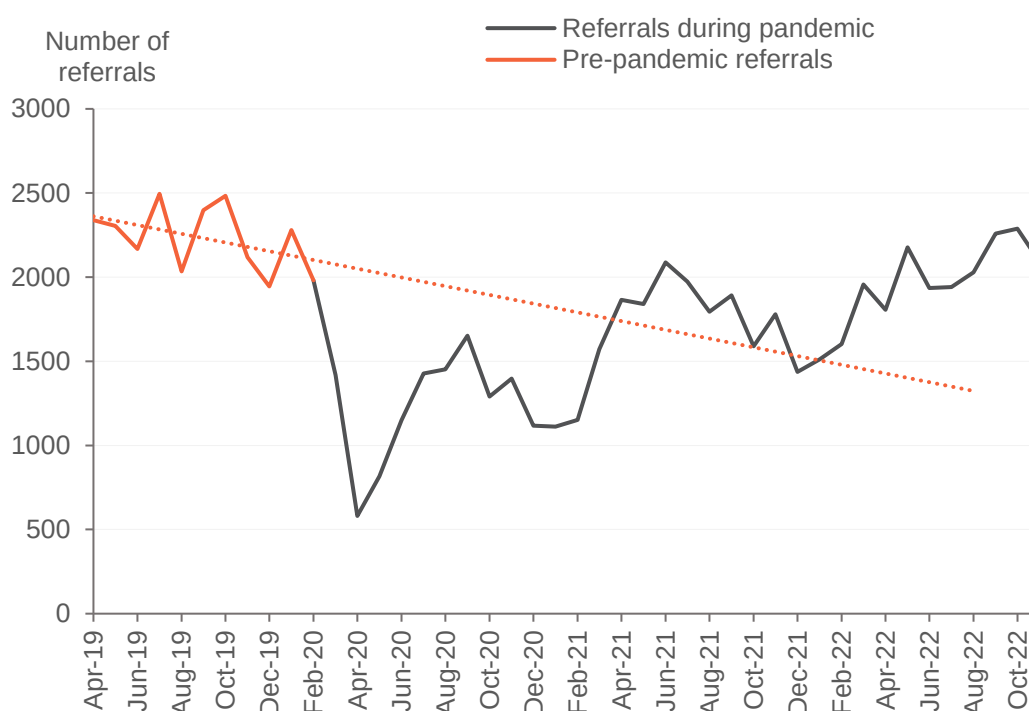


- Has the Health Board undertaken any recent analysis of variation in waiting times by type of surgery and hospital site? If so, what does the analysis show?
 - What action is the Health Board taking to reduce variations in lengths of wait for the same treatment across different hospital sites?
-

Referrals and demand

13 **Exhibit 7** shows the trend in the Health Board's orthopaedic referrals over time and the reduction in referrals during the pandemic. The volume of the Health Board's orthopaedic referrals, unlike many other health boards, has returned to pre-pandemic average referral levels⁴.

Exhibit 7: Trend in referrals to the orthopaedic waiting list, April 2012 to November 2022 – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales data

⁴ Based on average referral rates for 2019-20

14 The extent of the lower levels of referrals during the last couple of years suggests that patients who would have normally been referred potentially still have a need for treatment. Our calculations suggest around 135,000 orthopaedics latent or ‘lost’ referrals across Wales. The numbers vary quite significantly by health board with the Health Board having the third highest proportion (**Exhibit 8**). The effect of this latent demand returning to the system and referral demand returning to pre-pandemic levels more generally, will be to make an already challenging waiting list recovery position even more daunting.

Exhibit 8: Number of potentially latent ‘lost patients’ between March 2020 and March 2022

Health Board	Latent ‘lost’ referrals	Percentage of all-Wales total
Aneurin Bevan	42,438	32%
Hywel Dda	22,860	17%
Cwm Taf Morgannwg	18,294	14%
Cardiff and Vale	17,576	13%
Betsi Cadwaladr	15,987	12%
Swansea Bay	13,046	10%
Powys	4,204	3%
Total	134,406	

Source: Audit Wales analysis of Stats Wales

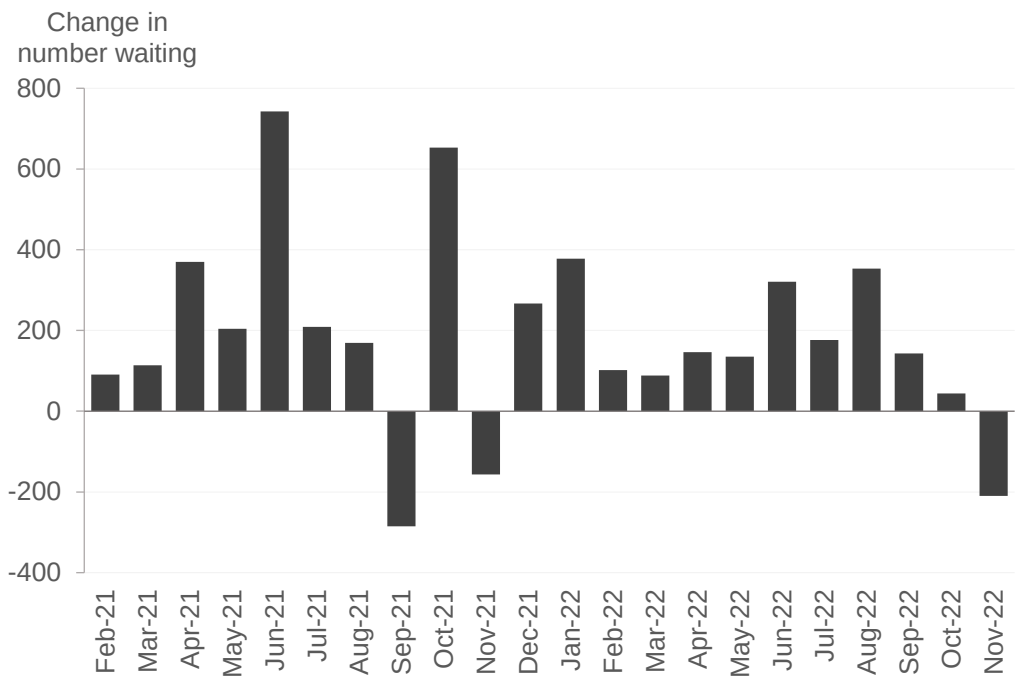


Suggested board member questions

- To what extent is the Health Board seeing, or expecting to see, the latent demand return? If not expected to return, does the Health Board know where the demand has gone?
- Does the Health Board have a good understanding of the current and future demand for orthopaedic services?
- How is the Health Board ensuring that only appropriate referrals are made into secondary care services?
- Are community-based prevention and treatment approaches such as Clinical Musculoskeletal Assessment and Treatment Services operating effectively, and are there opportunities to exploit community-based services further?

15 **Exhibit 9** shows a month-on-month trend of orthopaedic waits, i.e., whether and by how much each month the waiting list has increased or decreased. Across Wales, some health boards have recently managed to stem the growth in waits in some months, either using short-term additional capacity to meet demand or through validation exercises to cleanse waiting lists. But these reductions have not been sustained. With referrals starting to return to pre-pandemic levels, it illustrates the difficulty health boards are having balancing capacity to meet levels of demand.

Exhibit 9: Month-on-month change in numbers of orthopaedic waits – Cwm Taf Morgannwg University Health Board



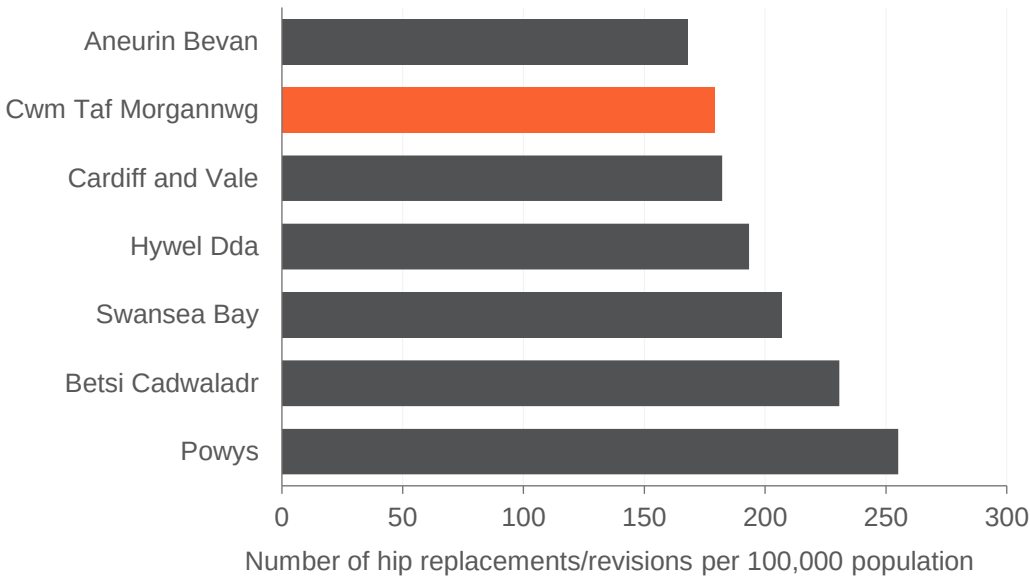
Source: Audit Wales analysis of Stats Wales



- What is the Health Board doing to stem the growth in the numbers of people waiting?
- To what extent has list validation been the main factor in reducing waiting lists? To what extent are removals because of validation due to administrative issues? If so, what lessons are being learnt?
- How is the Health Board ensuring the elective orthopaedic capacity is protected from unscheduled care and wider pressures?

16 **Exhibit 10** provides a comparative historical average trend in the rate of hip revisions or replacements over three years from 2017 to 2020 per 100,000 population. While there are demographic differences in each health board, the exhibit shows quite wide variation which is unlikely due to demographics alone.

Exhibit 10: Admission rates for hip replacements/revisions per 100,000 population based on a three-year average, 2017-18 to 2019-20



Source: Audit Wales analysis of Health Maps Wales



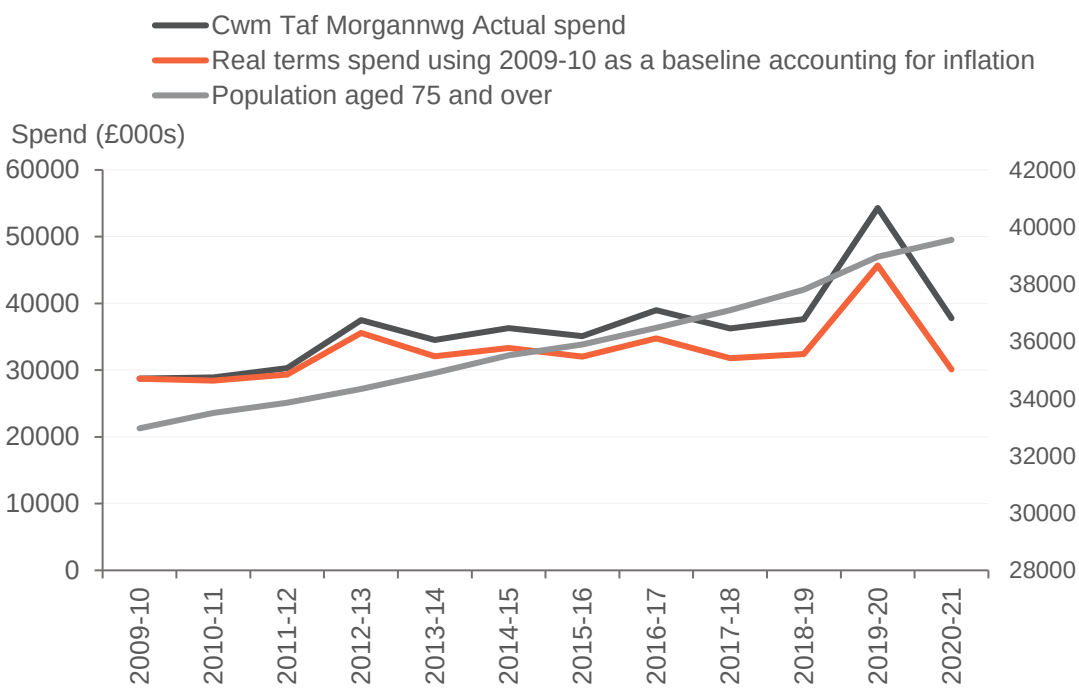
- Has the Health Board undertaken any analysis to understand whether there is a higher or lower rate of procedures, such as hip and knee replacements, than would be expected for the local population? If so, what does it show and are there opportunities for improving productivity and efficiency?
- Does the Health Board understand whether the procedures are delivering positive outcomes for patients?

Resources and capacity

- 17
- Exhibit 11** provides a long-term perspective on actual spend⁵ on orthopaedic services in the Health Board, and the spend adjusted for inflation (i.e., real terms). In general, and across Wales, the pre-pandemic 'real terms' spend on orthopaedics has remained largely static up until the impact of the pandemic. The transfer of Bridgend services however saw an increase in the spend for the Health Board.

- 18
- Service demand is linked to an aging population, with the number of people aged 75 and over increasing by around 19% between 2009 and 2020. This trend is expected to continue. Between 2020 and 2032 across Wales the number of people aged 75 and over is forecast to grow by a further 27%, which could create additional strain on orthopaedic services already struggling to recover.

Exhibit 11: actual spend and real terms spend on orthopaedics vs aging population profile – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales - Health programme budget and population mid-year estimates

⁵ Based on NHS Programme Budget spend for musculoskeletal system problems (excluding trauma)

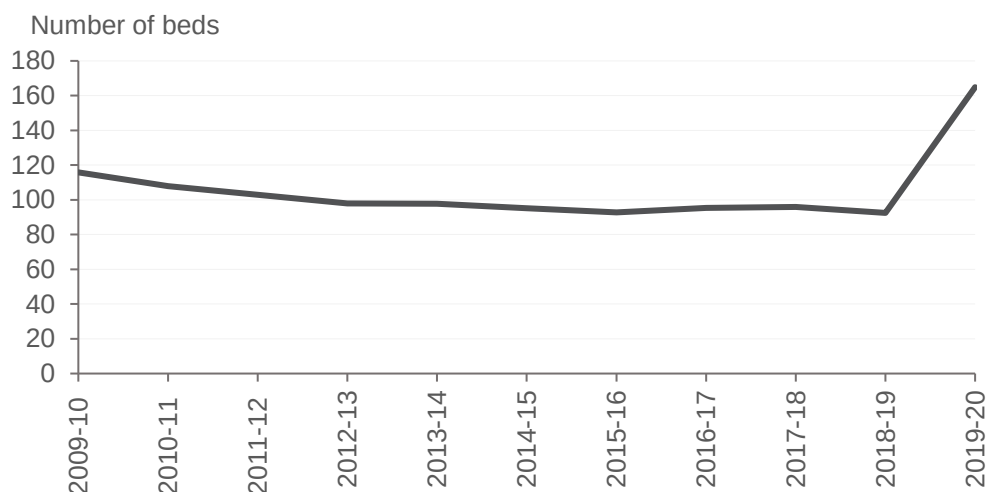
Suggested board member questions



- If the older population continues to grow, but real terms spend on orthopaedics does not keep pace, can the Health Board ensure that future service models will be sustainable?
-

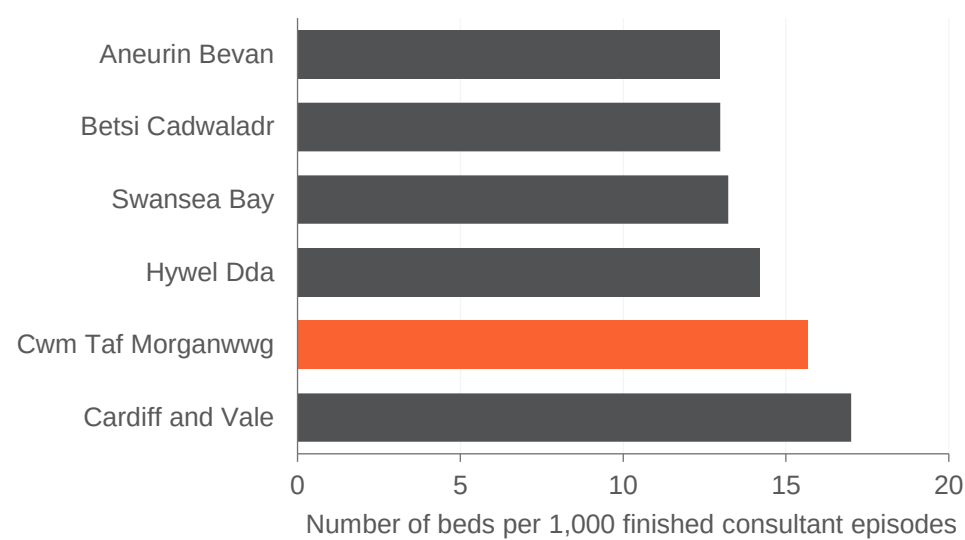
19 **Exhibit 12** and **Exhibit 13** provide trend and comparative data on the number of available orthopaedic beds. The Health Board has the one of the highest level of beds per 1,000 finished consultant episodes, noting the transfer of Bridgend services to the Health Board in April 2019. Given the potential increase in orthopaedic demand due to a growing elderly population, health boards will need to assess whether they can meet demand within existing bed capacity. The extent that efficiencies in bed utilisation can be made and the extent that elective orthopaedic beds can be protected from wider unscheduled care pressures will determine whether current and future demand can be met with the current bed capacity.

Exhibit 12: trauma and orthopaedic bed availability – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales

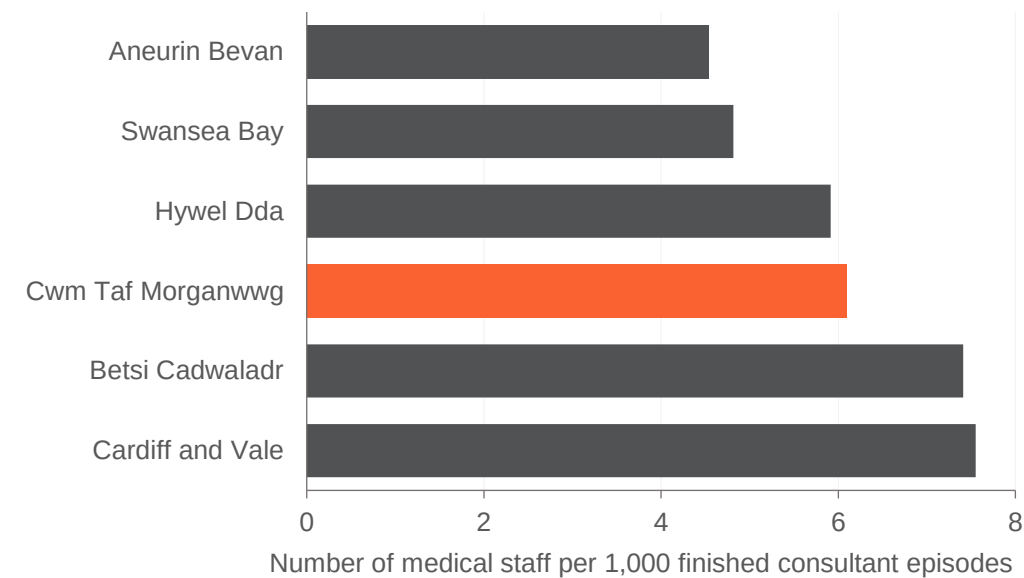
Exhibit 13: comparison of trauma and orthopaedic beds per 1,000 finished consultant episodes 2019-20



Source: Audit Wales analysis of Stats Wales and PEDW data

20 **Exhibit 14** provides a comparative perspective of the medical workforce. The Health Board has the third highest level of medical staff per 1,000 finished consultant episodes. The variation visible across Wales may be due to operational differences in ways of working. However, there is a need to consider optimal staffing levels, efficiencies, productivity, and different pathway models that maximise prudent healthcare principles. As part of this we would expect to see health boards planning on a regional footing to develop high-volume low complexity regional capacity to improve productivity and reviewing consultant job plans as part of pathway redesign.

Exhibit 14: comparison of trauma and orthopaedic medical workforce (WTE) per 1,000 finished consultant episodes 2019-20



Source: Audit Wales analysis of Stats Wales and PEDW data

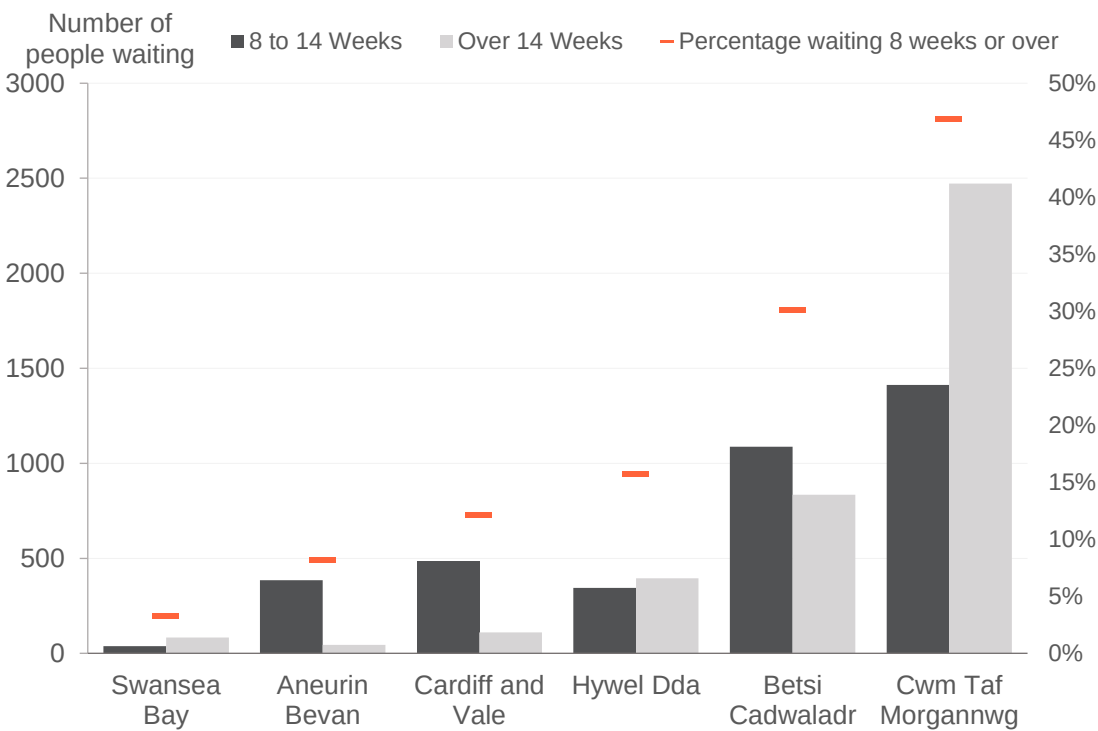


Board member questions

- To what extent does the Health Board currently have the capacity to meet orthopaedic service demand? Where are there capacity gaps?
- What are the workforce risks and challenges?
- How is the Health Board working regionally to create high volume low complexity capacity?
- What is the Health Board doing to create greater levels of efficiency in orthopaedic pathways?

21 People with musculoskeletal conditions often need diagnostic tests to provide clarity on the cause and extent of their problems. The Welsh Government targets say that patients should wait no longer than eight weeks for diagnostic tests. The Health Board has the longest waits for diagnostic tests in Wales. Delays in diagnostic tests are likely to impact on the overall timeliness of orthopaedic treatment. At present there is wide variation in the number and proportion of delays in access to radiology services across Wales (**Exhibits 15 and 16**).

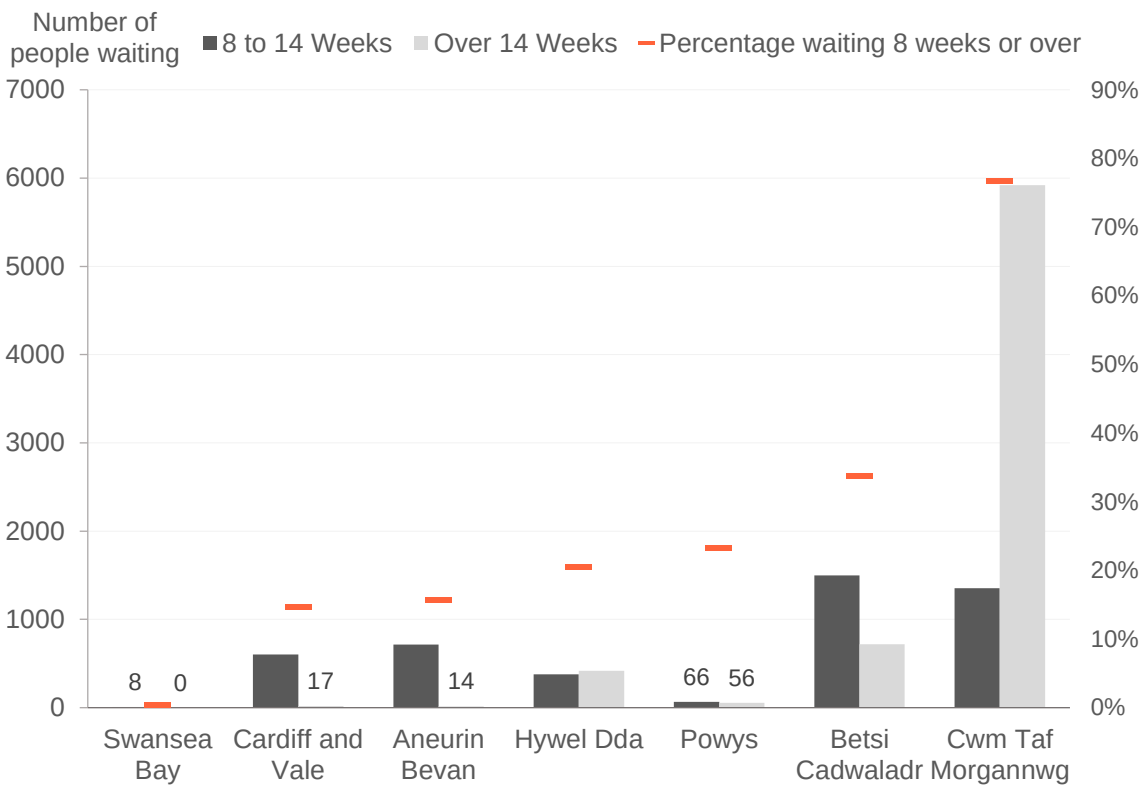
Exhibit 15: number and percentage of waits for consultant referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

Note: Powys consultant referred radiology requests are too low to be visible in the chart.

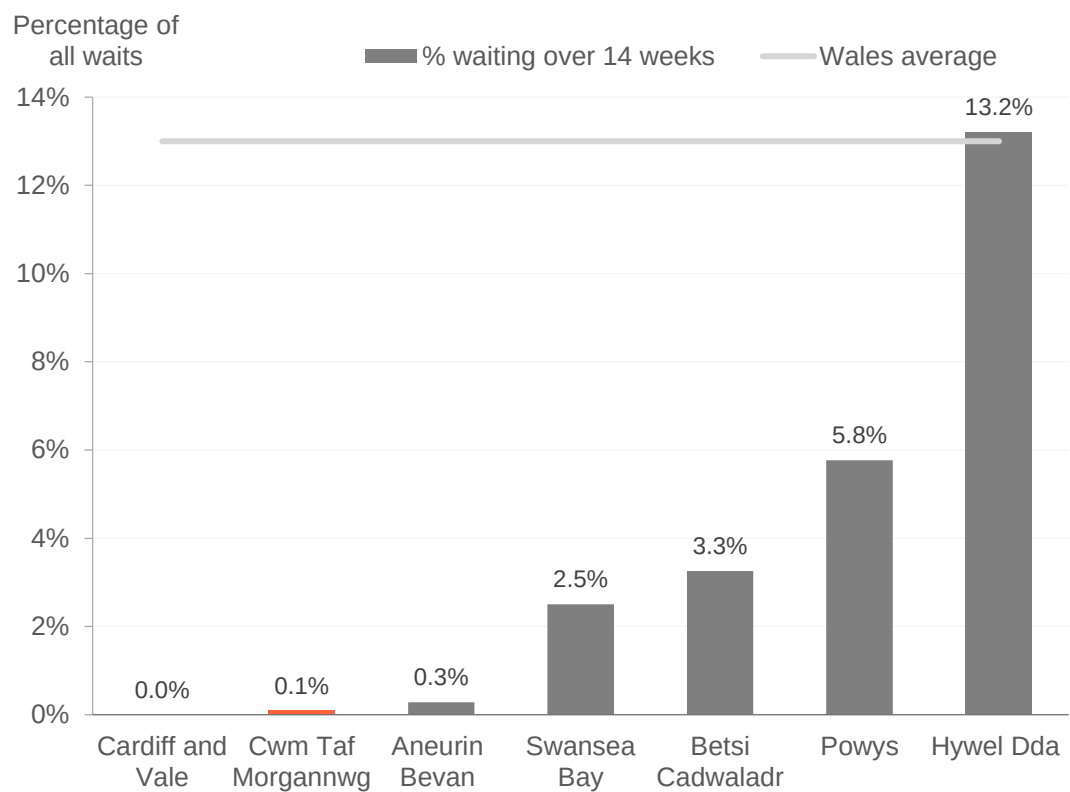
Exhibit 16: number and percentage of waits for GP referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

22 People with musculoskeletal conditions also often require physiotherapy. **Exhibit 17** shows the proportion of people waiting for physiotherapy who are waiting over the Welsh Government target of 14 weeks. The Health Board has very few patients waiting over 14 weeks, and the second-best performance in Wales.

Exhibit 17: percentage of waits over 14 weeks for physiotherapy, November 2022



Source: Audit Wales analysis of Stats Wales



- To what extent is radiology or physiotherapy capacity having an impact on the timeliness of the overall orthopaedic pathway?
- Are there costed plans to match demand and capacity in those areas if required?

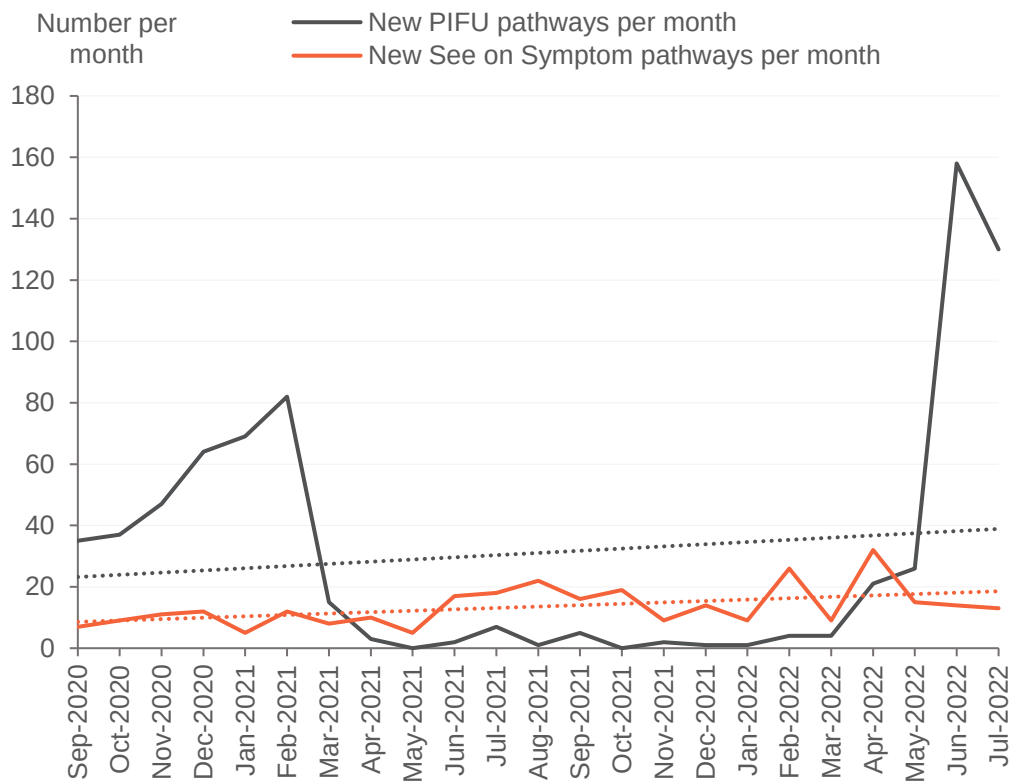
Outpatient models

23 Health boards are implementing new ways of working. The pandemic resulted in a greater extent of ‘digitally enabled’ working. This helped enable continuation of some services at times where face-to-face appointments were not available. Health boards are also on a journey of implementing new outpatient pathways known as ‘see on symptom (SOS)’ and ‘patient initiated follow up (PIFU).’ These approaches are designed to reduce unnecessary follow up outpatient appointments. The aim is

to improve efficiency, reduce unnecessary patient journeys, empower patients to manage their own condition and provide access when they need it.

24 **Exhibit 18 and 19** show the trend in the uptake of new ‘see on symptom’ and ‘patient initiated follow up’ pathways. In most health boards in Wales, we are seeing growth in the use of these new pathways but compared to overall numbers of follow up outpatient appointments, these new approaches remain in the minority. For the Health Board, good progress was made with implementing PIFU pathways in 2020-21 but this waned until April 2022. Steady progress has been made with SOS pathways, but overall numbers are low.

Exhibit 18: trend in adoption of new Patient Initiated Follow Up and See on Symptom pathways per month – Cwm Taf Morgannwg University Health Board (September 2020 - July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 19: average number of Patient Initiated Follow Up and See on Symptom pathways per month compared to average number of follow up outpatient appointments (based on 2018-19 activity levels)⁶

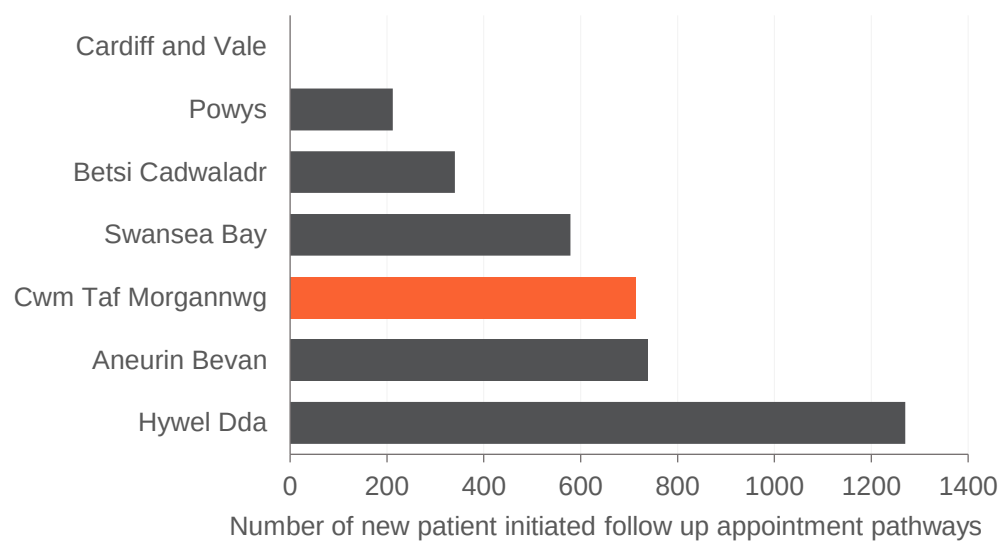
Health Board	Follow up outpatient appointments per month (18/19) average	‘Patient Initiated Follow up’ pathways per month (21/22)	‘See on symptoms’ pathways per month (21/22 average)
Abertawe Bro Morgannwg	5283	N/A	N/A
Aneurin Bevan	5840	31	607
Betsi Cadwaladr	4352	15	128
Cardiff and Vale	4317	0	1275
Cwm Taf	2529	N/A	N/A
Cwm Taf Morgannwg	N/A	3	15
Hywel Dda	3428	53	336
Powys	98	11	259
Swansea Bay	N/A	38	507

Source: Audit Wales analysis of Welsh Government provided data

25 **Exhibits 20 and 21** provide a comparison of the numbers of new ‘see on symptom’ and ‘patient initiated follow up’ pathways. These are actual numbers and have not been adjusted or weighted for organisational size.

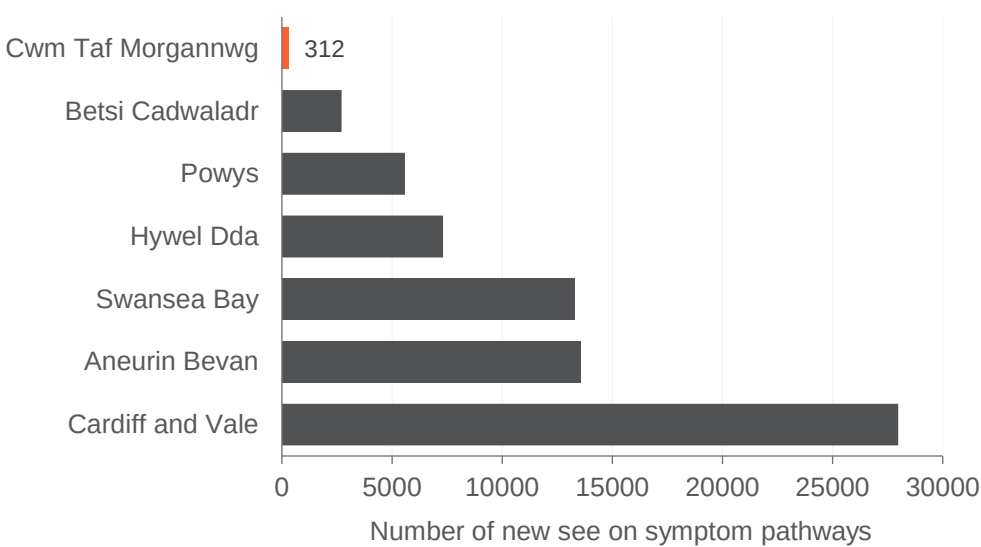
⁶ Total follow up outpatient activity levels have not been publicly reported on StatsWales since 2018-19

Exhibit 20: comparison of total new Trauma and Orthopaedic patient initiated follow up appointment pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 21: comparison of total new Trauma and Orthopaedic See on Symptom Pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Board member questions



- Is the Health Board adopting Patient Initiated Follow Ups and See on Symptoms pathways at sufficient pace? If not, what are the barriers?
 - Are consultant job plans being reviewed to adapt to new outpatient models and maximise use of their time?
 - To what extent are digital/virtual outpatient appointments being used? Is this delivering a better and more efficient service?
-

Appendix 1

Scenario modelling

Our scenario modelling in **Exhibit 5** draws on some initial modelling work conducted by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit, was:

- Removals are calculated by taking the number of patients waiting over 4 weeks (i.e., they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- Additions are the people reported in the monthly figures who have been waiting less than 4 weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their ‘clock’ reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 5**). We accounted for the possible pent-up demand (**see Exhibit 8**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario. **Exhibit 22** sets out our modelling assumptions.

Exhibit 22: waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90%	85%
Annual increase in additions 2025 onwards	99%	100%	98%
Latent ‘missing’ referral demand presenting	5%	10%	0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80%	80%	80%
2023-24	90%	85%	95%
2024-25	100%	95%	105%
2025 onwards	102.5%	100%	105%

Source: Audit Wales

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.



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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

April 2023

NWSSP Audit and Assurance Services

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5	Other activity	4

Appendix A – Tables showing detailed progress against audit plans



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

- 1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at **11 April 2023**. This report provides information on the status of progress of our reviews.
- 1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

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

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
Board Assurance Framework	-	1	2	3	Substantial
Reasonable offer	2	3	-	5	Limited
Board awareness of digital	-	2	-	2	Reasonable
Follow up – Bridgend transfer of IT	1	1	-	2	Reasonable
EASC – Ambulance handover improvement arrangements	-	-	1	1	Substantial

3 Delivering the Plan

3.1 Our agreed performance indicators are set out in table 2 below:

Table 2 – Performance Indicators 2022/23

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	95% (18/19)	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Amber	61% (11/18)	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100% (18/18)	80%	v>20%	10%<v<20%	v<10%

4 Feedback

4.1 Our final reports are issued with a post audit questionnaire, which is our way of getting feedback on the audit process so that we can look to make improvements. In 22/23 we have issued the questionnaires in relation to the finalised reports, and have received seven responses to date.

5 Other activity

Meetings

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

Planning for 2023/24

5.2 Our plan is on the agenda for the April committee.

Appendix A**Table 3: 2022/23 reviews on main programme of work**

Plan Ref.	Review	Rating	Review period	Status	Notes
27	Follow up - CAMHS - Workforce	Reasonable	1	Final	August Committee
30	Follow up - Single cancer pathway: data quality and integrity	Reasonable	1	Final	August Committee
1	Digital operating model	Limited	1	Final	October Committee
6	Medical records management	Reasonable	1	Final	October Committee
16	iCTM improvement team	Reasonable	3-1	Final	December Committee
3	Clinical service group review - Radiology	Reasonable/ Limited	1	Final	December Committee
9	Wellbeing	Reasonable	2	Final	December Committee
20	Cyber security	Reasonable	3	Final	December Committee
2	Decarbonisation	Advisory	± 2	Final	December Committee
26	Follow up - Fire safety	Reasonable	-	Final	February Committee

Plan Ref.	Review	Rating	Review period	Status	Notes
12	Medical variable pay – agency costs	Limited	2	Final	February Committee
8	Board awareness of digital	Reasonable	2	Final	April Committee
4	Reasonable offer	Limited	± 2	Final	April Committee
28	Follow up - Bridgend transfer of IT	Reasonable	4	Final	April Committee
14	Board Assurance Framework	Substantial	3 4	Final	April Committee
24	Welsh Risk Pool	Reasonable	4	Draft	Draft report issued 05.04.23
N/A	Follow up - Facilities governance	-	3	WIP	Fieldwork started 16.01.23
15	Performance monitoring and management	-	3	WIP	Fieldwork concluding
17	Contract and SLA arrangements	-	3	WIP	Have been delays obtaining information
N/A	Follow up - Patient pathway appointment management process	-	4	WIP	Fieldwork ongoing

Plan Ref.	Review	Rating	Review period	Status	Notes
5	National incident framework	-	± 4	WIP	Delays in getting reports from Datix.
29	Follow up - Concerns	-	4	WIP	Fieldwork started 28.03.23
7	Financial systems (financial savings)	-	± 4	WIP	Fieldwork started 02.03.23
11	Interventions Not Normally Undertaken (INNU)	-	± 4	WIP	Fieldwork started 11.04.23
25	Decontamination	-	4	Planning	Brief agreed. Ready to start
18	Health system	-	3	Defer	Is being done as part of 23/24 plan
10	Service configuration to meet cancer targets	-	± 4	Defer	Is being done as part of 23/24 plan

Table 4: Status of PCH plan 2022/23

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

Assignment	Status	Assurance	Notes
1B Final Account	Final	Substantial	-
Validation of management action	Final	Substantial	-
Change, risk and contingency	Draft	Reasonable	Combined draft report issued 06.04.23
Governance	Draft	Reasonable	
Community benefits	Draft	Reasonable	
Programme performance	Draft	Reasonable	

Table 5: Hosted bodies plan 2022/23

Ref.	Review	Rating	Status	Notes
32	WHSCC – Quality unit	Reasonable	Final	-
33	WHSSC – Neurosciences	Reasonable	Final	-
31	EASC review	Substantial	Final	April Audit Committee

Ref.	Review	Rating	Status	Notes
35	WHSSC – Mental health	-	Defer	Defer to next year as mental health strategy yet to be finalised.

Board Awareness of Digital Final Internal Audit Report

April 2023

Cwm Taf Morgannwg University Health Board



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Review reference:	CTMUHB-2223-08
Report status:	Final
Fieldwork commencement:	15.09.2022
Fieldwork completion:	31.01.2023
Draft report issued:	07.02.23
Management response received:	28.02.23
Final report issued:	06.03.23
Auditors:	Morgan Bartley-Edmunds, Principal Auditor
Executive sign-off:	Stuart Morris, Director of Digital
Committee:	Audit & Risk Committee



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Executive Summary

Purpose

The overall objective of the audit was to consider if the Board are equipped to ask the right questions and are aware of digital possibilities and opportunities.

Overview

We have issued reasonable assurance on this area.

We found the Board are aware of digital and are committed to maximising its full potential to transform the organisation. The Board has demonstrated leadership by promoting the Health Board’s new operating model which is anticipated to be digital focussed.

The matters requiring management attention include:

- Board members should familiarise themselves with digital training they have already received to aid their development and knowledge of the potential of digital.
- The Health Board should consider the need for more digital experts and champions to enable its digital agenda.

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives		Assurance
1	Board members are aware of digital and its potential.	Substantial
2	Appropriate training and development on digital is provided to Board members.	Reasonable
3	There is demonstrated leadership and visibility at Board level.	Reasonable
4	There is Health Board commitment to digital and digital transformation.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Board members training and development	2	Operation	Medium
2	Digital experts and champions	4	Operation	Medium

1. Introduction

- 1.1 In line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or 'organisation') we reviewed the Board's awareness of digital.
- 1.2 There is no consistently applied and agreed upon description of 'Digital', but it can be considered as the development of customer-led and data driven automation to create new value and services.
- 1.3 Digital transformation is a process of using technology to radically change service delivery. This transformation includes changing how the organisation works at every level and how technology underpins all digital transformation projects. The technology changes as time goes on, but organisations need to adopt technologies that help them harness and make sense of the vast quantities of data they are sitting on, as well as preparing for trends like the Internet of Things (IoT) and mobile.
- 1.4 These technologies have the potential to transform health care and organisational service delivery. Today the patient or service user is at the centre, surrounded by technologies transforming experience, reimagining care and providing opportunities to manage their health and engage with health care providers. Technologies that provide tools for health care professionals are embedded within the organisation, such as decision support, the capacity to access other professionals' expertise, tools to prioritise and manage their clinical workload and tools to identify the patients at greatest risk.
- 1.5 Although the Board does not need to be from a technical background, it should understand what can be accomplished at the intersection of business and technology and must be prepared to help shape how technology can transform the organisation. As such, the Board should sufficiently understand emerging technology well enough to see opportunities for a better operating model for the organisation. Without this understanding, and of the transformative potential of digital technology, the Board may not be maximising the use of digital.

Audit Risks

- 1.6 The organisation does not maximise the benefits from investment in technology; and
- 1.7 The organisation is unable to delivery its strategic programmes.

2. Detailed Audit Findings

Objective 1: Board members are aware of digital and its potential.

- 2.1 We approached every Health Board member, both executive and independent members, to establish the following:
- if they were familiar with the digital strategy and digital operating model, including the roles and responsibilities of those responsible for digital transformation in the Health Board;
 - if they were aware of digital and its potential to improve healthcare;
 - if they were involved in any digital strategies and to what extent they were using digital to improve their area of expertise; and
 - what the main digital gaps were in the Health Board at the time of the audit.
- 2.2 All Board members were asked the same pre-set questions to ensure fairness. We met with half of the members through virtual meetings, and sent the remaining half an electronic forms document to complete, although we did not get a return from four members.
- 2.3 We note the following summary of responses:
- Members were familiar with the terms 'digital' and 'digital transformation'.
 - Members were familiar with the Health Board's Digital Strategy and identified the key individuals responsible for enabling it, citing the Board itself as a key enabler. All members were committed to digital and its potential, and each member provided good examples of how digital can improve healthcare.
 - Members were involved in digital transformation to some extent, with three Independent Members on the Digital and Data Committee. All Executive Members provided examples of digital projects that they are involved in.
- 2.4 The members provided mixed feedback when asked to rate their digital awareness and literacy, ranging from 'beginner' to 'advanced'. Some members highlighted the need for more digital experts to enable transformation on their behalf.
- 2.5 There was a consensus from Board members that the Health Board's digital maturity was poor at the time of our review, but several members stressed it had improved since the appointment of the new Director of Digital. During our discussions, some key gaps in digital transformation were highlighted, such as the need for a cohesive electronic health record, and a perceived disconnect with the Bridgend care group.

Conclusion

- 2.6 We found digital awareness at Board level has improved since the introduction of the Director of Digital role. Board members are aware of digital and digital transformation and appear enthusiastic about its potential to transform healthcare. They are all involved in digital initiatives in some capacity and have an appetite for digital capabilities, although some members are involved more heavily with digital than others. Digital literacy amongst Board members ranged from beginner to

advanced, but all members signposted us to the appropriate digital experts who they would approach for support when needed. (Substantial Assurance)

Objective 2: Appropriate training and development on digital is provided to Board members.

- 2.7 We asked Board members what digital training and development opportunities they had been offered. It appears that the training varied. Some Board members had received Information Governance and Cyber Security training, whilst others highlighted digital sessions delivered by the Director of Digital at recent board development sessions. However, it appears that ongoing and refresher training would benefit Board members. (**Matters Arising 1 - Medium Priority**)
- 2.8 We note that Board members had received three digital training sessions at Board Development Sessions since 2021. The topics of these training sessions were; the disaggregation of the Bridgend ICT system, Cyber Security, and a Digital Update presentation which included an overview of future digital plans. We reviewed the content of these training sessions and found they were appropriate for Board level.
- 2.9 We understand additional training is planned for 2023. Training sessions on the progress of Bridgend ICT systems and alignment of care groups, cyber security, and patient centred care, are scheduled for the Board development sessions.

Conclusion

- 2.10 Board members have been given appropriate and relevant digital training sessions which have focussed on digital gaps identified by Board members themselves, including the disaggregation of the Health Board's ICT systems and electronic patient records. We found relevant training is planned for 2023 which is aligned to the Health Board's IMTP and strategic goals. However, refresher training may be needed on topics that have previously been covered. (Reasonable Assurance)

Objective 3: There is demonstrated leadership and visibility at Board level.

- 2.11 We reviewed 2022 Board papers and found all meetings had digital representation from the Director of Digital and the Digital and Data Committee chairperson.
- 2.12 We found digital features as a regular item for discussion at Board meetings; the disaggregation of ICT systems was discussed at length in 2022. Digital risks are considered in the Board Assurance Framework.
- 2.13 We note that risks, escalatory matters and other problematic issues relating to digital are of a primary focus, whilst the potential of digital and the future digital strategy are not as prominent as they should be given the Health Board's commitment to digital and transformation. However, we understand that service transformation and digital are well embedded within the new IMTP (due for publication in early 2023) and the Health Board's four strategic objectives. As such, digital and its transformative potential should be discussed at greater lengths at 2023 Board meetings. Consequently, we have not raised a matter.
- 2.14 The Digital and Data Committee provides the Board with assurance on the quality, safety and security of all digital matters. Quarterly highlight reports are presented to the Board, and an annual summary report is expected in early 2023.

- 2.15 We reviewed Digital and Data Committee papers from 2022 and found that all had appropriate Board representation as each meeting was attended by at least three Independent Board members.
- 2.16 We understand that under the 2023 IMTP and Unified Change Programme, a new Digital Session will be introduced which will report to the Digital and Data Committee. This session will replace the current Digital and Delivery Board meeting and will include attendees from across all care groups to provide greater health Board wide representation and dissemination of digital knowledge.

Conclusion

- 2.17 We found there was appropriate digital expertise and representation at Board level. Digital and Data Committee reports are shared with the Board regularly to inform all members of key digital issues and plans. Digital features as a prominent item at Board meetings but is discussed in a reactive way to key problems, rather than in terms of its transformation potential. However, we understand that digital will be a key enabler for service transformation in-line with the new IMTP and strategic objectives from 2023 onwards, and so should feature as a transformative topic in future Board meetings. (Reasonable Assurance)

Objective 4: There is Health Board commitment to digital and digital transformation.

- 2.18 We reviewed the Health Board's key documents and found that digital is a key feature. The 2020-23 IMTP highlights the Health Board's commitment to digital, and we understand the new IMTP, due for publication in early 2023, will have stronger links to digital through its four strategic goals. The Clinical Strategy also outlines the benefit of digital, whilst the Board Assurance Framework specifically highlights the risk of digital transformation.
- 2.19 We reviewed the Health Board's Digital Strategy (2017). We found its notable themes are still relevant but key information (including roles and responsibilities, governance arrangements and specific ICT projects) are no longer accurate. We discussed this issue with the Director of Digital who informed us they want to avoid another lengthy strategy and instead focus on embedding digital within other key Health Board documents. We understand that at the time of our fieldwork, a consultation process was underway to produce a 'digital on a page' document which is intended to highlight key information from the digital strategy which will underpin delivery of the Digital aspects of the IMTP. Consequently, we will not raise an issue concerning the Health Board's Digital Strategy.
- 2.20 We considered the Health Board's media presence and its commitment to digital. Until recently the Health Board has not had a clearly coordinated approach to digital media. However, we understand the Health Board has recently employed a communication lead who will work with the Director of Digital to improve the Health Board's digital media presence. We note that the new Director of Digital, since coming into post, has actively publicised the Health Board's digital achievements on social media.

- 2.21 We spoke with the Director of Finance to understand the Health Board's financial commitment to digital. There is an acknowledgement of the need for digital investment, but the ability to invest is constrained by financial pressures on the NHS. We understand that at the time of our review there was an identified deficit in digital of almost £5,000,000.
- 2.22 In addition, we spoke with a small number of service group leaders to obtain their perspective on the Health Board's commitment to digital. There was an acknowledgment of the All Wales approach, the difficulties taking forward the digital agenda when there are many pressures on the NHS, and specifically the number of ICT systems that need to work effectively and be able to interact.
- 2.23 Our discussions with the service group leaders identified that their view of the key barriers to successful implementation of the digital agenda were ICT systems not working effectively and not interacting with each other, and better overall staff knowledge of the use of IT.
- 2.24 There was a mixed response relating to digital literacy. While there may be distinct pockets of staff that need better skills to engage with digital effectively, more digital experts and champions were needed within speciality areas to drive digital literacy and enable improvement. (**Matters Arising 2 – Medium Priority**)

Conclusion

- 2.25 We found the Health Board are committed to digital and this is expected to be demonstrated in the new IMTP and strategic objectives. It appears that digital transformation will feature more heavily in Health Board documentation, key meetings and media presence from 2023. However, there remain pressures on digital investment and a need for more digital experts to enable the digital agenda to be taken forward. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Board members training and development (Operation)		Impact
Our fieldwork involved liaising with all 12 Board members. We met six members, and sent a questionnaire to a further six, receiving two returns. We understand that in addition to mandatory training, which includes information governance and cyber security, the Director of Digital has delivered three digital training sessions at Board Development sessions. These sessions were the disaggregation of the Bridgend ICT system, Cyber Security, and a Digital Update presentation, which included an overview of future digital plans. One of the pre-set questions we asked Board members pertained to what digital training and development opportunities they had been offered and received. The responses indicate that refresher and ongoing training would be beneficial to ensure Board members are able to lead and enable the Health Board's digital strategy and agenda.		Potential risk of: - The organisation does not maximise the benefits from investment in technology. - The organisation is unable to delivery its strategic programmes.
Recommendations		Priority
1.1	Training sessions that have already been delivered at Board Development sessions should be revisited as part of the 2023 Board members training and development schedule. Board members are encouraged to proactively familiarise themselves with training topics to aid their ability to lead the digital agenda and enable digital transformation.	Medium
Agreed Management Action		Target Date
1.1	In partnership with the Corporate Governance team, we will ensure regular board development sessions to include topics such as Cyber, Data Visualisation and awareness of the latest digital developments.	Dec 2023
		Responsible Officer
		Director of Digital

Matter Arising 2: Digital experts and champions (Operation)			Impact
We approached six Service Group leaders to gain an understanding of their views on digital and how digital transformation was progressing across the Health Board. Two of the Service Group leaders highlighted the need for more digital experts and champions across all areas of the Health Board to increase digital literacy and aid the digital agenda. The other Service Group leader highlighted the importance of the Health Board engaging people early in digital initiatives to get staff onboard and enthused about engaging with digital transformation projects.			Potential risk of: • The organisation does not maximise the benefits from investment in technology. • The organisation is unable to delivery its strategic programmes.
Recommendations			Priority
2.1a	We encourage the Board to reflect on the above feedback and consider the need for more digital experts and champions across all areas of the Health Board to help engage staff with digital transformation and increase their digital literacy.		Medium
Agreed Management Action		Target Date	Responsible Officer
2.1	In partnership with the Chief Operating Officer, there is now Digital & Data representation at the new Care Group Operating Management Board and Improving Care Board	March 2023	Director of Digital

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Reasonable Offer Process Internal Audit Report

April 2023

Cwm Taf Morgannwg University Health Board



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Review reference:	CTMUHB-2223-04
Report status:	Final
Fieldwork commencement:	22 September 2022
Fieldwork completion:	18 January 2023
Draft report issued:	7 February 2023
Debrief meeting:	8 March 2023
Management response received:	31 March 2023
Final report issued:	03 April 2023
Auditors:	Andrea Calise – Principal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Gethin Hughes – Chief Operating Officer
Distribution:	Sarah James – Deputy Chief Operating Officer Neil Cooper – Acute Services Manager, Merthyr Cynon Tarek Allouni – Acute Services Manager, Rhondda Taff Ely Gavin Owen, Acute Services Manager, Bridgend Sandra McConnel – RTT Manager Diane Chick –Medical Records Sandra Lloyd – WPAS Compliance, Training & Systems Manager
Committee:	Audit & Risk Committee



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Executive Summary

Purpose

To provide assurance that the reasonable offer process is being correctly and consistently applied.

Overview

We have issued limited assurance on this area. The key matters which require management attention include:

- Review and revision of the Waiting List Management Standard Operating procedure and dissemination to staff.
- Inadequate training and system support arrangements for staff operating in Bridgend.
- Inconsistent application of the Waiting List Management SOP/RTT rules in relation to time adjustments.
- No data validation checks to identify instances of non-conformance to the rules.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives		Assurance
1	Policies, procedures and training are in place.	Limited
2	Appointment offers comply with the Reasonable Offer process.	Reasonable
3	Appropriate application of waiting times adjustments.	Limited
4	Data validation processes are routinely undertaken.	No Assurance

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Standard Operating Procedures out of date	1	Operation	Medium
2	Inconsistent training and WPAS system support	1	Design	Medium
3	Provision of Reasonable Offers	2	Operation	Medium
4	Incorrect application of Waiting Time Adjustments	3	Design	High
5	Lack of validation and data integrity arrangements	4	Operation	High

1. Introduction

- 1.1 Our review of the Reasonable Offer process was completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').
- 1.2 The length of time a patient waits for NHS treatment is a significant quality and clinical governance issue for healthcare providers, particularly at a time when NHS waiting lists are long as a consequence of the pandemic.
- 1.3 A reasonable offer to a patient is defined as '*any date mutually agreed between the patient and the organisation*'. Any subsequent application of waiting times' rules based on this offer, may only be applied if the appointment date has been mutually agreed, and is therefore considered to be reasonable. Patients can be offered any number of dates and times, at least two of which must be more than two weeks in the future.
- 1.4 The Health Board has a Standard Operating Procedure (SOP) for waiting list management that sets out the methods for managing elective waiting lists and the procedures that staff should follow when making and recording a 'reasonable offer'.
- 1.5 The Health Board's appointment booking arrangements are not fully centralised. There are two central booking teams: one team covering the former Merthyr Cynon and Rhondda Taff Ely localities; and another covering the Bridgend locality. Between them, they are responsible for managing approximately 75% of appointment bookings. The rest of the appointment bookings are managed by local teams as some specialities have chosen to manage their own booking processes. All are required to follow the SOP – Waiting List Management 2020. Our substantive testing focussed on the appointments made by the two centralised booking teams.
- 1.6 The potential risks considered in this review were as follows:
 - Patients not treated equitably if the SOP is interpreted inconsistently.
 - Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed.

2. Detailed Audit Findings

Objective 1: There are up to date policies and procedures in place, and relevant staff have been trained in their application.

- 2.1 The Health Board's Waiting List Management SOP was approved by the Strategic Leadership Group in February 2020. Whilst it was then due to be presented at the Quality and Patient Safety Committee, we have not seen the document taken to a committee of the Board. We confirmed that the SOP aligns to the latest guidance from Welsh Government – 'Rules for Managing Referral to Treatment – 2017' ('RTT Rules').
- 2.2 The Health Board's intranet had a link to the previous SOP, dated 2016, and not the current version. **(Matter Arising 1)**

-
- 2.3 Whilst the current SOP was agreed in February 2020, it was scheduled for review in October 2020. Due to the pandemic, the review was put on hold. In June 2021 supplementary guidance from Welsh Government on the management of waiting lists during the pandemic was published that is not included in the current SOP. **(Matter Arising 1)**
- 2.4 All appointment bookings and waiting lists are managed within the Welsh Patient Administration System (WPAS). The Health Board operates two databases within WPAS. One, which is hosted internally by CTM and is used by staff in Merthyr Cynon and Rhondda Taff Ely localities, and a second, used by staff in Bridgend, which is hosted by Swansea Bay Health Board. The database hosting arrangement dates back to the Health Board's merger with former Abertawe Bro Morgannwg University Health Board (ABMU) in 2019.
- 2.5 The current hosting arrangements of the WPAS limits and restricts the ownership and control of the system used by Bridgend staff, and at times leads to a disjointed and inconsistent use of the system. At the time of our audit, there were functionality issues with the WPAS used by Bridgend staff, which had been reported to Digital Health and Care Wales (DHCW). We understand that the same issue has been experienced by the other booking team and has been resolved. The Health Board has recognised these limitations and a project is ongoing to move the Bridgend database over to the CTM version. Full migration is not expected until 2024/25 as there are significant differences that need to be addressed before the data can be migrated. The project aims to migrate data in various phases, beginning with smaller specialties/services.
- 2.6 The Health Board's appointment booking arrangements are partially centralised with a booking team for Merthyr and Rhondda localities and one for Bridgend. However, there are a number of specialties that have responsibility for managing their own booking process, so have local arrangements. Localised booking arrangements could mean that:
- People could be working in 'silos', meaning that there is over-reliance on a small number of staff and a lack of support or guidance from others with more experience of the booking process.
 - Lack of coordinated or comprehensive training on the SOP and the WPAS system meaning that patients may not be treated in line with RTT rules. **(See Matter Arising 2)**
 - An inconsistent approach to bookings that deviates from the centralised process and several localised procedures being created. **(Matter Arising 2)**
- 2.7 Furthermore, there are inconsistent practices across the two booking teams for ensuring that staff responsible for making bookings have been appropriately trained in the application of the SOP/RTT rules.
- Bridgend staff, within their centralised team, are provided with some in-house training, though the resources available to provide the training are

limited and as such the arrangements are informal and there are no records kept. Bridgend staff, which use the WPAS database hosted by Swansea Bay HB, do not have access to dedicated WPAS training and system support in the same way as their counterparts. **(Matter Arising 2)**

- Staff within the central booking team for Merthyr and Rhondda localities are provided with in-house training from supervisors within the team. They also have access to WPAS support, training and guidance provided by the WPAS Training Team. Records of the training provided are held. The arrangements in place for the central booking staff in Merthyr/Rhondda are more robust with documentation available.

Conclusion:

- 2.8 We have provided Limited Assurance for this objective. The Health Board has a Waiting List Management SOP, which was due for review in October 2020. The training and support for the two central appointment booking teams varies considerably and there are separate training arrangements in place for the specialties that manage their own booking appointments.

Objective 2: The reasonable offers that are made to patients comply with the Health Board's SOP.

- 2.9 The SOP clearly defines 'a reasonable offer of appointment' and the RTT rules which must be followed when managing appointments.
- 2.10 We tested a sample of appointment offers for three specialties managed by the centralised booking teams to confirm they followed the RTT rules. The specialties were: General Medicine; General Surgery; and Women and Children. While in the majority of cases the SOP /RTT rules were followed, we identified that for 6/45 patients there was no evidence to confirm that the appointments had been mutually agreed with the patient and confirmation letters had not been sent. As such, these appointments did not appear to be 'Reasonable Offers'. **(Matter Arising 3)**

Conclusion:

- 2.11 We have provided Reasonable Assurance for this objective. Our review of the WPAS confirmed that for our sample, staff generally followed the SOP/RTT rules on reasonable offers.

Objective 3: Waiting time adjustments are appropriately applied in line with the SOP.

- 2.12 The WPAS records the length of time a patient waits for treatment (Referral to Treatment pathway). The system has built-in clocks that start, stop and can be reset depending on the recorded pathway status or clinical outcome. Staff in the central booking teams and clinic secretaries/booking receptionists are responsible for ensuring that the correct pathway status is applied within the WPAS, with adjustments for patients that 'Did Not Attend', 'Could Not Attend', or where the appointment was cancelled by the hospital.

2.13 We tested a sample of 18 pathways on the WPAS where time adjustments had been made. For 9/18 cases, the adjustments did not meet the SOP/RTT requirements. In most of these cases, the patient had been given two more appointments, shortly after one another, despite failing to attend earlier appointments. The reason why the patient did not attend was not recorded in the system, and unless a clinician advises otherwise, under the SOP/RTT rules, these patients should have been marked as 'DNA' and then discharged. There was no evidence in these cases to suggest the clinician had instructed for the patient to remain on the waiting list. **(Matters Arising 4)**

Conclusion:

2.14 We have provided Limited Assurance for this objective. Our testing concluded that booking staff do not always follow the SOP/RTT rules when applying waiting time adjustments to patient pathways. In turn this can have an impact on the correct reporting of waiting lists.

Objective 4: Data validation processes are routinely undertaken to capture instances of non-conformance with the SOP, with appropriate scrutiny and review.

2.15 The Waiting List Management SOP requires the Performance and Information Directorate to *'audit compliance across all Clinical Directorates highlighting any issues that require immediate resolution in order to ensure consistent compliance'*.

2.16 We held several discussions with key members of staff across the Health Board to determine what data validation arrangements are in place to ensure there has been the correct application of the SOP/RTT rules. However, there are no formal arrangements in place to validate appointment booking data.

2.17 Speciality/Service Managers are responsible for the management and monitoring of waiting lists in their areas. These managers have access to the WPAS and a daily 'RTT Status' report provided by Performance and Information. Whilst the report is Health Board wide, filters can be applied that allow managers to drill down to their respective speciality/areas.

2.18 These reports show the open pathways of patients that are approaching their waiting time target date, rather than historic appointment data that could be used to identify issues of non-conformance with the SOPs/RTT rules. We understand that, when reviewing reports, managers should be mindful of non-conformance with the SOP/RTT rule, for example patients who have multiple appointments, but fail to attend.

2.19 While our sample testing focused on appointments made by the two centralised booking teams, the matters we have identified, and the risks identified in paragraph 2.6, highlight the need to apply validation checks in accordance with the Health Board's policy. **(Matters Arising 5)**

Conclusion:

- 2.20 We have been unable to provide assurance for this objective. Findings from our testing (see objective 2 and 3) and discussion with key members of staff concluded that there are no formal arrangements in place centrally or by Speciality/Service Managers to review and validate WPAS data and ensure that the appointment booking processes comply with the Reasonable Offer rules.

Appendix A: Management Action Plan

Matter Arising 1: Review of Standard Operating Procedures (Operation)		Potential Impact	
The Health Board's Waiting List Management SOP, which includes the application of the reasonable offer process, was published in early 2020 and was due for review later that year. During the pandemic additional guidance was issued, but this is not reflected in the SOP. In 2021, there was communication from Welsh Government indicating revised RTT guidance would be issued, but this has not yet happened. The Health Board has not started its SOP review process to ensure that the document is up to date. Our review of the Health Board's intranet identified the version of the Waiting List Management SOP available is dated 2016, and as such is an earlier version of the 2020 document. The Health Board must ensure that staff have access to the most up to date procedural documentation.		• Patients not treated equitably if the SOP is interpreted inconsistently or where older versions remain in circulation. • Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed. • Patient dissatisfaction leading to complaints/distrust in the service.	
Recommendation		Priority	
1.1	As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	Standard Operating Procedures to be reviewed and updated with approval at OMB and Executive Leadership Group. Once approved, the SOP will be published and issued to all booking teams.	End April 2023	Tarek Allouni – Director of Operations Planned Care & Matthew Swarfield -

	Previous versions of the SOP will be removed from the intranet and kept in a historical record.		Head of Clinical Administration Transformation

Matter Arising 2: Inconsistent training and WPAS system support (Design)	Potential Impact
The Health Board's appointment booking arrangements are partially centralised to one of two booking teams, dependant on locality. The two centralised teams undertake approximately 75% of the bookings made. In Bridgend, there is no formal training in place on the application of the SOP and there is informal training on the use of WPAS. Furthermore, there are numerous specialties which manage their appointments so have local arrangements in place. Whilst no sample testing was undertaken in these areas, from our discussions with key officers, we have determined that this approach could pose a number of risks as follows: • Staff in those specialties that manage the process locally could be working in silos with over reliance on one or a small number of staff within that department. • Lack of formal training, with training provided by any existing team members who undertake bookings. This may lead to a greater chance of deviation and inconsistency of practices, as staff may start to misinterpret the reasonable offer rules and end up not complying with the Waiting List Management Standard Operating Procedures. • Numerous localised procedures are created which may deviate from the SOP/RTT rules and, which will all need updating following any future revisions to the RTT rules. In addition, there is currently no validation work being undertaken to ensure compliance with the SOP/RTT rules (see Matter Arising 5). As such, we have been unable to determine if the approach to having some specialties taking responsibility for their own bookings increases the risk of non-compliance with the SOP/RTT rules.	• Ineffective working practices. • Inefficient operation/delivery. • Low staff morale. • Patient dissatisfaction leading to complaints/distrust in the service.
Recommendations	Priority
2.1 We recommend that the Health Board review and revise the training arrangements in place for appointment booking staff in the Bridgend booking team and those that are working directly within specialties, to ensure that they have consistent training, with access to the same level of support and training currently being provided to the booking team based in Merthyr/Rhondda.	Medium

2.2	Further consideration be given to the sharing of training materials, checklists and guidance between Merthyr/Rhondda and Bridgend staff.	Low	
2.3	Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	A review of the booking process in Bridgend will be carried out and a training compliance plan for Bridgend developed.	End April 2023	Matthew Swarfield - Head of Clinical Administration Transformation
2.2	In line with 2.1, checklist and guidance will be standardised.	End April 2023	Matthew Swarfield - Head of Clinical Administration Transformation
2.3	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	End June 2023	Tarek Allouni – Director of Operations Planned Care & Matthew Swarfield - Head of Clinical Administration Transformation

Matter Arising 3: Reasonable Offer appointments (Operation)		Potential Impact	
We sampled 45 appointment offers across three specialities (General Medicine, General Surgery and Women & Children) and reviewed the audit trail within WPAS to verify compliance with the SOP/RTT rules. Our selection included samples across all three Integrated Locality Groups (Bridgend, Merthyr Tydfil and Rhondda Cynon Taff) and all appointments had been made by one of the centralised booking teams. We identified that for 6/45 offers from across the sampled specialities, the SOPs/RTT rules had not been followed. There was no evidence to confirm if the appointments were booked with prior mutual agreement with the patient, and confirmation letters of appointment were not attached to the relevant appointment pathway on WPAS. The SOPs/RTT rules state that an offer of appointment is only considered reasonable when the dates have been mutually agreed with the patient and that failure to document the offers of appointment will be considered unreasonable.		- Patients not treated equitably if the SOP is interpreted inconsistently. - Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed.	
Recommendation		Priority	
3.1	The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Medium	
Agreed Management Action		Target Date	Responsible Officer
3.1	A training needs assessment and compliance sign off will take place post implementation of the agreed SOP.	August 2023	CSGMs & for all operational/booking team managers
	Refresher training to be organised where required for staff identified.	August 2023	Matthew Swarfield - Head of Clinical Administration Transformation

Matter Arising 4: Incorrect application of Waiting Time Adjustments (Operation)	Potential Impact
We tested a sample of 18 pathways where waiting time adjustments had been applied to confirm that adjustments had been applied in accordance with the SOP/RTT rules. We noted issues with 9/18 of the pathways: - For six of the pathways, the patient failed to attend the agreed appointment ("Did Not Attend") without cancelling and giving sufficient notice. The clocks for these pathways were all "reset" but should have been "stopped". The patients remained on the waiting lists and in all cases two further appointments were scheduled, all of which were agreed with the patient, but again they failed to attend. In accordance with the SOP/RTT rules, the patients should have been discharged earlier in the process and removed from the waiting list. Had a clinician indicated that they wanted the patient to remain on the waiting list, then evidence of this should be recorded in the notes section of WPAS, and the patient moved to the end of the waiting list. However, this was not the case. - For two pathways, three appointments each were scheduled without the mutual agreement of the patients. All appointments were rescheduled within weeks of each other even though the patients failed to attend every appointment. The pathway clock had been "reset" several times and should have been "stopped" earlier in the process and/or appointments should have been booked with the mutual agreement of the patient. - For one pathway, no outcome had been recorded after the appointment had taken place and so was still "open" within the system with the clock running. There were no notes within the system of recent activity/review even though the pathway has been open for several months. The above findings suggest that there are control issues in the management of waiting lists within WPAS, especially in relation to the application of waiting time adjustments (clock "stops" and "resets").	- Patients not treated equitably and some patients waiting longer if the SOP is interpreted inconsistently. - Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed. - Detrimental impact on the Health Board's ability to manage waiting lists effectively. - Costs incurred and resources wasted if patients fail to attend.
Recommendations	Priority
4.1 Training in relation to application of waiting time adjustments should be provided to all booking staff to ensure they are fully aware of and complying with the relevant RTT rules.	High

Agreed Management Action		Target Date	Responsible Officer
4.1	An audit of the 'all users with WPAS compliance' report to take place and training arranged for identified staff.	August 2023	Tarek Allouni – Director of Operations Planned Care & Matthew Swarfield - Head of Clinical Administration Transformation

Matter Arising 5: No validation and data integrity arrangements (Operation)	Potential Impact
The SOP indicates that the Performance and Information Directorate will 'audit compliance across all clinical directorates and highlight any issues that require immediate resolution in order to ensure consistent compliance'. However, thorough discussions with a number of members of staff involved in the booking process, we established that there are no formal arrangements in place to validate appointment booking data. Service/ Speciality Managers have access to the WPAS and can review daily reports on waiting list management data which is published on SharePoint by the Performance and Information Team. However, the focus of the report is to provide visibility to management of the open pathways that do not include appointment booking data yet are approaching their waiting time target date. The issues identified as part of our testing confirm that there is a need to implement validation processes so that instances of non-conformance with the SOP/RTT rules can be identified and rectified and further training provided where necessary. This should not just relate to the bookings made by the central teams, but also to bookings made directly by specialities.	• Poor management/oversight of waiting lists. • Patient dissatisfaction leading to complaints/distrust in the service. • Inaccurate Waiting List Management reporting. • Patients not treated equitably if the SOP is interpreted inconsistently.
Recommendations	Priority
5.1 A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	High

Agreed Management Action		Target Date	Responsible Officer
5.1	5.1.1 - Identification of WPAS reports to allow for identification of compliance.	July 2023	Tarek Allouni – Director of Operations Planned Care & Matthew Swarfield - Head of Clinical Administration Transformation
	5.1.2 - Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements	August 2023	

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Follow-up: Bridgend Transfer of Informatics Services Final Internal Audit Report

April 2023

Cwm Taf Morgannwg University Health Board



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

Acknowledgement

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Disclaimer notice - please note

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Executive Summary

Purpose

To provide the Health Board with assurance regarding the implementation of the agreed management actions from the Bridgend Transfer of Informatics Services review.

Overview of findings

The planned work has continued on the disaggregation of digital services for Bridgend and the transfer into the Health Board.

There was funding allocated in September 2022 for the disaggregation of WPAS, however there has been no further funding for the move of services from Welsh Government, which has delayed disaggregation progress. We understand that funding is being sought on a case by case basis with digital services operating within its current resource envelope.

The risk associated with the Information Governance function has been assessed by the Health Board, and the Head of Information Governance role is currently provided using agency staff.

The key management actions that remain outstanding are:

- To consider requesting that services quantify the impacts of the lack of disaggregation.
- To consider expanding the narrative of the risk on the risk register.

Follow-up Report Classification

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

Progress Summary

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Identification of impacts on Services	High		High
2	Risk Reporting	Medium		Medium
3	Information Governance resource	Medium		Closed
4	Plans and progress	High		Closed

1. Introduction

- 1.1 The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from our Bridgend Transfer of Informatics Services (2122-21) review that was reported as part of our 2021/22 work programme.
- 1.2 The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original review. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.
- 1.3 The areas that this review seeks to provide assurance on are:
- 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; and
 - the actions implemented have effectively addressed the issues highlighted during the original audit.
- 1.4 The potential risk considered in the original review was as follows:
- The organisational transfer results in a degradation in the Informatics service, loss of data or inappropriate access to information.

2. Findings

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

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	1	1	-
Medium	2	1	-	1
Low	-	-	-	-
Total	4	2	1	1

- 2.2 Full details of recommendations requiring further action are provided in the Management Action Plan in Appendix A.
- 2.3 Full details of recommendations that are considered to be closed with no further action required are provided in **Appendix B**.

Appendix A: Management Action Plan

Previous Matter Arising 1: Impacts on Services		
Original Recommendation		Original Priority
The real impact on services should be established and monitored with reporting at an appropriate committee. (planning and performance; Q&S) The risk on the organisational risk register should be reviewed to ensure it captures all the relevant information and actions.		High
Management Response	Target Date	Responsible Officer
The Swansea Bay and CTM joint management group (JMG) risk register and border change plan will be reviewed and updated to include the softer and organisational impacts in addition to the clinical and financial risks It is the expectation of Swansea Bay that the CTM UHB will vacate Neath Hospital by April 2023. The team to support the planning of this, including the digital element will be strengthened with the recruitment process for a designated planning lead to be placed by the end of November 2021. The programme leads for Digital will be an integral part of this process. All risks will be managed in accordance with the UHB's individual processes and significant risks will be escalated on to the organisational risk register.	6/1/22	Asst Director of Planning
	Recruitment to begin by 30/11/21	Asst Director of Planning
	6/1/22	Director of Strategy
Current findings		Residual Risk
There are structures in place to monitor and manage the transition of services from SBUHB to CTM, with a Joint Management Group and Joint Executive Group in place. We note that the JMG meetings do not routinely include a discussion of the risk registers, however updates on the work that is ongoing are provided and the impacts on services are discussed.		Organisational transfer results in a degradation in Informatics service, loss of data or inappropriate access to information and increases risks

We also note that the risk discussions at Quality & Safety Committee do not include the service impacts of the digital provision and these may hinder the delivery of some aspects of the IMTP in the future. The impacts include:		to patient safety and organisational performance.	
- costs associated with providing increased resource for additional steps within department processes; and duplication of effort; - lack of ability for departments to develop as a single unit and deliver single, standardised processes and pathways; - the operation of multiple wait lists, with different wait times; and - reduced patient choice.			
New Recommendations		Priority	
1.1	Consideration should be given to requesting that services fully quantify the impact of the lack of integration on the delivery of services and service change, with monitoring with reporting at an appropriate committee.	High	
Management Response		Target Date	Responsible Officer
1.1	Bridgend disaggregation is reported to every Digital & Data Committee. This reporting will be reviewed to ensure it covers integration, service delivery and service change. The programme is currently developing a template which will assess the impact of any of the repatriation. The template is planned to be completed by June 2023.	Qtr 2 2023/2024	Director of Digital / Assistant Director of ICT

Previous Matter Arising 2: Risk Reporting			
Original Recommendation			Original Priority
The Organisational risk register should be updated to fully identify the risks and issues associated with not moving digital services.			Medium
Management Response		Target Date	Responsible Officer
Agree – will be incorporate in the process described above			
Current findings			Residual Risk
The risk is on the Health Board risk register which notes that without unified integrated systems it will be unable to deliver safe, high quality, clinically and cost effective care. We also note that The Board Assurance Framework references a strategic risk (6) which relates to the delivery of a digital and information infrastructure to support organisational transformation. This notes one of the gaps in controls being the integration of information systems for services in the Bridgend area transferred from Swansea Bay University Health Board. The risk register notes key controls and actions, and the risk is subject to regular monitoring with updates provided. However, there has been no further expansion of the risk description to fully explain the risk of not moving the digital systems and processes.			Medium
New Recommendation(s)			Priority
2.1	Consideration should be given to expanding the risk description on the organisational risk register to bring in the wider financial, organisational and reputational impacts.		Medium
Management Response		Target Date	Responsible Officer
2.1	The relevant risk on the risk register will be reviewed to ensure it fully incorporates all aspects of financial, organisational and reputational risk impact	Qtr 1 2023/2024	Director of Digital

Appendix B: Previous Matters Arising Now Closed

Previous Matter Arising 3: Information Governance Resource		
Original Recommendation		Original Priority
An assessment of the IG resource level in place and the increased workload should be undertaken and the IG team resourced appropriately.		Medium
Management Response	Target Date	Responsible Officer
Our understanding is that the service and associated funding did transfer from Swansea Bay to CTM for the IG function. CTM UHB has since made decisions regarding how it uses this funding, in light of priorities experienced at the time (e.g. Targeted Intervention and RGH ED and paediatric service reviews). However we have taken an assessment of the requisite IG resource to deliver our strategic ambitions and manage our present business and fully concur with the assessment that we do not have the IG resource necessary. A business case has been completed, and this will be considered as part of the overall process for determining a clinically safe and effective, financially sustainable integrated medium term plan. The risk is on the risk register and other opportunities to improve our capacity and capabilities are being taken.	IMTP considerations be completed by 14 th February 2022 November 2021	Director of Governance DPO & SIRO
Current findings		Residual Risk
The organisational risk register now includes a specific risk for this (4699). The current resource is: 1wte Head of IG – Currently this person is a contractor whose contract ends 31 March 2023. We note that recruitment has been problematic and at the time of our follow up the Health Board was advertising the post for a third time.		N/A

- 1wte band 6 IG officer.
- 0.8 wte band 5 freedom of information officer.
- 1 wte IG admin band 3 - The person currently in post leaves in March 2023. We understand that at this time, there is no funding to continue this post.

Work continues to ensure that the Health Board complies with GDPR, with the risk being assessed and included as part of the cyber security work, which is the focus of attention. Work on Information Governance is focussed on areas where a breach would result in more serious consequences.

We note work is ongoing. The ICO plan a follow up visit in April 2023, although not all of the high priority actions may be completed by that time. We understand that recommendations are being managed on a prioritised and smart basis (aligned to other improvement areas).

As the resourcing issues are documented within the risk register, and subject to regular monitoring, we note that this matter is **closed**.

Previous Matter Arising 4: Plans and progress		
Original Recommendation		Original Priority
The actions required to mitigate the identified risks and impacts should be identified and plans and timescales developed with the appropriate funding level identified. These should be submitted to WG.		High
Management Response	Target Date	Responsible Officer
High level road map has been developed. A granular roadmap at the building block level for each service and app is now being finalised, which works around the SLA and how services can be separated without significant detriment to either party. As identified, this is being done at severe detriment to the rest of the CTM programme and on a beg, steal and borrow basis. Once the roadmap has been completed, and resources attributed, it will be set against the SLA to identify what could be done from resources already available to the NHS and then have the ongoing consequences added prior to being given to WG. Part of this will be to identify where the diseconomies of scale observed in SB will arise, and identify these to WG.	Feb 2022	Chief Information Officer & Assistant Director for ICT
Current findings		Residual Risk
There is a disaggregation workplan in place, and an identified critical path, with the detail of work to be done being factored into the annual planning and IMTP process. Work to move services and systems is continuing and there are ongoing discussions regarding items to be removed from the SLA following transfer of responsibility. For example, management of servers. No additional funding for disaggregation has been provided, and as such work continues to be on a case by case / piecemeal approach. However, we note that the network links have not been upgraded to 10GB, which would enable more services to transfer.		N/A

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Board Assurance Framework Internal Audit Report

April 2023

Cwm Taf Morgannwg University Health Board



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Auditors:	Lucy Jugessur, Internal Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Cally Hamblyn, Assistant Director of Governance and Risk
Distribution:	Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
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 and 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 and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Risk Committee.

Audit reports are prepared by the staff of the NHS Wales 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 the 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.

Executive Summary

Purpose

The purpose of the audit was to review the robustness of the Board Assurance Framework (BAF) process, as one of the key mechanisms that the Health Board has in place to monitor its strategic risks.

Overview

The Health Board has recently reviewed its approach to risk management. This process included updating its approach to Board Assurance. Our fieldwork has been undertaken within this first year of the new approach to the BAF, which will continue to evolve. The matters requiring management attention that we identified include:

- The recording of gaps in controls and assurance and the mitigating actions, including the alignment between them and consistency in capturing information.

Other recommendations points are within the detail of the report (see Appendix A).

Report Opinion

Substantial



Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary¹

Objectives		Assurance
1	Policies and procedures are in place	Substantial
2	The BAF aligns to strategic objectives set out in the Health Boards' IMTP	Substantial
3	Strategic risks are regularly reviewed	Substantial
4	Controls, assurance reports and mitigating actions identified in the BAF are in place	Substantial
5	Action plans are in place where gaps in control exist	Reasonable
6	Monitoring and scrutiny of the BAF takes place	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Greater clarity needed in relation to recording gaps in control and mitigating actions	5	Operation	Medium

1. Introduction

- 1.1 Our review of the Board Assurance Framework process was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation').
- 1.2 The Board Assurance Framework (BAF) is designed to provide a structure and process that enables the Health Board to focus on the risks that might compromise it achieving its strategic goals. In recent years work has been carried out to develop and improve the format of the BAF, with the concept for the current BAF approved by the Board in March 2022. A Risk Management strategy and Risk Management policy are in place and provide the framework for managing both operational and strategic risks within the organisation.
- 1.3 The risk considered in this review is that the Board is not receiving appropriate assurances in relation to the achievement of its strategic objectives.

2. Detailed Audit Findings

Objective 1: Policies and procedures are in place setting out the process for developing, maintaining and monitoring the BAF.

- 2.1 The Risk Management policy and Risk Management Strategy & Board Assurance Framework were approved by the Board in May 2022. Both documents are available for staff to access on both the Health Board's intranet and internet. Staff that undertake the risk management training are also provided with a link to the documents. We understand that the documents have been publicised through the staff newsletter with the promotion of risk training opportunities.
- 2.2 The Risk Management policy sets out the overarching approach to risk management within the Health Board. The Risk Management Strategy & Board Assurance Framework provides more detailed information on the application of the policy and the role of a Board Assurance Framework. Our review of the policy and strategy confirmed that they align to one another.
- 2.3 The Risk Management Strategy & Board Assurance Framework states that the '*Board Assurance Framework (BAF) will be used by the Board to identify, monitor and evaluate risks which impact upon strategic objectives*'. The benefits of the BAF are detailed, as are details of the difference between the BAF and the Organisational Risk Register. The strategy illustrates the process for ensuring that the BAF is monitored by the Health Board so that it remains up to date.
- 2.4 While the current Risk Management Strategy & Board Assurance Framework refers to the locality structure, we note that an updated document, aligned to the new care group structure, is scheduled to be received by the Board in May 2023.

Conclusion:

- 2.5 A Board approved Risk Management Policy and Risk Management Strategy & Board Assurance Framework are in place. The strategy details the process for developing, maintaining and monitoring the BAF. We have provided Substantial Assurance in relation to this objective.

Objective 2: The BAF aligns to the strategic objectives set out in the Health Board's IMTP and has given due consideration to risk appetite.

- 2.6 The Health Board's IMTP sets out its four strategic goals. The nine strategic risks captured in the BAF link to the strategic goals, with some goals, such as 'Improving Care', having a number of identified strategic risks.
- 2.7 Each of the four strategic goals within the IMTP has a number of high-level key statements setting out how the Health Board will achieve the goal. The BAF includes information on the controls, sources of assurance, gaps in controls and mitigating actions relating to these key statements, however the link to the IMTP was not always clear. **(Matter Arising 1)**
- 2.8 The risk appetite statement is recorded within the Risk Management Strategy & Board Assurance Framework. The Health Board's risk appetite was agreed following review of organisational risks, issues and consequences. The risk appetite of the organisation has been divided over a number of domains including quality and safety risks, business continuity risks and financial stability risks. Each of these have all been attributed with an appetite level.
- 2.9 Our review of the BAF confirmed that each of the strategic risks has an associated risk appetite.

Conclusion:

- 2.10 The Health Board's risk appetite is mapped to its strategic risks. The BAF aligns to the strategic goals recorded in the Health Board's IMTP, although there is an opportunity for the link to the associated key statements to be clearer. We have provided Substantial Assurance in relation to this objective.

Objective 3: Strategic risks are regularly reviewed, and processes are in place to support, and evidence changes in risk scores.

- 2.11 The individual strategic risks outlined in the BAF are each assigned a risk lead, which is an Executive Director.
- 2.12 The BAF is presented at each meeting of the Board. We confirmed that prior to Board meetings, the Assistant Director of Governance and Risk and the Head of Corporate Governance and Board Business meet each of the executive directors to review and update their respective strategic risks.
- 2.13 In line with the Risk Management Strategy & Board Assurance Framework, amendments to the BAF are reviewed by the Executive Leadership Group (ELG) ahead of presentation at Board. The Assistant Director of Governance and Risk advises the ELG of significant updates to the strategic risks.
- 2.14 We confirmed that the Board review the BAF at each meeting, which includes scrutiny and challenge of the detail recorded within it. Furthermore, we evidenced a change in risk score being challenged at the one of the Board meetings.

Conclusion:

- 2.15 Strategic risks detailed on the BAF are reviewed by the Executive Director in conjunction with the Assistant Director of Governance and Risk. The executive

directors are accountable for risks and provide updates and amended scores for their assigned strategic risks. The Executive team and Board also review and scrutinise the BAF. We have provided Substantial Assurance in relation to this objective.

Objective 4: Controls, assurance reports and mitigating actions identified in the BAF are in place, and the Board and its committees receive suitable assurance information specific to the strategic risks aligned to them.

- 2.16 The Risk Management Strategy details that the BAF report '*identifies the controls in place to manage the risks and the assurances*'. We tested a sample of controls, assurance reports and mitigating actions recorded on the BAF to ensure that they were in place and up to date. We did not identify any issues from our testing.
- 2.17 As part of our fieldwork we met with one executive to discuss a control, assurance report and mitigating action for a strategic risk that they led on. All expected evidence was in place.

Conclusion:

- 2.18 Controls, assurance reports and mitigating actions recorded in the BAF were in place and the specific information was taken to the Board and its committee. We have provided Substantial Assurance against this objective.

Objective 5: Where gaps in control and assurance are identified, action plans are in place setting out the work required to close those gaps. Action plans are regularly monitored.

- 2.19 For each strategic risk, the BAF highlights gaps in control and assurance. Mitigating actions are listed within the BAF and are monitored as part of the routine reviews carried out by the lead Executive. There are no standalone action plans setting out the work required to close the gaps.
- 2.20 We reviewed the gaps in control and mitigating actions listed in the January 2023 BAF. We note that the information was not always consistently or clearly presented. For example, we were not always able to clearly identify mitigating actions for gaps. Furthermore, where actions had been identified, often they did not have a clear timeframe. **(Matter Arising 2)**

Conclusion:

- 2.21 While the BAF identifies gaps in controls and assurance, and mitigating actions, it does not always clearly align the two sets of information. We have provided Reasonable Assurance against this objective.

Objective 6: Monitoring and scrutiny of the BAF takes place in line with the Risk Management Strategy.

- 2.22 The Risk Management Strategy & Board Assurance Framework details the process for monitoring and scrutinising the BAF. It identifies that the Assistant Director of Governance and Risk will '*review the risk score, action plan and current performance with the Lead Executive(s) in readiness for reporting to the Board*'. It also states that the '*Strategic Leadership Group (SLG) are responsible for reviewing*

the BAF prior to its presentation to the Board and Committees as appropriate'. We confirmed that these processes are happening.

- 2.23 The Strategy further states that each principal risk has an assigned assuring Board Committee which *'will scrutinise and seek assurances on the principal risks that they own'*. We saw evidence of the assurance reports that are listed in the BAF being presented to the relevant committees. We acknowledge that members of committees are also Board members. There is an opportunity to improve scrutiny by providing the relevant parts of the BAF to the owning committee. This may help ensure that committee members get full sight of the controls, assurance reports, gaps in controls and assurance, and mitigating actions for the strategic risks owned by the committee. **(Matter Arising 3)**
- 2.24 We confirmed that the Board reviews the BAF at each of its meetings. The Strategy states that the Board should *'consider annually whether the principal risks are comprehensive, or if the risks need to be added / removed / changed'*. We note that the revised BAF will be reviewed by the Board at its meeting in May 2023.

Conclusion:

- 2.25 The Risk Management Strategy & Board Assurance Framework sets out the process for monitoring and scrutinising the BAF. It was evident that the BAF is being monitored and scrutinised in line with the strategy, and assurance reports identified in the BAF are reported. We have provided Substantial Assurance in relation to this objective.

Appendix A: Management Action Plan

Matter Arising 1: Clear links between the key statements of each of the Health Board's strategic goals and the BAF (Design)		Potential Impact	
The 2022/25 three-year plan (IMTP) sets out the Health Board's four strategic goals. Each goal has a number of key statements which set out what is to be achieved as part of the goal. In the main, the detailed information contained within the BAF is provided in relation to the key statements listed under each strategic goal, but the link is not always clear. For example, the 'Sustaining our Future' strategic goal states that 'becoming a green organisation' is a key statement. Whilst the BAF references controls that appear to be linked to becoming a green organisation, it is not explicitly stated. As such, the assurance provided over the Health Board's key statements set out in the IMTP could be more clearly documented.		Assurance is not provided on the Health Board's ability to achieve its strategic goals.	
Recommendations		Priority	
1.1	Consideration should be given to ensuring the BAF captures the key statements that the Health Board has set out for each strategic goal within the IMTP, and the link to the associated control/s and assurance report/s or the gap in control and mitigating action.	Low	
Agreed Management Action		Target Date	Responsible Officer
1.1	The Assistant Director of Governance & Risk in conjunction with the Strategic Risk owner will review the narrative in the BAF to align to the Health Board's key statements as set out in the IMTP.	31.07.2023	Assistant Director of Governance & Risk & Strategic Risk Owners

Matter Arising 2: Gaps in controls and mitigating actions need greater clarity (Operation)	Potential Impact
The Risk Management Strategy & Board Assurance Framework states that the BAF <i>'highlights the gaps in controls and assurances. This enables the development of an action plan for closing the gaps'</i>. However, there are no separate action plans which set out what is required to close the gap in control and assurance. Instead, the BAF lists the mitigating actions that are required. From our review of the BAF we note: • The gaps in control and assurance identified, and the mitigation actions listed, do not appear to clearly align. For example, strategic risk two has six gaps in controls and assurance listed and 12 mitigating actions, but it is not clear which actions relate to which gaps. • Not all of the gaps identified have a mitigating action. For example, strategic risk three has an identified gap relating to the reporting of performance information on estates and premises, but there is no reference to this in the mitigating actions. • The wording used to describe some the gaps in control, is not always clear. For example, gap four of strategic risk two is <i>'Plans now in place to address any legacy issues to resolve any duplications identified on implementation'</i>. While this might explain that an historic gap has been closed, the document should be updated to appropriately reflect the status of the risk. • Mitigating actions are not always consistent. Some of the actions are to be undertaken in the future, such as the delivery of training, others are alternative controls, such as manually validating data. However, others are less clear, for example a mitigating action in strategic risk two states <i>'Nursing Productivity Group Operational'</i>, although it is not clear which gap in control this mitigates. • The timeframe for mitigating actions was not always documented. As such, there is some inconsistency and clarity with regards to the 'Gaps in Controls and Assurances' and 'Mitigating Actions' sections of the BAF. The Risk Management Strategy & Board Assurance Framework does not provide any detailed guidance in relation to this.	• The Health Board is unable to achieve its strategic objectives and deliver safe, effective services to its patients.

Recommendations		Priority	
2.1	The Risk Management Strategy & Board Assurance Framework should be reviewed to provide greater clarity in relation to 'action plans', making it clear that the action plans form part of the BAF. Guidance should be incorporated in relation to the expected information to be captured for the 'gaps in controls and assurances' and 'mitigating action', so a consistent approach across the strategic risks and a clear link between gaps and actions can be applied. Timeframes for actions should be included to allow ongoing monitoring.	Medium	
2.2	Management should review the 'gaps in controls and assurances' and 'mitigating actions' section of the BAF to ensure points clearly articulate what the gap is and what mitigating action is being taken to address the gap. There should be a clear link between gaps and mitigating actions.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	The review of the Risk Management Strategy and Board Assurance Framework will include explicit reference that the action plans for the strategic risks forms part of the Board Assurance Report and what is expected in terms of that section of the report.	31.5.2023	Assistant Director of Governance & Risk
2.2	The Assistant Director of Governance & Risk in conjunction with the Strategic Risk Owner will review all gaps in control to ensure there is a robust mitigating action aligned.	31.5.2023	Assistant Director of Governance & Risk and Strategic Risk Owners

Matter Arising 3: Holistic review of assurance relating to the principal risks within the BAF assigned to committees (Operation)		Potential Impact	
The Risk Management Strategy & Board Assurance Framework requires the nine principal risks to be monitored by a committee of the Board. The nominated assurance committee will <i>'scrutinise and seek assurances on the principal risks that they own'</i>. We reviewed documents and note that while assurance reports listed in the BAF are reported to the respective committees, the relevant part of the BAF itself is not taken to the committees. As such, it is unclear if the committees are getting a full understanding of the strategic risk assigned to them, evidence of the controls in place, and an awareness of the gaps in control and their mitigating actions. The strategy highlights that the Audit & Risk Committee (ARC) is <i>'responsible for reviewing the adequacy of the BAF'</i>. The strategy is silent on how often the ARC should review the BAFs' adequacy. The new BAF is scheduled to be reviewed by the ARC in April 2023.		The Health Board is unable to achieve its strategic objectives and deliver safe, effective services to its patients.	
Recommendations		Priority	
3.1	To allow Board committees greater oversight of the strategic risks that they are assigned responsibility for, each committee should receive a relevant extract of the BAF, thus allowing sight of all listed controls, identified gaps in controls and assurance and mitigating actions, to allow more detailed information to be requested if needed.	Low	
3.2	Consideration should be given to updating the Risk Management Strategy & Board Assurance Framework to give greater clarity on how regularly the Audit & Risk Committee is expected to review the adequacy of the BAF, with future reviews falling in line with that timeframe.	Low	
Agreed Management Action		Target Date	Responsible Officer
3.1	In the current review of the Risk Management Strategy, this statement has been removed as the BAF is reserved for the Board review, scrutiny and approval.	31.5.2023	Assistant Director of Governance & Risk

	However, the assigned risks are now considered at Committee Agenda planning sessions to support agenda planning.		
3.2	The revised Risk Management Strategy will include the frequency of review for the BAF by the Audit & Risk Committee.	31.5.2023	Assistant Director of Governance & Risk

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Annual Internal Audit Plan

Internal Audit Charter

April 2023

Cwm Taf Morgannwg University Health
Board



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Cydwasaethau
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Audit and Assurance Services



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1. Introduction

This document sets out the Internal Audit Plan for 2023/24 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Health Board Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Risk Committee (the 'Audit Committee'), with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2023/24. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and the Health Board (for WHSSC and EASC) but the results, as in previous years, are reported to the Health Board and relevant trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

1.2 Joint Committees

The proposed Plan includes our planned audits with regards to the Health

Board's two hosted joint committees: Welsh Health Specialised Services Committee (WHSSC); and the Emergency Ambulance Services Committee (EASC). These audits are included as an additional section in Appendix A. As in previous years, the results of these audits are reported to the relevant health boards and trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and

other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the continued impact of COVID-19. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP), and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular subset, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

- 1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance and the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
- 2) Organisation based audit work – this covers key strategic risks and priorities from the Organisational Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
- 3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- 4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the organisational risk register;
- risks identified in papers to the Board and its committees (in particular the Audit and Risk Committee, the Quality and Safety Committee, and the Planning, Performance and Finance Committee);
- strategic risks identified within the Board Assurance Framework and significant risks identified within the organisational risk register and assurance processes;
- discussions with directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in

support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board executives and independent members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's executive team, the Chair of the Audit and Risk Committee and the Chair of the Board.

The draft Plan has been provided to the Health Board's executive management team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our, and the organisation's, assessment of risk and assurance requirements as defined in the Health Board's risk management policy, Board Assurance Framework and organisational risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2023/24

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the organisational risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept apprised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based

teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, as in previous years, capital audit work in relation to the Prince Charles Hospital refurbishment project will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. A provision for this work was included by the Health Board in its business case submission.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2023/24 and:

- approve the Internal Audit Plan for 2023/24;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Paul Dalton

Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2023/2024

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Leadership and management development	1	SRR7	To consider the management of the programme, and the uptake and evaluation process.	Director of People	Q1
Gastro-intestinal pathway	2	SRR1/2/4071	Compliance against national standard (NICE (NG12)) and approach across different locations.	Chief Operating Officer	Q1
Performance management of 4-hour target	3	SRR1	Process for reporting and validating urgent care performance data.	Chief Operating Officer	Q1
Estates Assurance / condition	4	SRR3/9	Recognising the high profile afforded to the condition of the NHS Estates and the associated risks, focus will be targeted to the Estate Condition. The areas of review may include, Estates Strategy, Scale of the issue, Risk Exposure, Records management, and progress in addressing key risk areas.	Director of Finance	Q1

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Charitable funds	5	SRR1/3	To consider controls and governance arrangements plus the fundraising aspect.	Director of Finance	Q2
Management of controlled drugs	6	-	To consider governance and control arrangements (Storage, security).	Medical Director	Q2
Deprivation of Liberties (DoLs)	7	4148	To consider the current process and timeliness. Possible second phase considering preparation for the new legislation from October 2023.	Director of Nursing	Q2
Finance - Budgetary controls	8	SRR3	To review approach to budgetary control at localised level.	Director of Finance	Q2
Adult mental health – CSG review	9	SRR1/3/4512	Similar to directorate review where we focus on governance, performance, finance, and workforce arrangements.	Chief Operating Officer/ Director of Therapies	Q2
Regional integration fund	10	SRR1/5	Consideration of arrangements to deliver project work identified in the pillars of the model of care.	Director of Strategy	Q3
Medical job planning	11	SRR4	Link of job planning to pay and to demand and capacity planning within service groups.	Director of People/ Medical Director	Q3

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Finance - Savings delivery	12	SRR3	To review approach to financial savings at localised level.	Director of Finance	Q3
Decarbonisation	13	SRR9	To consider progress against the NHS Wales decarbonisation strategic delivery plan and the Health Board's decarbonisation action plan. Following on from the advisory review delivered in 2022/23, the proposed scope will include governance, strategy progress and implementation.	Director of Strategy	Q3
Welsh risk pool	14	SRR3 / 8	Work required by WRP guidance. Will include element relating to learning from events (LFER).	Director of Nursing	Q4
Embedding the quality framework	15	SRR2	To consider the listening and learning framework. Implementation and alignment to care group model. To include duty of quality.	Director of Therapies	Q4
New Care group model	16	SRR1	To consider how the model is bedding in. Are governance arrangements operating.	Chief Operating Officer	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Risk management	17	SRR1-9	Care group model – service to Board escalation. Consideration of scoring consistency.	Director of Corporate Governance	Q4
IT Service Management	18	SRR6	To consider governance and reporting arrangements.	Director of Digital	Q2
IT infrastructure	19	SRR6	To consider the management of the IT infrastructure and network.	Director of Digital	Q1
Technical resilience	20	SRR6	To consider enactment of technical resilience.	Director of Digital	Q4
Capital project provision	-	-	Focus of work to be determined	Director of Finance	TBC
Follow up work					
Follow up – PoW theatres	21	-	Previous year limited assurance report.	Director of Finance	TBC
Follow up – Radiology – workforce	22	-	Previous year limited assurance report.	Director of People	Q1
Follow up – medical variable pay	23	-	Previous year limited assurance report.	Director of People	Q2

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Follow up – Digital operating model	24	-	Previous year limited assurance report.	Director of Digital	Q3
Follow up – Reasonable offer	25	-	Previous year limited assurance report.	Chief Operating Officer	Q3
Follow Up Action Tracker	-	-	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Director of Corporate Governance	Q4
Other activity					
EASC review	26	-	Focus to be determined	CASC	TBC
WHSSC – Integrated commissioning plan (ICP)	27	-	To consider financial planning.	WHSSC	Q1
WHSSC – Welsh Kidney Network	28	-	To consider governance arrangements.	WHSSC	Q2
WHSSC – Mental Health	29	-	Focus to be determined.	WHSSC	Q4
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation	Director of Corporate Governance	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
			and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, and Digital Health and Care Wales.		
Integrated Audit & Assurance Plans					
Management of Prince Charles Hospital capital project	-	-	See Separate Integrated Audit & Assurance Plan (IAAP).	Director of Finance	Q1-Q4

Please note: National audits undertaken at DHCW₇ and NWSSP will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2023/24
Audit plan 2022/23 agreed/in draft by 30 April	✓	100%
Audit opinion 2021/22 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

- 1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.
- 1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:
- Board means the Board of Cwm Taf Morgannwg University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
 - Senior Management means the Chief Executive as being the designated Accountable Officer for Cwm Taf Morgannwg University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.
- 1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

- 2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Cwm Taf Morgannwg University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.
- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:

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- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
 - the appropriate assessment and management of risk, and the related system of assurance;
 - the arrangements to monitor performance and secure value for money in the use of resources;
 - the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
 - compliance with applicable laws and regulations; and
 - compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

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- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
 - 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.
 - 3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
 - 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

- 4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.
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6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
 - reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
 - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
 - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
 - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
 - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
 - reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the organisational or corporate risk register;
 - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
 - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.
- 7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

- 8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

- 8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.
- 8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
 - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
 - b) Disclose any qualification to that opinion, together with the reasons for the qualification;
 - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
 - d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
 - e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
 - f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Board Secretary and Chair of the Audit Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
 - Specific
 - Measurable
 - Achievable
 - Relevant / Realistic
 - Timely.

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- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
 - The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.
- 9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision may be made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.
- 9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

- 10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.
- 10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.
- 10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.
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12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

- 14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
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NHS Wales Shared Services Partnership
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