CTMUHB Audit & Risk Committee

Tue 19 December 2023, 13:00 - 15:00

Virtually via Microsoft Teams

Agenda

13:00 - 13:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Patsy Roseblade, Independent Member/Committee Chair*

1.2. Apologies for Absence

Information *Patsy Roseblade, Independent Member/Committee Chair*

1.3. Declarations of Interest

Information *Patsy Roseblade, Independent Member/Committee Chair*

13:05 - 13:10
5 min

2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the meeting held on 24 October 2023

Decision *Patsy Roseblade, Independent Member/Committee Chair*

2.1.1 Unconfirmed Minutes CTMUHB Audit and Risk Committee 24 October 2023 ARC 19 December 2023.pdf (14 pages)

2.1.2. Unconfirmed Minutes from the In Committee meeting held on 24 October 2023

Decision *Patsy Roseblade, Independent Member/Committee Chair*

2.1.2 Unconfirmed Minutes In Committee Audit and Risk 24 October 2023.pdf (2 pages)

2.2. FOR NOTING

2.2.1. Audit & Risk Committee Annual Cycle of Business

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

2.2.1a Committee Annual Cycle of Business ARC 19 December 2023.pdf (3 pages)
2.2.1b Audit Risk Committee Cycle of Business ARC 19 December 2023.pdf (5 pages)

2.2.2. Audit & Risk Committee Forward Work Programme

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

2.2.2 Audit & Risk Committee Forward Work Plan ARC 19 December 2023.pdf (3 pages)

2.2.3. Declarations of Interest and Gifts & Hospitality Report

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

2.2.3a DOI and GHS Cover Report ARC 19 December 2023.docx (4 pages)
2.2.3b Appendix 1 - DOI Register Board and Non Board 23-24 ARC 19 December 2023.xlsx (24 pages)

2.2.3c Appendix 2 - Register of Gifts Hospitality and Sponsorship 2023-24 ARC 19 December 2023.xlsx (1 pages)

2.2.4. Clinical Audit Annual Report

Information *Dom Hurford, Medical Director*

2.2.4a Clinical Audit Report ARC 19 December 2023.pdf (4 pages)
2.2.4b ClinicalAuditAndQIAnnualReport2022_23Ver1_0 ARC 19 December 2023.pdf (18 pages)

13:10 - 13:15
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 December 2023.pdf (7 pages)

3.2. Matters Arising not contained within the Action log

Discussion *Patsy Roseblade, Independent Member/Committee Chair*

13:15 - 14:00
45 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

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

4.1a Local Counter Fraud Update Report ARC 19 December 2023.pdf (3 pages)
4.1b Local Counter Fraud Update Report Dec 23 ARC 19 December 2023.pdf (4 pages)
4.1c Appendix 1 Counter Fraud Benchmark Report ARC 19 December 2023.pdf (5 pages)
4.1d Appendix 2 -Counter Fraud Investigations Update ARC 19 December 2023.pdf (7 pages)

4.2. Procurement and Scheme of Delegation Report

Discussion *Sally May, Executive Director of Finance*

4.2a Procurement & SoD ARC report ARC 19 December 2023.docx (9 pages)
4.2b Appendix A - Proposed changes to the Scheme of delegation ARC 19 December 2023.xls (1 pages)

4.3. Losses and Special Payments Report

Discussion *Sally May, Executive Director of Finance*

4.3a Losses Special Payments Report - Oct 2023 ARC 19 December 2023.docx (10 pages)
4.3b Full Losses Rec Oct 23 ARC 19 December 2023.xlsx (10 pages)

14:00 - 14:50
50 min

5. IMPROVING CARE

5.1. Organisational Risk Register

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

The following question has been raised by an Independent Member ahead of the Audit & Risk Committee taking place on Tuesday 19th December.

Risk 5579 regarding the lack of children and young people's weight management service – I can see that we have increased the risk and done an options appraisal and wondered what the timescales are for a full business case and if agreed, to hopefully find funding in the new year for a service – although I obviously appreciate our funding pressures etc?

We have been provided with the following response:

Thanks for requesting information on this risk. I have attached the SBAR which was presented to the Improving Care Board on the 18th Oct 23 and the Creating Health Board on the 5th Dec 23 for your information. Both strategy boards have provided approval and support to progress to full business case and we are aiming to work this up by the end of Jan 24. I would be more than happy to pick up a conversation around the need for the children's weight management service with you and get your advice / support for the business case.

5.1a Org Risk Register -November 2023 - ARC 19 December 2023.docx (7 pages)
5.1b Appendix 1 - Approved Master Organisational Risk Register ELG 131123.xlsx (9 pages)

5.2. Audit Recommendations Tracker

Discussion *Emma Walters, Head of Corporate Governance & Board Business*

5.2a Audit Recommendations Tracker Cover Report ARC 19 December 2023.docx (7 pages)
5.2b Internal Audit Recommendations Tracker December 2023 ARC 19 December 2023.xlsx (21 pages)
5.2c External Audit Recommendations Tracker December 2023 ARC 19 December 2023.xlsx (4 pages)

5.2.1. Audit Tracker Automation Update - Verbal Update

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

5.2.2. Consultant Job Planning Report

Discussion *Dom Hurford, Medical Director*

5.2.2 Consultant Job Plannning ARC 19 December 2023.pdf (6 pages)

5.2.3. Medical Rostering Progress Report

Discussion *Dom Hurford, Medical Director*

5.2.3 Medical Rostering Progress Report Approved ARC 19 December 2023.pdf (4 pages)

5.3. INTERNAL AUDIT

5.3.1. Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

5.3.1 IA CTM -Progress report - December 2023 ARC 19 December 2023.pdf (9 pages)

5.3.2. Internal Audit Review - Arrangements for Financial Savings 2022/2023

Discussion *Internal Audit*

5.3.2 IA CTM 2223.07 Financial Savings Final Internal Audit Report ARC 19 December 2023.pdf (19 pages)

5.3.3. Internal Audit Review - Deprivation of Liberty Safeguards

5.3.3 IA CTMUHB 2324-07 DoLS Final Internal Audit Report ARC 19 December 2023.pdf (19 pages)

5.3.4. Internal Audit Review PCH Quality – Site Supervisor Role

5.3.4 IA CTM-SSU-2324-07 PCH Supervisor Role Final Report ARC 19 December 2023.pdf (14 pages)

5.3.5. Internal Audit Review - PCH Validation of management actions

5.3.5 IA CTM-SSU-2324-01 PCH Validation of Management Action Final Report ARC 19 December 2023.pdf (9 pages)

5.4. AUDIT WALES

5.4.1. Audit Wales Audit & Risk Committee Update

Discussion *Sara Utley, Audit Wales*

5.4.1 AW CTMUHB December 2023 AW Audit Update ARC 19 December 2023.pdf (12 pages)

5.4.2. Structured Assessment 2023

Discussion *Sara Utley, Audit Wales*

5.4.2 CTMUHB Structured Assessment 2023 Report Final (1) ARC 19 December 2023.pdf (42 pages)

5.5. Audit & Risk Committee Annual Self-Effectiveness Assessment - Verbal

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

14:50 - 14:55
5 min

6. CLOSE OUT BUSINESS

6.1. Any other Business

Discussion *Patsy Roseblade, Independent Member/Committee Chair*

6.2. How Did we do in this Meeting

Discussion *Patsy Roseblade, Independent Member/Committee Chair*

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

Is there anything we should do more or less of?

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

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

Have we received sufficient assurance from a range of sources?

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

6.3. Highlight Report to Board

Discussion *Patsy Roseblade, Independent Member/Committee Chair*

14:55 - 15:00
5 min

7. PRIVATE/IN COMMITTEE SESSION

Information *Patsy Roseblade, Independent Member/Committee Chair*

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

- Organisational Risk Register - Cyber Security Risks
- Medical Variable Pay Reports
- Audit of Accounts Addendum Report

15:00 - 15:00
0 min

8. DATE AND TIME OF NEXT MEETING THURSDAY 22 FEBRUARY 2024 AT 2:15PM

Agenda Item Number:

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)

Audit and Risk Committee held on 24 October 2023 as a virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member (Vice Chair)

In Attendance:

Darren Griffiths	Audit Wales
Anthony Veale	Audit Wales
Paul Dalton	NWSSP- Internal Audit and Assurance
Emma Samways	Internal Audit & Assurance
Matthew Evans	Head of Local Counter Fraud Services
Amanda Legge	All Wales Post Payment Verification Manager (In part)
Sara Jeremiah	Post Payment Verification Location Manager (In part)
Sarah James	Deputy Chief Operating Officer (In part)
Jill Venables	Divisional Director of Facilities (In part)
Sally May	Executive Director of Finance
Owen James	Head of Corporate Finance (In part)
Nigel Downes	Assistant Director of Quality & Safety (In part)
Gareth Watts	Director of Corporate Governance/Board Secretary
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Head of Corporate Governance & Board Business

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

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

Apologies had been received from:

- Geraint Hopkins, Independent Member
- Sara Utley, Audit Wales

1.3 Declarations of Interest

There were no interests to declare.

2. CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on 16 August 2023

Resolution: The Minutes were **APPROVED.**

2.1.2 Unconfirmed Minutes of the IN Committee Meeting held on 16 August 2023

Resolution: The Minutes were **APPROVED.**

2.1.3 Amendment to Standing Financial Instructions

The Committee Chair advised that whilst any changes made had been identified in red, it would have been helpful if a summary of changes was also included in the cover report. C Hamblyn advised that this had been included in the cover report produced for Board and advised that she would share this with Members for reference.

Resolution: The Amendments to the Standing Financial Instructions were **ENDORSED** for Board Approval.

Action: Cover report produced for Board outlining the changes made to the Standing Financial Instructions to be shared with Committee Members.

FOR NOTING

2.2.1 Audit & Risk Committee Annual Cycle of Business

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

2.2.2 Audit & Risk Committee Forward Work Programme

The Committee Chair made reference to the JAG Accreditation update report and reminded Members that a detailed verbal update was shared at the meeting held in August 2023 and added that she had agreed outside the meeting with the Chief Operating Officer that a written report would be presented to the Committee in June 2024.

The Committee Chair advised that she did have some concerns as to whether this matter was being discussed at the correct Committee and questioned whether a discussion on this matter was best undertaken at the Quality & Safety Committee, particularly following discussions held at the last Board meeting in relation to the consequence of the whole of the Endoscopy issues where it was agreed that further discussion needed to take place at Quality & Safety Committee. I Wells advised that he would welcome further discussion on this outside the meeting as he felt that this report had been deferred on a number of occasions. The Committee Chair advised that a discussion on this matter could take place at the next Board meeting.

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

Action: Discussion to take place at the next Board meeting as to whether it would be more appropriate to discuss JAG Accreditation/Endoscopy issues at the Quality & Safety Committee moving forwards.

2.2.3 A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report - March 2023

Resolution: The report was **NOTED.**

2.2.4 Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation

Members noted that a report on this item would be received at the June 2024 meeting.

3. MAIN AGENDA

3.1 Audit & Risk Committee Action Log

G. Watts presented Members with the Action Log and highlighted key updates to Members.

In relation to the action related to whether funding for the Business Case referred to in relation to Princess of Wales Fire Safety had already been included in the current plan, S May advised that funding had been received for the fees for the development of the scheme and added that this figure moved significantly to a £52m scheme for some temporary theatres and some minor works, which Welsh Government then asked the Health Board to review. Members noted that the Project Board, which was chaired by L Prosser as the Senior Responsible Officer, were currently reviewing the best value option, which looked like it would have a significant revenue impact which would require further discussion with Welsh Government. The Committee Chair advised that the risk register did not contain all of this information and requested that the risk register was updated to reflect this. C Hamblyn advised that she would ensure this was reflected in the November iteration of the report.

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

Action: Organisational Risk Register to be updated to reflect the current position in relation to the Princess of Wales Fire Safety risk.

3.2 Matters Arising not Contained within the Action Log

There were no matters arising.

5.4.3 Facilities Governance (Limited Assurance)

E Samways presented Members with the Follow Up Review into Facilities Governance which had been allocated a Limited Assurance rating. Members noted that given that this was a limited assurance

follow up review this area would be revisited in the future to ensure recommendations were being closed off.

S May advised that she had specifically requested that an audit was undertaken having discovered a significant amount of issues in relation to non-payment/non-accrual of invoices and failures in following procurement guidance and added that she felt disappointed that things had not moved forward up until the date this audit was undertaken.

J Venables advised that whilst she felt that the Facilities Hub Team had answered all the recommendations positively, she could not find any evidence or data that work had been completed, with no monitoring in place to evidence that essential procedures had been implemented and checked. The Deputy COO and Divisional Director of Facilities recognised that the action plan in response to the audit needed further work as the assurances provided were insufficiently robust.

The Committee Chair was provided with assurance that J Venables had a background in Facilities Management and had significant experience in this area. As it appeared J Venables was a finance colleague.

In response to a concern raised by I Wells as to why no progress had been made in this area and whether this related to issues with culture or whether any decisions being made at senior level were not being cascaded down to staff who were carrying out the tasks, S May advised that the Facilities Hub had been provided with significant support from Finance and Procurement Teams following the identification of the issues in the first review but chose not to embed and follow the procedures.

S James advised that she felt confident that J Venables had the right level of experience and background to take Facilities forward in tackling the issues identified and added that J Venables skills and experience would ensure that these issues would not reoccur and advised that she was confident that there would be significant improvements being made in lots of areas within the Facilities service.

The Committee Chair advised that there seemed to have been a complete disregard of financial control procedures here by the Facilities Department andas it appeared that they felt it to be

appropriate to make retrospective Purchase Orders for emergency purchases. S May advised that this did not solely relate to emergency purchases and advised that the audit initially uncovered that no Purchase Orders had been raised at all with the discovery of 850 invoices being sat in an electronic drawer, which did appear to look like a disregard of procedures. Members noted that S James was maintaining management oversight of this.

In response to a question raised by the Committee Chair as to when it was likely that improvements would be made, J Venables advised that she expected the action plan to be completed by end of February 2024 and had requested a further audit to be undertaken following February in respect of this. P Dalton advised that he would be happy to work with the Team to identify the most appropriate time to undertake the further follow up review. J Venables assured Members that the action plan would be monitored on a regular basis to ensure actions were being taken forward.

Resolution:

The report was **NOTED.**

4.

SUSTAINING OUR FUTURE

4.1 Local Counter Fraud Report

M. Evans presented Members with the report and highlighted key updates to Members.

I Wells made reference to the Inform and Involve section which referred to the e-learning package and questioned whether counter fraud training needed to be made mandatory, which had been discussed previously at the Committee. M Evans advised that a Business Case was in the process of being developed for consideration by the Executive Team which proposed that Counter Fraud Training became mandatory on a three year cycle. M Evans added that if this training did become mandatory, he would still like to provide bespoke training for higher risk staff groups which he felt could be undertaken alongside the mandatory training.

The Committee Chair made reference to a case reported in June 2023 regarding false overtime and commented that the update advised that whilst enquiries were ongoing, it had been implied that managers were aware of the practices and had been allowing the conduct to take place. M Evans advised that this was quite a serious case made more difficult as the Team had been unable to approach

the supervisor to gather evidence given that they were a named witness. M Evans advised that clarity would need to be obtained either by way of a criminal case or by undertaking a proactive piece of work where the controls, policies and procedures were reviewed in relation to the allegation to test whether they were strong enough to mitigate the allegation that had been made.

The Committee Chair sought clarity as to whether there had been a recent internal audit undertaken on the policy and process for the booking and completing of overtime and questioned whether consideration could be given to undertaking a review on this matter in next year's plan.

Resolution: The report was **NOTED.**

4.2 Procurement & Scheme of Delegation Report

S. May presented Members with the report and highlighted key updates to Members. Members noted that O James and E Price were in the process of reviewing the format and content of the report given the format had not changed for some time.

In response to a question raised by the Committee Chair as to whether there was a training requirement in Estates in relation to waivers and single tenders given that most of the waivers were being received from that department, S May advised that the Head of Procurement was working with the Assistant Director of Planning (Capital & Estates) to determine whether framework agreements should be in place or whether an alternative structure was required. Members noted that there would always be some waivers and single tenders that would need to be undertaken at short notice, for example, the loss of electricity supply at Royal Glamorgan Hospital which meant that the Team could not go through the procurement process to address this.

In response to a question raised by the Committee Chair as to how many waivers had been rejected and forced into a procurement process within the last two month period, S May advised that procurement were constantly working with budget holders in relation to the way to access markets and added that she regularly asked difficult questions when she was receiving waivers for approval. S May added that further reflection did need to be given to the process given that there were some significant differences in the way in which things were operating in relation to shared service partnerships. The

Committee Chair advised that this was a significant improvement on the differential price which used to happen previously within Health Board's.

Resolution: The report was **NOTED.**

4.3 Post Payment Verification Mid Year Update

A Legge presented Members with the report and highlighted key updates to Members.

S May expressed concern in hearing that a payment system had been designed which did not meet the basic requirement of being able to check to an NHS number and questioned whether there was any learning to be taken from this given that the Health Board was seeing a few design issues with systems at present. A Legge confirmed that there was some learning to be taken from this which was being addressed and added that more Post Payment Verification involvement was required early on in the design of the system.

In response to a question raised by I Wells as to whether the electronic prescription service which would be launching soon would have an impact on Pharmacy Services, A Legge advised that this would not have an impact from a Post Payment Verification point of view and added that it may make things easier for the service as there would be less paper prescriptions to review and would potentially enable the service to carry out more checks.

The Committee Chair made reference to the statement made that the Team were going to catch up on all the visits between now and December and added that given there were 46 planned visits and eight which were either completed or in progress, this was a significant number to complete in a short space of time. A Legge confirmed that this related to routine visits which would all be in progress, if not completed, by end of December. In relation to the revisits to areas of concern, Members noted that these would be undertaken during January, February and March 2024. A Legge highlighted an error contained within the report relating to revisits and confirmed that the reason the Health Board had one completed revisit was as a result of the closure of a practice and advised that she would amend the report for recirculation.

Resolution: The report was **NOTED**

Action: Report to be amended given the error contained within it regarding revisits completed and re-circulated to Members.

4.4 Changes to the Welsh Risk Pool Agreement

N Downes presented the report and highlighted the key matters for Members attention. S May advised that there were quite significant movements in relation to the measures which was why the report was being presented to Committee Members.

I Wells made reference to the Claims history element which was referring to a backlog that the Health Board has had to pay and questioned whether the Health Board was likely to see more backlog or whether there was a general increase being seen in these claims. N Downes confirmed that the Claims figures do increase year on year and added that work was being undertaken by the Team to ensure the backlog position was being addressed given the current difficult financial situation. Members noted that sickness absence issues within a small team had impacted on the position and had resulted in some claims with a value of under 25k being submitted to Legal & Risk for processing which had resulted in a slight increase in the Putting Things Right element.

S May advised that whilst current indicators were predicting that the proportionate share of total reimbursement would be lower than anticipated, this can change depending on the types of cases. S May expressed the importance of focussing on Claims history and Putting Things Right and advised that this was an unhelpful variability at this time of the year.

In response to a query raised by the Committee Chair as to when budgets were allocated out to Health Board's and whether there was an uplift from Welsh Government specifically in relation to Welsh Risk Pool, S May advised that planning was based on previous figures and what the Welsh Risk Pool was expected to do in terms of allocations.

The Committee Chair requested that this report was shared with the Planning, Performance & Finance Committee for information only given that this matter impacts on the financial position and the financial performance of the organisation.

Resolution: The report was **NOTED.**

Action: Report to be shared with the Planning, Performance & Finance Committee for information only.

5. IMPROVING CARE

5.1 Organisational Risk Register

C Hamblyn presented Members with the report and highlighted key updates to Members.

The Chair commented on the cover paper which she felt could be misleading if you read this in isolation without reading the detail of the report, particularly in relation to risks which were being decreased. The Committee Chair made reference to the Pathology risk (Pathology service unable to meet current workload demands), Children & Families Risk (Special Care Baby Unit does not comply with recommendations), Infection, Prevention & Control (no IPC resource for Primary Care) and no centralized decontamination unit for the Princess of Wales Hospital and advised that she felt that some kind of reason needed to be provided for decreasing the risk. C Hamblyn agreed with the comments made and advised that she would ensure that the rationale for closing the risk was included in the next iteration of the cover report.

Resolution: The report was **NOTED.**

Action: Cover report to be amended to include the rationale for closing the risk.

5.2 Audit Recommendations Tracker

E. Walters presented Members with the report and highlighted key updates to Members.

I Wells expressed concern at the number of recommendations which remained open under the remit of the Executive Director of Nursing with a number of implementation dates being passed and sought clarity as to the reasons behind this as it appeared that no progress was being made. E Walters advised that in relation to these recommendations, the Patient Care & Safety Team had provided assurance that progress was being made and it was hoped that the vast majority of recommendations would be marked as completed in December and would be recommended for closure from the tracker.

The Committee Chair made reference to the recommendations relating to the Patient Pathway Appointment Management Process, and advised that whilst an update had been provided it appeared that the same comment had been provided against all the recommendations. The Committee Chair added that she hoped to see some action against this area at the next meeting given that the recommendations had some direct patient impact and required robust scrutiny.

The Committee Chair made reference to the response that had been provided for the Fire Safety Management recommendation 4.1 and advised that the update provided did not seem to relate to the recommendation and wondered whether the update provided had been included against the right recommendation.

Resolution: The report was **NOTED.**

5.2.1 Update on Consultant Job Planning

Members noted that this report would be deferred to the December 2023 meeting given that there was no representative from the Medical Directors office available to present the report.

5.3 AUDIT WALES

5.3.1 Audit Wales Audit & Risk Committee Update

D Griffiths and A Veale presented Members with the report and highlighted key performance audit and financial audit updates to Members.

Resolution: The report was **NOTED.**

5.3.2 Audit Wales/Healthcare Inspectorate Wales Joint Review Follow Up Report

D Griffiths presented Members with the report and highlighted that there were four recommendations which Audit Wales considered to be partially implemented. Members noted that the Health Board would be asked to provide a written update on progress against these recommendations in the new year and noted that a further report would be presented to the Audit & Risk Committee on progress

made. The Committee Chair reminded Members that this report was also received and discussed at the September Public Board meeting.

The report was **NOTED.**

Resolution:

5.4 INTERNAL AUDIT

5.4.1 Internal Audit Progress Report

P. Dalton presented Members with the report and highlighted key updates to Members. Members noted the issues reported in relation to management response turnaround times and noted that work would need to be undertaken with Health Board officers to determine the reasons as to why it was taking so long to produce management responses. P Dalton advised that Internal Audit were receiving support from the Director of Corporate Governance and the Assistant Director of Governance & Risk to try and resolve the issues.

The Committee Chair requested that the Director of Corporate Governance refers the issues regarding management response turnaround times to the Executive Leadership Group given that the Health Board were only achieving 25% against a target of 80% which was unacceptably low and impacted on Internal Audit being able to complete their work. G Watts advised that he would be happy to raise this at the Executive Leadership Group and would feedback to the Committee accordingly.

Resolution: The report was **NOTED.**

Action: Discussion to be held at the Executive Leadership Group in relation to issues being received regarding timely submission of Management Responses.

5.4.2 Interventions Not Normally Undertaken (Limited Assurance)

E Samways presented Members with the report and highlighted key updates to Members. Members noted that the review had been given a limited assurance rating.

S May advised that this formed part of the Value and Sustainability work being undertaken across Wales and added that there was an All Wales Policy in place regarding Interventions not Normally Undertaken. S May advised that consideration needed to be given

as to whether a Standard Operating Procedure needed to be in place for every policy and consideration also needed to be given to where this sits within the Health Board's overall record keeping policy as opposed to this being a stand-alone response to INNUs.

I Wells made reference to matters arising two and advised that the agreed management action stated that an individual patient funding panel would be established and sought clarity as to how this would be implemented, what would trigger a panel to meet and what the scale of this process would be given the issues that had been experienced by the Welsh Health Specialised Services Committee regarding the All Wales IPFR panel. The Committee Chair advised that she was aware that in other Health Board's in Wales, a smaller panel was required to meet and added that it would be helpful if a response could be received on this matter outside the meeting regarding the practicalities of setting up a panel.

The Committee Chair made a general comment in relation to the management responses and advised that she felt they were quite short and not particularly descriptive.

Resolution: The report was **NOTED.**

Action: Response to be provided outside the meeting as to the practicalities involved in setting up an individual patient funding request panel, to include how this would be implemented, what would trigger a panel to meet and the scale of the process.

5.4.4 IT Infrastructure (Reasonable)

P. Dalton presented Members with the report and highlighted key updates to Members. Members noted that a Reasonable assurance opinion had been allocated to this review.

I Wells advised that he had some concerns in relation to old equipment and the older servers as opposed to switches and advised that this would be a matter that he would wish to discuss ay the Digital & Data Committee as an In Committee matter.

Resolution: The report was **NOTED.**

6. CLOSE OUT BUSINESS

6.1 Any Other Business

There was no other business to report.

6.2 How Did we do in this Meeting

The Committee Chair advised that if Committee Members had any comments to raise as to how the meeting went today, then they could share these with herself and the Head of Corporate Governance outside the meeting.

6.3 Highlight Report to Board

The Committee Chair advised that this would be drafted outside the meeting by the Head of Corporate Governance.

7. PRIVATE/IN COMMITTEE SESSION

Members noted the following item would be discussed at the In Committee session:

- Organisational Risk Register – Cyber Security Risks

8. DATE AND TIME OF NEXT MEETING - WEDNESDAY 19 DECEMBER 2023 AT 2.15PM

Agenda Item Number:

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)

Audit and Risk IN Committee held on 24 October 2023 as a virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member (Vice Chair)

In Attendance:

Darren Griffiths	Audit Wales
Paul Dalton	NWSSP- Internal Audit and Assurance
Emma Samways	Internal Audit & Assurance
Sally May	Executive Director of Finance
Owen James	Head of Corporate Finance
Gareth Watts	Director of Corporate Governance
Cally Hamblyn	Assistant Director of Governance & Risk
Matthew Evans	Head of Local Counter Fraud Services
Emma Walters	Head of Corporate Governance & Board Business

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

P Roseblade, Committee Chair welcomed everyone to the meeting.

1.2 Apologies for Absence

Apologies have been received from:

- Geraint Hopkins, Independent Member
- Sara Utley, Audit Wales

1.3 Declarations of Interest

There were no interests declared.

2. MAIN AGENDA

2.1 Organisational Risk Register – Cyber Risks

C Hamblyn presented Members with the report and highlighted the key updates.

I Wells advised that he felt assured by the work being undertaken by the Team to address these risks. The Committee Chair advised that it would be helpful if a glossary of terms could be included in the next iteration of the report given the number of acronyms contained within it.

3. ANY OTHER BUSINESS

I Wells raised some concerns in relation to the findings contained within the Internal Audit Review into IT Infrastructure and advised that he would discuss his concerns further at the Digital & Data Committee.

4. DATE AND TIME OF NEXT MEETING TUESDAY 19 DECEMBER 2023

Agenda Item
2.2.1

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

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.

1.3 Any changes made to the Annual Cycle of Business since the last meeting have been identified in red.

2. Specific Matters for Consideration

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

3.1 Please refer to **Appendix 1** – Audit & Risk Committee Cycle of Business for further detail. Any changes have been identified in red.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Audit & Risk Committee are asked to **NOTE** the report.

6. Next Steps

6.1 There are no next steps required.

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.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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

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

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Local Counter Fraud Report	Director of Finance	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				⚑								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				⚑								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				⚑								
National Fraud Initiative Progress and Outcomes	Head of Local Counter Fraud	Bi-Annually from June 2023 onwards						⚑						
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				⚑								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										⚑		
Medical Variable Pay Reports (for In Committee discussion)	Medical Director	All Regular In Committee Meetings								⚑		⚑		⚑
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				⚑						⚑ Defer to Dec 2023		⚑
Medical Rostering	Medical Director	Bi-Annually				⚑						⚑ Defer to Dec 2023		⚑
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				⚑								

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
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												
Audit Wales Annual Audit Report	Audit Wales	Annually												
Audit Wales Audit Plan 2022	Audit Wales	Annually												
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually							Extra ordinary meeting					
Structured Assessment	Audit Wales	Annually												
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually								Defer to Oct		Defer to Dec		
Hosted Bodies														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings												
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings												
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually						(draft report)	Extra ordinary meeting					
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings							Extra ordinary meeting					
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually						(draft report)	Extra ordinary meeting					
WHSSC & EASC Annual Accounts	WHSSC/EASC	Annually						(draft accounts)	Extra ordinary meeting					
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						(draft report)	Extra ordinary meeting					

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
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually												

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 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 August 2023 as per action log update. Verbal Update received at the August 2023 meeting. Written progress report to be presented to the meeting being held on 24 October 2023. Agreement given by the Chair outside the meeting for a report to be presented to the Committee in **June 2024.**

Completed				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Email Request from the Assistant Director of Governance & Risk	Additional Item	A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report - March 2023	Medical Director	Completed – Report received and noted at the meeting held on 24 October 2023.
Email Request from the Assistant Director of Governance & Risk	Additional Item	Audit Wales/Healthcare Inspectorate Wales Joint Review Follow Up Report	Director of Corporate Governance	Completed – Report received and discussed at the meeting held on 24 October 2023
Email Request from the Deputy Director of Finance	Additional Item	Changes to the Welsh Risk Pool Agreement	Director of Nursing	Completed – Report received at the meeting held on 24 October 2023
Email Request from the	Additional Item	Amendment to the Standing Financial Instructions	Director of Corporate	Completed – Report received at the meeting held on 24 October 2023

Assistant Director of Governance & Risk			Governance/Director of Finance	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
2.2.3

Audit & Risk Committee

Declarations of Interest & Gifts, Hospitality and Sponsorship Register

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risks
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risks
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	27/11/2023	Reviewed

Acronyms / Glossary of Terms	
Nil identified.	

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 Executive Leadership Group.

2. Specific Matters for Consideration

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 May 2023 all Board Members were asked to complete/update their annual declarations of interest. All declarations have now been received and are detailed in Appendix 1 – Sheet 1 "Board Members". Any in year amendments are also indicated in red.

2.3 A targeted email was also issued by the Corporate Governance Team in May 2023 to 746 members of staff, which included all Consultants, Very Senior Managers and Staff at Band 8d and Band 9). It should be noted that some of the returns received in this period may have been received from individuals that did not receive the targeted email as there is an onus on all employees to declare interests. This exercise will be repeated in May 2024 for the 2024-2025 reporting period.

2.4 During the last two quarters of 2023-2024, declarations in relation to Gifts Hospitality and Sponsorship have also been received as outlined in section 2.5 below.

2.5 In summary the position as at the end of Quarter 2, 31st October 2023 is:

- 26 declarations of interest received from Board Members (Independent Members, Associate Members, Executive Directors and members of the wider Executive Team). Please see Appendix 1 – Sheet 1 – "Board Members".
- 436 declarations of interest received from staff (excluding Board Members / Executive Team colleagues). Please see Appendix 1 – Sheet 2 - "Non Board Members".
- 4 declarations received in relation to Gifts, Hospitality and Sponsorship (Appendix 2).

2.6 The Declaration of Interest Register and Gift Hospitality and Sponsorship Register for the financial year 2023-2024 is available upon request.

2.7 Previous advice from Information Governance is that any information published on the register, which is then published in the public domain, excludes first and last names and includes job titles only (for non-Board Members). This has been actioned in terms of the appendices to this report

3. Key Risks / Matters for Escalation

3.1 Following a recent review it was identified that the report received by the Committee in August 2023 may have included some double counting in terms of number of declarations received where Board Members were captured twice. A cleansing exercise has been undertaken and for completeness the data captured in section 2.5 is the total declarations received from the 1st April 2023 to the 31st October 2023.

3.2 Awareness around responsibilities for declaring in accordance with the requirements of the Standards Behaviour Framework Policy is planned, utilising the staff newsletter. Board Members will also be asked to undertake a mid-year review to consider if any declarations require updating.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Effective
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for this report.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for this report.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

6. Next Steps

6.1 The Board Members register of interest will be published on the Health Boards public facing website.

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind
New Starter Request	Jonathan Morgan	Chair	30/03/2023 Hard Copy Submission	Director of Insight Wales Consulting Limited (100% Share Ownership: Insight Wales Consulting Limited)	2012	Present	Dividend
				Associate with Practice Solutions Limited	2011	Present	Consultant fee
				Wife employed as a Welsh Government Lawyer	2010	Present	Salaried
09/05/2023	Dom Hurford	Executive Medical Director	06/11/2023 Hard Copy Submission	Nil Interests Declared	Not applicable	Not applicable	Not applicable
09/05/2023	Paul Mears	Chief Executive	09/05/2023 Online Submission	Director of Drake Consultancy Services (dormant company)	May 2018-present Amendment 17.11.2023 - declaration updated to confirm company dissolved 1st October 2023.		Nil
			Email amendment received 17.11.2023.	Member of Advisory Board, Awen Cultural Trust	Sep-22	Present	Nil
				Observer Member, Board of Life Sciences Hub Wales	Jun-22	Present	Nil
09/05/2023	Dilys Jouvenat	Independent Member (Third Sector	10/05/2023 Online Submission	Chair of the Rhondda Cynon Taff Citizens Advice	Jun-15	Present	Not applicable
				Trustee Newport Citizens Advice	2 Years	Present	Not applicable
				Trustee South East Wales Citizens Advice	1 Year	Present	Not applicable
				Trustee Interlink	6 months	Present	Not applicable
09/05/2023	Lauren Edwards	Executive Director of Therapies & Health Science	10/05/2023 Online Submission	Nil Interests Declared	Not applicable	Not applicable	Not applicable
			21/08/2023 - In Year Change (Online Submission)	Trustee and Director of Royal College of Speech and Language Therapists	Ongoing	Ongoing	Nil
09/05/2023	Linda Prosser	Executive Director of Strategy & Transformation	12/05/2023 (Online Submission)	Director Altyn Tepe Ltd	Since 2019	Ongoing	Yes
45055	Carolyn Donoghue	Independent Member (University)	18/05/2023 (Online Submission)	Welsh Wound Innovation Centre - Chair	9 Years	Ongoing	Payment for each Board meeting
				Independent Governor University West of England	2 years	Ongoing	None
				Magistrate - Newport Bench	3 Years	Ongoing	None
				Chair South East Wales Student Mental Health Partnership	3 Years	Ongoing	Consultancy Fee-Hourly
				Senior Professional Fellow - Cardiff University	3 Years	Ongoing	None
				Son (ED) is employed by Seating Matters a company which supplies clinical seating to healthcare organisations. I am not involved in any way	1 Year	Not applicable	Not applicable
			21/11/2023 - Update to current DOI noted. Additional Entry received via email notification	Appointed as Independent Member on the Welsh Health Specialised Services Committee (WHSSC)	1st July 2023	30th June 2025	Remunerated
09/05/2023	Hywel Daniel	Executive Director for People	22/05/2023 (Online Submission)	Nil Interests Declared	Not applicable	Not applicable	Not applicable

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind
09/05/2023	Jayne Sadgrove (Term ended 31.8.2023)	Vice Chair	23/05/2023 (Online Submission) Confirmed 31.10.2023 that declaration did not change at date of term ending.	Director, Cardiff Union Services Ltd	2019	Ongoing	Voluntary/Unremunerated
				Vice Chair of Trustee Board , Cardiff University Students Union	2019	Ongoing	Voluntary/Unremunerated
				Director, home study courses ltd	1994	Ongoing	None stated
				Director, Keyford Properties Ltd	2023	Ongoing	50%
				Senior Professional Fellow, Cardiff University	2019	Ongoing	Honorary Title
				IM (designate) HEIW	2023	Ongoing	Remunerated
				Spouse: Director, home study courses ltd Director, Keyford Properties Ltd	 1994 2023	Ongoing	50%
09/05/2023	Nicola Milligan	Independent Member (Trade Union)	12/07/2023 (Online Submission)	Royal College Of Nursing Wales Board member	Term completes December 2024	Term ends December 2024	Nil
09/05/2023	Gregory Padmore-Dix	Executive Director of Nursing, Midwifery & Patient Care / Deputy CEO	12/07/2023 (Online Submission)	Trustee - Royal College of Nursing Foundation	September 2021	Ongoing	Voluntary role, travel / accommodation paid for by the charity
				Board Director - Welsh Wound Innovation Centre	Jan-22	Ongoing	No financial or benefits in kind
				Visiting Professor, University of South Wales	2020	Ongoing	Nil
				Associate Professor, University of Plymouth	2015	Ongoing	Nil
09/05/2023	Gethin Hughes	Chief Operating Officer	04/08/2023 Hard Copy Form	Nil Interests Declared	Not applicable	Not applicable	Not applicable
09/05/2023	Sally May	Executive Director of Finance	04/08/2023 Hard Copy Form	Cousin is Director of DECIPHER; Professor in Social Interventions and Health, Cardiff University Ongoing Salaried position	Ongoing	Ongoing	Salaried
				Cousin is Regional Sales Manager South West Arthrex Ltd Ongoing Salaried position	Ongoing	Ongoing	Salaried
				Cousin is Partner, Knight Frank Project and Building Consultancy Ongoing Salaried position	Ongoing	Ongoing	Salaried
09/05/2023	Stuart Morris	Director of Digital	04/08/2023 Hard Copy Form	Chair of Governors for Penyfai Primary School, Bridgend	2017	Ongoing	Nil
09/05/2023	Lisa Curtis-Jones	Associate Member - Third Sector	17/08/2023 Hard Copy Form	Statutory Director of Social Services in MerthyrTydfil	Apr-15	Ongoing	Member of the regional partnership board (RPB) – RIF funding to local authorities through RPB.
09/05/2023	Mel Jehu	Independent Member (Community)	17/08/2023 Hard Copy Form	Independent Member (Vice Chair) South Wales Police Crime Panel.	2012	Ongoing	Attendance Fee
				Trustee, Safe Merthyr Tydfil.	2008	Ongoing	Voluntary no financial gain
				Independent Member - Merthyr Tydfil County Borough Council Standards Committee	24th February 2022	Ongoing	Attendance Fee
				Deputy Lord Lieutenant for Mid Glamorgan	Sep-21	Ongoing	No remuneration or benefits in kind

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind
				Spouse is employed in CTMUHB in a part time role as Lymphoedema Nurse since 2012 and prior to that Breast Care Specialist Nurse	2012	Ongoing	Not applicable
09/05/2023	Patsy Roseblade	Independent Member (Finance & Audit)	17/08/2023 Hard Copy Form	Non Executive Director Tennis Wales	2020	Ongoing	Voluntary
25/10/2023	Philip Daniels	Interim Executive Director of Public Health	30.10.2023 Hard copy form	Board Member / Welsh Chair - Faculty of Public Health	Jun-23	Ongoing	Nil
				Partner is Director - The Performance Centres	2011	Ongoing	Owner / Chief Executive
09/05/2023	James Hehir (Term ended 30.09.2023)	Independent Member (Legal)	Confirmed no change to declarations on term ending 30.09.2023. Email dated 27.10.2023 on file.	Non-Executive Director, Llandarcy Park Ltd.	14/06/2018	Present	None
				Trustee Neath Port Talbot Contact Centre.	01/05/2007	Present	None
				Vice Chairman, Neath Port Talbot Group of FE Colleges.	29/03/2006	Present	None
				Solicitor of the Supreme Court.	14/02/1984	31/8/2016.	None
				Honorary Vice President, West Glamorgan Magistrates Association.	16/10/2017	life time appointment.	None
				Associate member, magistrates Association.	01/06/1993	Present	None
				Patron Neath YMCA.	Apr-15	Present	None
09/05/2023	Ian Wells	Independent Member (Digital)	8/11/2023 Hard Copy Form	Director of the Wales Institute of Digital Information which undertakes research with Digital Health and Care Wales/NHS Wales Informatics Service in collaboration of University of Wales Trinity St David and the University of Wales. Research projects also undertaken for various health boards including CTM.	3 days per week from 1/2/20	Present	Nil financial transactions or benefits in kind.
New Starter Request	Gareth Watts	Director of Corporate Governance / Board Secretary	13/09/2023 Hard Copy Form	Board Member of Coleg Gwent (Further Education College) Since 2015 onwards	2015	Present	Voluntary
				Voluntary Member of the Joint Audit Committee of Gwent Police and the Police and Crime Commissioner for Gwent	2022	Present	Daily rate for meeting attendance and preparation
09/05/2023	Geraint Hopkins	Independent Member (Local Authority)	7/11/2023 Hard Copy Form	Llanharan Community Development Project Limited	10 years +	Present	Not applicable
				Elected Member, Rhondda Cynon Taff County Borough Council	19 years	Present	Not applicable
09/05/2023	Lynda Thomas	Independent Member (Corporate Business)	8/11/2023 Hard Copy Form	Chair of Norfolk Community Health and Care NHS Trust.	Since February 2023	Present	Remunerated.
				Trustee of Age UK	Jan-23	Jan-26	None
09/05/2023	Anne Morris	Associate Member - Chair of SRG	7/11/2023 Hard Copy Form	Nil interests declared.	Not applicable	Not applicable	Not applicable
09/05/2023	Sally Bolt	Associate Member - Chair of CAG	7/11/2023 Hard Copy Form	Nil interests declared.	Not applicable	Not applicable	Not applicable
New Starter - November 2023	Kath Palmer	Vice chair	Hard Copy Form	Natural Resources Wales – Board member and Chair of Audit, Risk and Assurance committee.	Feb-23	Present	Paid Position
				Interim CEO Cynon Taf Community Housing Group which has a Care and Repair subsidiary and Down to Zero subsidiary.	Sep-23	November 2023 - with a handover period between November and December 2023.	Paid Position

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind
				Trustee of Crisis (national homelessness charity) and chair of the client services governance committee.	Dec-22	Present	Voluntary (Expenses Paid)
				Member of the Residential Decarbonisation Implementation Group for Welsh Government.	Sep-19	Present	Voluntary

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
04/04/2023		Acute Clinical Lead Dietician	Nutrition and Dietetics	Work as an associate lecturer for Cardiff Metropolitan University on an ad hoc basis.	Applied for the role in March 2022 but first paid session was 27th March 2023.	Paid £50 per session.	No
06/04/2023		Department Professional Lead	Adult Weight Management Service	Nil Interests Declared	Not applicable	Not applicable	No
11/04/2023		Senior Applied Psychologist	Psychology	Nil Interests Declared	Not applicable	Not applicable	No
11/04/2023		Chief of Staff	Executive Office	Nil Interests Declared	Not applicable	Not applicable	No
12/04/2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/04/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Community Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Director of Improvement and Innovation	Improvement and Innovation	Trustee and Board Secretary Brynawel Rehab Llanharry Rd, Llanharan, Pontyclun CF72 9R Independent Member St John Ambulance CymruPriory House, Beignon Close, Ocean Way, Cardiff. Spouse/Partner/Close Family or Friend: Independent Member St John Ambulance Cymru Priory House, Beignon Close, Ocean Way, Cardiff.	Since 2021 Since 2022 Since 2015	Not applicable	No
17/04/2023		Consultant Gastroenterologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Radiologist Director of NIAW	Medical	Part-time employment from May 2023: Deputy Clinical Lead, Musculoskeletal Radiology, Telemedicine Clinic Private Practice: Cobalt Health Care & Nuffield-Vale Healthcare. Wardle Consulting Partnership Spouse/Partner/Close Family or Friend: Board Member, Techniquest Board Member, Theatr Iolo	Telemedicine Clinic since July 2023 Nuffield Private Practice since 2015 Cobalt Private Practice since 2009. 2011 2017 & 2020 respectively	TMC - salaried position Private Practice, paid on a patient case basis. See Personal Entries Nil	No
17/04/2023		Locum Consultant Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Assistant Director Informatics	Digital	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Nurse Director	Mental Health & Learning Disabilities Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant in Anaesthetics & Intensive Care	Medical	President of the Society of Anaesthetists of Wales	16 March 2023 to present	No Financial Involvement	No
17/04/2023		Consultant Histopathologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Assistant Director Governance & Risk	Corporate Governance	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Deputy Medical Director	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Gynaecologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Head of Capital	Capital Planning	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Deputy Director of Planning	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant (CAMHS)	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		ICU Consultant - Long Term Locum	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Director of Operations	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Anaesthetist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Medical Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Medical Director - Planned Cre Group	Medical	Director Stephen Sarasin Ltd. 50% Shareholder Stephen Sarasin Ltd. Spouse - 50% Shareholder Stephen Sarasin Ltd.	2014 - Present	Dividends and Expenses	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
17/04/2023		Head of Health Psychology Service	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Medical Secretary	Health Psychology Office	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Principal Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Assistant Director of Communications & Engagement	Executive Office	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Haematology Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Hepatologist	Medical	Non Executive trustee of Brynawel Rehabilitation Centre	March 2023 - Present	None	No
17/04/2023		Assistant Director - Capital and Estates	Capital & Estates	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Deputy Director of Strategy & Partnerships	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Director of Nursing - Planned Care	Planned Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Assistant Finance Director	USC and Children and Families Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Community Paediatrician	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Assistant Director of Finance	Planned Care and DT&S Care Group	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Locum T&O Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
17/04/2023		Consultant Anaesthetics and Intensive Care	Medical	Community Governor - YGG Abedar (Primary School) Regional Clinical Lead for Organ Donation (NHS Blood and Transplant)	March 2022- Present March 2022- Present	None 1 PA (NHSBT Funded)	No
17/04/2023		Consultant Psychiatrist: Clinical Service Group Director	Mental Health	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Volunteer as a telephone Befriender with Age UK	Since November 2021 - present.	None - Volunteer Role.	No
18/04/2023		Assistant Director of OD & Wellbeing	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		ENT Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Consultant Clinical Psychologist	Medical	Research collaboration with Dr JB's team at the National Centre for Mental Health, Cardiff University Part of the research team with Dr CL and RESCAPE (Virtual Reality Company providing VR equipment to the hospital as part of two ongoing research projects - SIESTA (looking at VR and improving sleep in staff and VR Ready looking at developing rehab for ITU patients through the medium of VR)	Since April 2022 - ongoing September 2022 - ongoing	Not applicable at this time.	No
18/04/2023		Critical Care Psychology Team	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Paediatric Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Consultant Physician	Medical	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Clinical Director of Pharmacy & Medicines Management	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
18/04/2023		Consultant Respiratory Physician	Medical	Consultant respiratory physician at CTM - 2016 onwards. Lung Health Check clinical lead for the Wales Cancer Network since 2019. Lung Health Check Wales Operational Pilot, for which I am clinical lead, has been financially supported by Novartis, Bristol Myers Squibb, Roche, Tenovus and MSD. My role is paid for exclusively by NHS Wales/Wales Cancer Network. I was previously an affiliated consultant for Respiratory Innovation Wales (2021-22) and have received honoraria for speaking at an educational event from Novartis in 2022. I am a member of the following groups: NICE Expert Advisers Panel UK Lung Cancer Clinical Expert Group Respiratory Health Implementation Group (Wales) British Thoracic Society British Thoracic Oncology Group Welsh Thoracic Society Wife: is Primary Care Cancer Lead for Swansea Bay UHB, and a GP at New Surgery, Pencoed	2019 Onwards	None	No
18/04/2023		Consultant in Acute Medicine	Medical	I have spoken on behalf of Bayer at a medical educational event. I received no personal remuneration but the company has made a donation to the Welsh Acute Physicians' Society for my services.	Oct-22	£400 (Paid to WAPS)	No
18/04/2023		Consultant Gastroenterologist	Medical	Personal & Spouse / Partner or other Close Family and/or Friend: Director of Minesh Gastro Ltd	Nov-22	Salary	No
18/04/2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable at this time.	No
18/04/2023		Consultant Orthogeriatrics	Medical	Nil Interests Declared	Not applicable	Not applicable at this time.	No
18/04/2023		Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	I hold a part-time position at Cardiff Metropolitan University. I oversee the work of students and research projects.	Ongoing	None	No
18/04/2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Strategic Lead for Employee Experience & Wellbeing	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Consultant Cardiologist	Medical	Private practice clinic Independent General Practice, Cardiff Gate Running at weekends and during time off or annual leave.	2019-to date	Private income submitted to HMRC (tax return)	No
18/04/2023		Consultant Oral and Maxillofacial Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Consultant Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
18/04/2023 Hard Copy Form		Director of Midwifery & Nursing, Children & Families Care Group	Children & Families Care Group	Spouse is Director of Workforce at NWSSP.	Not applicable	Not applicable	No
19/04/2023		Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Practice in Clinical Psychology. Primary School Governor	Ongoing	Payment received for work done	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
19/04/2023		Consultant	Medical	Infiniti Healthcare Ltd- this is a private women's health clinic based in Cardiff - Beyond Healthcare Academy Ltd: This company offers teaching, training, medicolegal support and coaching Practising privileges with the Nuffield Health group. Husband is joint director of these two companies Infiniti Healthcare Ltd Beyond Healthcare Academy Ltd Husband has practising privileges at Spire Cardiff.	2013 Onwards 2022 Onwards 2018 Onwards 2013 Onwards 2022 Onwards 2004 Onwards	Not stated	No
19/04/2023		Consultant T & O	Medical	Nil Interests Declared	Not applicable	Not applicable	No
19/04/2023		Interim Deputy Medical Director for acute services	Medical	Nil Interests Declared	Not applicable	Not applicable	No
19/04/2023		Consultant in Palliative Medicine	Medical	Nil Interests Declared	Not applicable	Not applicable	No
19/04/2023		Consultant EM	Medical	Nil Interests Declared	Not applicable	Not applicable	No
19/04/2023 & 26/06/2023 (See in year amendment)		Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Partner - Locum Paediatric SHO, often working at royal glamorgan hospital.	April 2022 - ongoing	None	No
19/04/2023		Consultant Radiologist	Medical	Director TP Radiology Services LTD Provide teleradiology reporting for 4ways healthcare Ltd Provide teleradiology reporting for Heart Lung Healthcare Spouse: Shareholder in TP Radiology Ltd.	Since 2019 Since 2019 Since 2022 Since 2019	None stated	No
19/04/2023		Physiotherapist Rotational	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/04/2023		Consultant Physician	Medical	Nil Interests Declared	Not applicable	Not applicable	No
19/04/2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
20/04/2023		Assistant Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
20/04/2023		Principal Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Providing private psychological input to a nursing home outside of UHB	January 2023 - April 2023	Financial Transaction	No
20/04/2023		Consultant	Medical	Director of SAARK	From 2018	Annual Dividend	No
21/04/2023		Consultant Old Age Psychiatrist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
21/04/2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
21/04/2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
21/04/2023		Medicines Management Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
22/04/2023		Clinical Lead GPOOH	Medical	Nil Interests Declared	Not applicable	Not applicable	No
24/04/2023		Care Group Service Director	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
24/04/2023		Consultant O&G	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
24/04/2023		Consultant Acute Medicine	Medical	Nil Interests Declared	Not applicable	Not applicable	No
24/04/2023		Nurse Director USC	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	No
24/04/2023		Consultant Pathologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
24/04/2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
24/04/2023 Hard Copy Form		Consultant General Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No
25/04/2023		Consultant Anaesthetist	Medical	Husband is Director of Cowbridge Specsavers Franchise	2018-Present	None stated	No
25/04/2023		Consultant Anaesthetist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
25/04/2023		Lead Contact Lens Optometrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	CTM HB Optometric Advisor (Primary Care Team)	Since January 2023	0.2 wte 8b	No
25/04/2023		Consultant Radiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
26/04/2023 Hard Copy Form		Consultant Surgeon	Medical	Nil Interests Declared	Not applicable	Not applicable	No
26/04/2023		Consultant Community Child Health	Medical	Nil Interests Declared	Not applicable	Not applicable	No
26/04/2023		Acute General Services Manager	Chief Operating Officer Function	Nil Interests Declared	Not applicable	Not applicable	No
26/04/2023		Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
27/04/2023		Chief Information Officer	Digital	Ownership of shares > £5000 in: Berkshire Hathaway Inc(NYSE:BRK.B) Invesco S&P SmallCap 600 ETF (LSE:USML) iShares Core S&P 500 ETF USD Acc GBP (LSE:CSP1) Markel Corp (NYSE:MKL) iShares Core MSCI Japan IMI ETF USD Acc GBP (LSE:SJPA) Baillie Gifford Japan Ord (LSE:BGFD) Baillie Gifford Shin Nippon Ord (LSE:BGS) Herald Ord (LSE:HRI) Oryx International Growth Ord (LSE:OIG) Edinburgh Worldwide Ord (LSE:EWI) iShares Core MSCI Pac ex-Jpn ETF USD Acc GBP (LSE:CPJ1) Aberdeen New India Investment Trust (LSE: ANII) Spouse / Partner etc: Ownership of shares > £5000 in: Berkshire Hathaway,Markel Corp, Aberdeen Asia Focus Herald Ord Oryx International Growth Edinburgh Worldwide Aberdeen New India	Greater than 12 months	Value >£5000 - nb these are investment trusts or holding corporations and I have no ability to influence what stocks are held within the trusts	No
27/04/2023		Consultant Dermatologist and Clinical Lead	Medical	DIRECTOR 1) KAMATH DERMATOLOGY LIMITED 2)ANTANA KAMHAT LIMITED 3)CARDIFF MULTI SPECIALITY CLINIC AND DIAGNOSTICS LTD PI for UCB sponsored NIS trial ELEVATE with CTM R&D SPOUSE is also a director in companies 1 &2 listed above.	3 Years 2 Years 6 Months Similar as above	None stated	No
02/05/2023		Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private work at; Neuro Physio Wales, 60 Commercial Street, Kenfig Hill, Bridgend CF33 6DL	May-23	Paid by the hour	No
02/05/2023		Consultant Radiologist	Medical	Director: Acorn Diagnostics Ltd Director: Proton Medical Ltd Shareholder: Radiology Seminars Group Ltd Spouse/Partner or Close Family and/or Friend: Director: Proton Medical Ltd Shareholder: Radiology Seminars Group Ltd	Since 23 August 2021 to present 10 June 2019 to present	Dividends	No
02/05/2023		Clinical Director for Growing Well Strategy Group	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
02/05/2023		Consultant in Public Health Medicine	Medical	Husband - Manager of Books Plus Cardiff and member of the committee for the managing charity "Light on the Mount". Registered Charity No: 1074480.	2014 - ongoing	Wage paid by charity. No other financial benefits received from the charity.	No
03/05/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
03/05/2023		Primary Care Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Practice ~ offering counselling/psychotherapy to privately paying clients	Since 2019; 2 evenings per week, maximum of 1 hour each evening	payments received from clients	No
03/05/2023 Hard Copy Form		Consultant in Public Health	Public Health	Nil Interests Declared	Not applicable	Not applicable	No
04/05/2023		Primary Care Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private client work (outside of contracted hours) - non NHS clients) Tutor and course leader at Ty Elis on Counselling Diploma	ongoing ongoing	payment for private sessions payment as a private contractor	No
05/05/2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
05/05/2023		Registered Nurse	Nursing Bridgend	Declaring secondary employment/private aesthetics practice.	January 2023 ongoing	Private Ltd Company. (HanAesthetics Ltd)	No
05/05/2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
06/05/2023		Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
09/05/2023		Medicines Management Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Husband is a Director and land Surveyor for John Vincent Surveys.	Ongoing	Employed through Architect as and when requested / quote accepted for works.	No
09/05/2023		ENT Consultant	Medical	Nil Interests Declared	Not applicable	Not applicable	No
09/05/2023		Accuracy Checking Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
09/05/2023 & 12/06/2023		Physiotherapy Health Care Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
10/05/2023		Consultant Paediatrician	Medical	Director of limited company Paediatric-care limited Private practise in my non-contracted session on Tuesday morning at spire. Family member: Secretary to the limited company	Commenced May 2023	None stated	No
10/05/2023		Assistant Director of Improvement	Improvement and Innovation	Have agreed to judge on the Welsh Pharmacy Awards which are sponsored by TEVA ?(a pharmaceutical company). Host of the Aural Apothecary podcast - a podcast about medicines, improvement and prescribing.	3 Months Ongoing	Possible invite to awards dinner. Unpaid but previously has led to paid speaking engagements and expenses paid invites to conferences. These are done on own time.	No
11/05/2023		Pharmacy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/05/2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/05/2023		Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/05/2023		Medicines Management - Pharmacy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
16/05/2023		Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Bank work for Spire healthcare Wife works for Cardiff and vale UHB	2016 20+ Years	Paid Work	No action at this point noted.
16/05/2023		Consultant Cardiologist		Director of limited company: R&P Mitra Ltd	From April 2019 onwards	Yearly dividends if any	No conflict of interest identified following discussion with consultant

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
17/05/2023 Hard Copy Form		Consultant Obstetrician and Gynaecologist	Medical	Personal General Medical Healthcare Limited (Director) Spouse/Partner/Close Family and/or Friend General Medical Healthcare Limited (Director (Partner))	Not stated	Not stated	No
18/05/2023		Consultant	Medical	ERH PATH LTD & E&J PATH LIMITED Both: specialists medical practice activities	2022 & 2020	Director & Director Adhoc payments	Need to establish any potential conflict of interest. Finance colleagues have confirmed that no transactions between CTM and 'ERH PATH LTD' or 'E&J PATH LIMITED' from April 22 onwards.
19/05/2023		Project Manager	Mental Health - YCC	Nil Interests Declared	Not applicable	Not applicable	No
22/05/2023		Advance Pharmacist NICE and HCD Medicines	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
24/05/2023		Consultant Dermatologist	Medical	Sponsorship by UCB pharma to attend the European Academy of Dermatology and Venerology 2023 in Berlin. UCB pharma sponsorship to attend the British Association of Dermatologist Conference in June 2023 I hold the title of Honorary lecturer for the University of Cardiff.	11.10.23 - 14.10.23 27th June till 29th June 2023 Current	Financial: Flight and Conference fees and hotel. Financial: Train Travel and Hotel and Conference fees No financial transactions or Benefits. I am involved in medical students on their placements at Princess of Wales Hospital.	No
24/05/2023 Hard Copy Submission		Consultant Child LD Psychiatrist	Medical	Director of own company A Hassan Ltd - Private assessments and consultations Husband is a partner in A Hassan Ltd.	Since 12 May 2022	Financial Transactions	No
25/05/2023		Academy Administrator	National Imaging Academy Wales (Hosted Organisation)	Nil Interests Declared	Not applicable	Not applicable	No
30/05/2023		NICE Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
01/06/2023		District Nurse	Nursing	Nil Interests Declared	Not applicable	Not applicable	No
01/06/2023		Head of Speech & Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
01/06/2023		Consultant Neonatologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
01/06/2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
01/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
02/06/2023		Deputy Ward Manager	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
02/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
05/06/2023		Therapies Clinical Quality Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
06/06/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
06/06/2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
06/06/2023		Clinical Specialist Physiotherapist - Palliative Care	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/06/2023		Therapies Administration Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
07/06/2023		Clinical Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/06/2023		Assistant Head of Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Family Member: Father-in-law - Aled Edwards Lay Representative for Health Education improvement Wales and also member of Welsh Government Board - Civil Service	Current	Not applicable	Agreed to discuss with Head of Physiotherapy if any potential conflict if the situation arises, although considered very unlikely.
07/06/2023		Physiotherapist Team Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/06/2023		Head of Podiatry and Orthotics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/06/2023		Administration	National Imaging Academy Wales (Hosted Organisation)	Nil Interests Declared	Not applicable	Not applicable	No
07/06/2023		Deputy Head of Podiatry and Orthotics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/06/2023		MSK Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023 Hard Copy Form		Band 7 Physiotherapist in ESD (secondment)	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023 Hard Copy Form		Physio Tech	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023 Hard Copy Form		Team Lead Physiotherapist - Acute Stroke	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023 Hard Copy Form		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Head Sports Therapist at Rugby Club	3 Years	Voluntary	No
08/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023		Consultant Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Director of charity : Canolfan a Theatre Soar Private Practice	May 2023 Resumed April 2023	Voluntary Salaried	Undertaking private practice is normal business within the profession
08/06/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023		Band 7 Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
08/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Head of Occupational Therapy Services	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Neuro clinical specialist physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Lecturing in Cardiff met university for a social care course.	Not stated	No payment	No

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09/06/2023		Neurological Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Completed level 3 sports massage diploma, will consider private work in the future.	None currently	None currently	No
09/06/2023		Principal Occupational Therapist - Adult Mental Health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Clinical Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
09/06/2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/06/2023		Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/06/2023		Neuro Rehab Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/06/2023		Assistant Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/06/2023		Rotational Inpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Guest lecturer for Cardiff University	Yearly	Paid personally / special leave granted by health board	No
12/06/2023		Consultant Child and Adolescent Forensic Psychiatrist	Medical	Honorary Research Fellow role at Cardiff University. I have an NHS Locum Consultant role in Aneurin Bevan University Health Board for 2 sessions a week. These two sessions are accounted for in my job plan.	Honorary Research Fellow contract with Cardiff University since November 2020. Locum Consultant contract with ABUHB since August 2022.	The honorary contract confers no financial benefit. I am paid for my NHS Locum role through a salary as usual.	No
12/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/06/2023		Dietetic Professional Manager - Public Health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023 Hard Copy Form		Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Senior Public Health Practitioner	Public Health	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Deputy Head of Service - Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
13/06/2023		Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Professional Manager - Acute Speech & Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Head of Adults Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Department Professional Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Project Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Professional Manager Speech and Language Therapy in Community	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13-Jun-23		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Head of Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Specialist Adult Weight Management Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Public Health Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Clerical Support Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023		Departmental Administrative Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/06/2023 Hard Copy Form		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023 Hard Copy Form		Band 6 neuro rotational physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023		Macmillan AHP Lead for Cancer.	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Volunteer committee member (secretary) on the British Dietetic Association Oncology group Volunteer committee member on a social running group	2018-Present 2019-Present	Nil	No
14/06/2023		Public Health Dietetic Administrator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023		Neuro Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023		Head of Children's Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
14/06/2023		Public Health Administration and Clerical Officer	Public Health	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023		Highly Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/06/2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
15/06/2023		Clinical Lead Orthotist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
15/06/2023		Lead Podiatrist In Acute Foot	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
15/06/2023		Public Health Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
15/06/2023		Highly Specialist Public Health Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
16/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
16/06/2023		Physiotherapy Clinical Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
18/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Dept Head of Service, Nutrition and Dietetics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Wife - Emma James (Director of Nursing, Unscheduled Care)	Married since 2014	Not applicable	20/6/23 - Conversation with Ceri today regarding the potential conflict, nil concerns aware of professional conduct and confidentiality that is required.
19/06/2023		Specialist Oncology Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023 & 13/09/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Orthotic Services Administrator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Physio Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Dietetic Professional Manager - Acute Services	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Specialist Diabetes Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Occasional dance instructor (unpaid, once/monthly) Not actively teaching as of June 2023.	April 2022 - June 2023	None. Unpaid/volunteered.	No
19/06/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Dietetic Administration Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Diabetes Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
19/06/2023		Professional Lead Speech and Language Therapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
20/06/2023		Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
20/06/2023		Generic Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
20/06/2023		Adult SLT Department	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Work 1 day per week for Severn Health care technologies Provide lecturing and exam marking for Cardiff Met	Started in post June 22. Permanent position Lecturing between Feb/March each year. Exam marking in May annually	Hourly rate	No
20/06/2023		General Therapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023 Hard Copy Form		Specialist MSK Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	I work privately as a Physiotherapist for Weston House college, part of Bridgend College. This is a specialist unit for young adults with physical disabilities. This secondary employment is term time only and is a commitment of 3 hours a week.	Term time only, annually. 3 hrs a week maximum.	Paid Secondary employment	No
21/06/2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Lead Specialist Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Podiatrist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Owner of Podiatry Practice	2022 - to date	No financial payments received	No
21/06/2023		Static MSK Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Employment - Self Employed Business working privately delivering sports rehabilitation and performance clinics WRU - Casual Contractor S&C Coach	2020-Current 2019-Current	Financial Transactions	No
21/06/2023		Static Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Major Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Major Trauma Rehab Co-ordinator	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Clinical Lead MSK Outpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
22/06/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
22/06/2023		Team Lead Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Sole trader for own business - SoPhysio. Veterinary Physiotherapy Husband part director of Specsavers Bridgend, Porthcawl and Bridgend Derwen	Since September 2021 Since 2003	Nil	No
22/06/2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
22/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
22/06/2023		Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
22/06/2023		Clinical Specialist Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
22/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
22/06/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
22/06/2023		RGN	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
23/06/2023		PH Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
23/06/2023		Pelvic Health Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
23/06/2023		Pelvic Health Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
23/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
23/06/2023		PH Physio	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
23/06/2023		Clinical specialist physiotherapist womens health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Carry out occasional private work	0 hours contract	Not stated	No
23/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	My sister works in IT in Velindre Trust	Not applicable	Not applicable	No
26/06/2023		Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Physiotherapist Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Paediatric Team Lead	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Mrs Carol Miller sister Employee in health board Mrs Ruby James Niece Employee in health Board	1995 onwards 2019 onwards	Not applicable	No
26/06/2023		Principal Occupational Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Admin and Clerical	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
26/06/2023		Clerical Officer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
26/06/2023		Clinical Director of AHPs	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Husband is director of a Renewable energy Limited company I ha3/100th of husbands limited company as above Husband has 77% of company above 2 x daughters have 10% each of above company	Since September 2008 Since September 2008 Since September 2008 and 2018	As a shareholder i receive dividends	No
27/06/2023		Clinical Lead ED Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
27/06/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
27/06/2023		Highly Specialist Podiatrist acute foot	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
28/06/2023		Speech and Language Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
28/06/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
28/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
28/06/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private consultancy work for Alliance Pharmaceuticals	commenced June 2023	Paid private work in own time operating within HCPC codes of conduct.	No
28/06/2023		Physiotherapist (Junior)	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Rotational Inpatient Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Integrated Community Network and CRT Lead Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Community Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Sophie Lewis Physiotherapist	3 Years	None	No
29/06/2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Macmillan UGI Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Admin Roster Support	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Advanced Pharmacist in Surgery	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
29/06/2023		Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
29/06/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
30/06/2023 Hard Copy Form		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
30/06/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
01/06/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
03/07/2023		Team Lead Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
03/07/2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
03/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
03/07/2023		Deputy Head Occupational Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
04/07/2023		Bank Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
04/07/2023		Clinical Specialist Physiotherapist T&O	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
04/07/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
04/07/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
05/07/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
05/07/2023		Professional Manager Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
06/07/2023		Medical Team Assistant Surgical & Orthopaedics	Clinical Support Services	Nil Interests Declared	Not applicable	Not applicable	No
06/07/2023		District Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
06/07/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/07/2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/07/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
10/07/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
10/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
10/07/2023		District Nurse - Deputy Team Leader	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
10/07/2023		Static Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
10/07/2023		Physiotherapist Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/07/2023		Clerical Officer - Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
11/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
12/07/2023		Ward Manager	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
12/07/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
13/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
14/07/2023		Health Care Support Worker - Community	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
17/07/2023		Band 4 Primary Care	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
18/07/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
18/07/2023		High intensity therapist Mental Health	Diagnostic, Therapies, Specialties & Pharmacy Care Group	I work in private practice 1 day a week in Cardiff as a counsellor seeing approx 4 clients a week.	Have worked in private practice since 2008	Clients pay at each session via bank transfer per hourly session	No
18/07/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
20/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
20/07/2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/07/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/07/2023		Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
24/07/2023		Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
25/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
25/07/2023		Speech and Language Therapy Professional Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
25/07/2023		Team Leader	Primary Care	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Clinical Lead Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Project Manager / TSW Manager	Corporate	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Physiotherapy Technician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Service Director	Mental Health and Learning Disabilities Care Group	Voluntary Chair - West Wales Care & Repair	Since 2019	£0	No
26/07/2023		Physiotherapy Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
26/07/2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Public Health Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Advanced Pharmacist Formulary and Interface	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/07/2023		Administration and Clerical - Weight Management	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
27/07/2023		Dietetic Professional Manager - Paediatrics	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
27/07/2023		Paediatric Dietitian	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
27/07/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
27/07/2023		Physiotherapy Technical Instructor	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Company Secretary for Amerex Fire International and Director Director and secretary for Thornhill Global Ltd Thornhill Global Ltd Husband Director for Amerex Fire International and Thornhill Global Ltd Husband - Thornhill Global Ltd	From 16 April 2014	Unpaid position & Health Insurance (family Business) Unpaid position (family business)	No
27/07/2023		Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
28/07/2023		Team Lead Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
31/07/2023		Administrative Support MMPU	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
01/08/2023		Paeds Physio Admin	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
01/08/2023		Highly Specialist Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
01/08/2023		Clinical Specialist Paediatric Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	James Smith	Jun-22	None	No
02/08/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
02/08/2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
03/08/2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
03/08/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
03/08/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
03/08/2023		GPER/Obesity Medicine physician, locum	Keir Hardie Health Park	Own the company S Kenneally Medical for the purposes of private medical work	January 2019-to present and ongoing	Not stated	No
04/08/2023		Dietetic Support Worker	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
04/08/2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/08/2023		Care Home Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/08/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
07/08/2023		Dietetic Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
07/08/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
08/08/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
10/08/2023		Dietetic PA and Administration Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/08/2023		Macmillan Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/08/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
11/08/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
13/08/2023		District Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
16/08/2023		DHoP - Clinical Lead Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
22/08/2023		Sonographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Locum Sonographer in ABUHB	October 2021 - Present	Financial Transaction	No
22/08/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
24/08/2023		Business Support Manager	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No
24/08/2023		Senior Clinical Psychologist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private practice as a Clinical Psychologist. I do not work with anyone who lives in the catchment area of my work (ie within Cynon Valley) to ensure that no one can 'jump the waiting list' by paying to see me. I also do not do any private work within my employed NHS hours.	Since March 2022	The work is paid.	No
29/08/2023		Physiotherapy Assistant Practitioner	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
30/08/2023		Employee Experience Lead	People Services Team	Nil Interests Declared	Not applicable	Not applicable	No
31/08/2023		Community Stroke Nurse	PCH	Nil Interests Declared	Not applicable	Not applicable	No
31/08/2023		Consultant Cardiologist	Medical	Nil Interests Declared	Not applicable	Not applicable	No
05/09/2023		Manager Looked After Children Health Team	Community	Nil Interests Declared	Not applicable	Not applicable	No
05/09/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
07/09/2023		Head of Clinical Education	Patient, Care and Safety - Clinical Education	Director of Mosaic Leadership LTD (Private). 25% share in Mosaic Leadership	Since November 2020	Company commenced trading September 2023	No
07/09/2023		Staff Nurse	Ysbyty Cwm Rhondda				
12/09/2023		Advance Pharmacist Primary Care	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
12/09/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
13/09/2023		Acute Team Lead Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14/09/2023		Acute Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
14/09/2023		Speech and Language Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	External guest lecturer on a casual basis with The University of the West of England (UWE), in the education field delivering adhoc lectures on work about Speech and Language Therapy. I will not hold a contract with the university.	This is an adhoc period of involvement. I am likely to only deliver 2-4 hours worth of lectures per academic year	I will be paid a standard hourly rate for an external guest lecturer by UWE.	No
19/09/2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
20/09/2023		Specialist Head and Neck Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
20/09/2023		Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
21/09/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
22/09/2023		Rotational Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/09/2023		Strategic Planning & Commissioning Manager	Strategy & Partnerships	Nil Interests Declared	Not applicable	Not applicable	No
26/09/2023		Acute Lead and ICU Specialist Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
26/09/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
02/10/2023		Dietician	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Podcasting (personal project)	As of October 2023	Nil to declare currently.	No
02/10/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
04/10/2023		Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
05/10/2023		Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
10/10/2023		CAMHS Therapist	CAMHS	clinical supervisor-own private practice guest lecturer at University of South Wales for MSc Play Therapy course	Current November 2023 - ongoing	Hourly rate paid.	No
10/10/2023		Deputy Chief Pharmacist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Expert advisor to Public health ombudsman for Wales	November 2016 - current	Payment for advice March 2017	No
11/10/2023		Senior Pharmacy Technician - Medicines Information & Governance	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/10/2023		Superintendent Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
11/10/2023		Advance Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
19/10/2023		Principal Pharmacist Anticoagulation & Thrombosis	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
24/10/2023		Advance Nurse Practitioner	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
24/10/2023		Community Staff Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
24/10/2023		Senior Radiographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
25/10/2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
25/10/2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
25/10/2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
25/10/2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
25/10/2023		Community Nurse	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
25/10/2023		Clinical Specialist Physiotherapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
31.10.2023		Physio Assistant	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Approved	Name	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
3.11.2023		Assistant Head of Physiotherapy	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
14.11.2023		Sonographer	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No
15.11.2023		Speech and Language Therapist	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Private Welsh medium speech and language assessment carried out on 18/05/2023 in Ceredigion. Work carried out for Clinical Psychologist based in N.Wales	1 day - 18.5.2023	Payment for travel assessment, observation and report.	No
15.11.2023		Health Care Support Worker	Ysbyty Cwm Rhondda	Nil Interests Declared	Not applicable	Not applicable	No
16.11.2023		Radiology Nurse Manager	Diagnostic, Therapies, Specialties & Pharmacy Care Group	Nil Interests Declared	Not applicable	Not applicable	No

Date Declaration Made	Date Received by Corporate Governance	Name	Designation / Department	Provided by / From	Date Received	Details	Gift/Hospitality and or Sponsorship	Accepted or Declined
18/04/2023	19/04/2023		Director of Midwifery	Welsh Government, Office of the Chief Nurse	12th June to 16th June 2023.	Conference attendance at International Confederation of Midwives – Bali, Indonesia Sponsored by Welsh Government, Office of the Chief Nurse - Annual leave is required £800 (fees were paid in 2019, conference postponed due to COVID-19)	Sponsorship	Accepted and supported by Executive Director of Nursing / Deputy Chief Executive
17/08/2023	17/08/2023		Head of VBHC	Novartis Pharmaceuticals UK Ltd	September 2023 - Annual Leave will be taken for the date required.	1hr VBHC expert interview Meeting organised and funded by Novartis Pharmaceuticals UK Ltd Novartis Pharmaceuticals UK Ltd, London 2nd Floor, The WestWorks Building White City Place 195 Wood Lane London, W12 7FQ MLR ID: 292006 £250 Honorarium - Annual leave required	Honorarium	Accepted and supported by Director of Improvement & Innovation
26/09/2023	26/09/2023		Head of VBHC	Kings Fund	11-12th October 2023	Part of panel at the Kings Fund Digital Congress in London Webinar organised Kings Fund Partnerships Manager The King's Fund Telephone 020 7307 2490 Email r.gorringe@kingsfund.org.uk Website www.kingsfund.org.uk The King's Fund, 11-13 Cavendish Square, London W1G 0AN Registered Charity 1126980 £184.20 - £310 – estimated on Internet search, as cost not provided	Honorarium	Accepted and supported by Assistant Director of improvement culture capability and delivery, Patient Care & Safety
28/09/2023	28/09/2023		Director of Digital	Patient	28th September 2023	Location: Llantrisant – Snowdrop Centre / Hyb Event: Two CTM Patients were left without transport home. Both patients were very emotional. On leaving work at approximately 18:00 I offered to take them home to Mountain Ash. One of the patients wanted to offer me money which I repeatedly declined. On arrival home I found £20 hidden on my backseat under my running clothes which were also on the backseat. No idea of the patients full names. I have donated the money to charity.	Gift	Declined. Supported by Chief Executive.

Agenda Item
2.2.4

Audit & Risk Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) CLINICAL AUDIT ANNUAL REPORT 2022-2023

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit and Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford – Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
NCA&ORP	National Clinic al Audit & Outcome Review Plan
CA&QI	Clinical Audit and Quality Informatics

1. Situation /Background

1.1 The purpose of this report is to provide an annual review for the Audit & Risk Committee on compliance with the CTMUHB Clinical Audit Forward Plan 2022-2023 aligned to the NCA&ORP for 2022/23. (See Appendix 1: Clinical Audit Annual Report 2022-23).

1.2 To inform the committee of the other activities provided by the CA&QI department e.g. Mortality Review, NICE monitoring and Informatics functions.

2. Specific Matters for Consideration

The clinical audit team are working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

3. Key Risks / Matters for Escalation

3.1 The challenging backdrop of reduced budget, decreased staffing and increased demand to deliver an increasing programme of tier 1 national audits resulting in reduced capacity to support tier 2 essential organisation priority clinical audits.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is not a policy or service review
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 That the committee **NOTE** receipt of the Annual CTMUHB Clinical Audit Report for 2022-23.

6. Next Steps

6.1 To ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

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

Llywodraeth Cymru
Welsh Government

TARN
THE TRAUMA AUDIT & RESEARCH NETWORK

HQIP

Evidence
Guidance
Quality standards
Improved outcomes

NJR Quality Data Provider
for commitment to patient safety through the National Joint Registry
2022/23
CERTIFICATION FOR DATA SUBMISSION & QUALITY

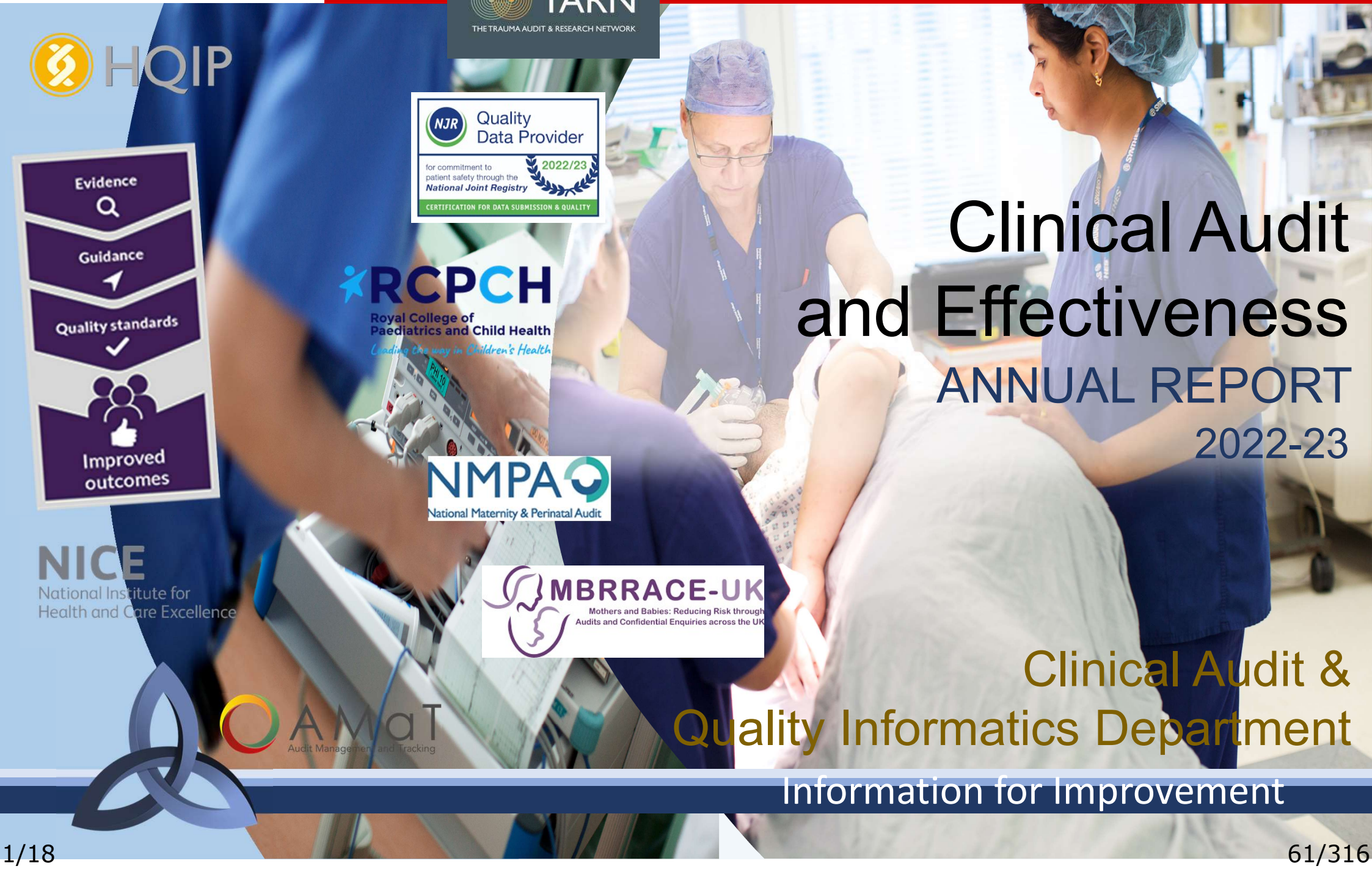
RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

NMPA
National Maternity & Perinatal Audit

NICE
National Institute for Health and Care Excellence

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

AMaT
Audit Management and Tracking



Clinical Audit and Effectiveness

ANNUAL REPORT 2022-23

Clinical Audit & Quality Informatics Department

Information for Improvement

Section	Page
• Forward – Deputy AMD for Clinical Audit & Effectiveness	3
• The Department	4
• Workforce (staff development)	5
• Training Programme	6
• Sharing the learning from Clinical Audit	7
• NHS Wales National Clinical Audit and Outcome Review Plan 2022-23 (Sample of 2022-23 national audit findings)	8
• Ward & Community Team real-time clinical audits	15
• NICE	16
• Learning from Mortality Reviews	17

Deputy AMD for Clinical Audit & Effectiveness

The National Clinical Audit and Review Outcome Plan confirms the National Clinical Audits and Outcomes that health boards are expected to participate in. This annual rolling program shows how findings from audits and reviews will be used to evaluate and improve healthcare quality and safety in Wales.

Clinical Audit is an integral part of the process for measuring the quality of services against set standards for comparison and identification of improvement opportunities.

Considering the challenges, the Health Service is now facing across Wales being able to identify improvements and optimise efficiency has never been more important. When working in partnership with multiple disciplines, managers and policy makers the NCAROP enables objective assessment of the quality of healthcare to guide decision making.

The Clinical Audit and Quality Informatics Department champions education and engagement with the process at every level within the Health Board. There are clear lines of communication to ensure escalation to the Executive board and Medical Director as well as dissemination to all relevant departments.

The Mortality Review process, which continues to expand in scope and demand, is also being run by the Audit Department to great effect.

I wish to commend and recognise the hard work and dedication of our Clinical Audit and Quality Informatics Department who have produced all of this against a challenging backdrop of squeezed budgets, decreased staffing and increased demand. I also wish to thank the Clinical Audit Leads, the Medical Director and all those who have participated in the Audit process for their engagement and enthusiasm.

Department

The Clinical Audit and Quality Informatics (CA&QI) Department is responsible for facilitating all clinical audit projects, incorporating both national, organisation and local priorities, throughout CTMUHB. It is an integral part of the Medical Directors Office which is accountable to the Executive Director of Nursing, Medical Director and Executive Board.

The department provides expertise and support to clinical specialties to monitor and improve patient care through:

- Clinical audit training, awareness and support to all clinicians
- Support and facilitation to clinicians and other relevant staff conducting and / or managing clinical audits
- A formal review of the Clinical Audit & Effectiveness Programme to ensure that it meets the organisations aims and objectives as part of the wider quality improvement agenda.

Findings from national audits are presented quarterly to the Clinical Audit, NICE and Effectiveness Group (CANE) prior to inclusion in update reports to the Quality & Safety Committee. The Quality and Safety Committee is responsible for receiving assurances for all national audits.

A report is also provided annually for the organisation Audit Committee on clinical audit activity.

Clinical directorates hold bi-monthly Clinical Audit / Quality Assurance and Governance meetings at which they cover standing quality agenda items which include clinical audit. The meetings are also used to plan how the directorates will implement the recommendations made as a result of national clinical audits.

The CA&QI department also manages the organisation's Mortality Review process, NICE compliance (through national audits), ward audits and provision of an informatics service.

Workforce
Staff Development

Staff retention and development remains a key goal six staff have secured promotion, one external to CTMUHB. The Lead Nurse for Clinical Effectiveness appointed as Deputy Director of Nursing in Tŷ Hafan Children's Hospice.

In addition, Specific staff achievements have included:

- Band 3 bank post appointed to permanent band 4 Mortality Review administrative post
- A band 5 secondee securing a permanent band 6 post in the Medical Directors Office
- Band 6 securing an 8a post in Acute services
- Band 6 completing BSc
- 6 staff completed Microsoft office training
- 1 member of staff completing ILM level 5 training
- Audit Manager appointed as Art & Health Champion for CTMUHB
- Band 6 completed Mental Health First Aide course

Training Programme

Total clinicians Trained 2022-23

Clinical Audit **98**

Ward & Area Audit **158**

In addition to the standard package of training the following tailored group sessions were provided:

July 2022

A programme of bespoke clinical audit and effectiveness training for year 2 Student Nurses commenced. Student nurses spent two weeks gaining an insight into the portfolio of the Clinical Audit & Quality Informatics department

August 2022

Clinical audit training was delivered to Primary Care-based Nurse practitioners

February 2023

clinical audit and effectiveness training was delivered to Pharmacy trainees and technicians from across the HB

March 2023

Clinical Audit and AMaT training was also delivered to trainee doctors as part of the post graduate teaching programme

Workshop-based group training spread over 4 sessions has been provided that covered clinical audit techniques from inception to presentation. The core topics are; (1) Clinical audit overview; (2) Identifying your audit criteria; (3) Preparing an audit proforma and data collection; (4) Analysing audit results; (5) Preparing for presentation and sharing the findings (report writing and action planning).

Training sessions have been adapted for delivery using MS Teams in a condensed format and tailored to the needs of clinical teams. In addition to formalised training sessions, all clinical audit staff are able to provide clinical audit advice, support and training on an ad-hoc basis.

In addition, training sessions have been provided for clinicians on the use of the Audit Management and Tracking (AMaT) system. Demonstrations are a regular feature of clinical audit meetings, to ensure that clinical staff are able to register audits and upload audit information on the new system.

Sharing the learning from Clinical Audit

Since October 2021, a clinical audit newsletter is published on a quarterly basis to publicise key national audit findings, information on clinical audit services and to provide evidence of any associated improvement work.

Clinical Audit Newsletter

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

Quarter 1
Apr – Jun 2022

Spotlight on TARN Trauma Audit & Research Network

Overview of the TARN national audit:
The Trauma Audit and Research Network (TARN) is a national organisation that collects and processes data on moderately and severely injured people, collecting data from across 220 hospitals covering England, Wales, Northern Ireland and the Republic of Ireland.

TARN is the national clinical audit for traumatic injury, it TARN began in 1990 and is the largest European Trauma Registry, holding data on > 800,000 injured patients including > 50,000 injured children.

The TARN Objectives
Provide a national baseline of current trauma patient demands, clinical practice and performance
Identify current practice for trauma patients, map trends and to develop improved care pathways
Identify variance in patient processes and the impact of such variance on patient care
Promote reflective clinical practice and to encourage performance review at local and national level
Provide quality data to enable research and to drive clinical change

TARN Reporting:
TARN allows networks, major trauma centres, trauma units, ambulance services and individual clinicians to benchmark their trauma service with other providers across the country through reports.

Reporting Schedule

TARN in CTM:
Sean Thomasson, Senior Clinical Audit Facilitator oversees the TARN data capture with Samantha Bryant, TARN Co-ordinator.
All Clinical Audit Facilitators play an active role in TARN data collection and informal in-house training took place throughout the Quarter to expand knowledge and skills for TARN data capture.
Due to a number of constraints during Quarter 4 2021/22 TARN data capture declined, however during Quarter 1 2022/23 the Clinical Audit team has rallied to improve performance by focussing energy on this high profile national clinical audit.

Recognition of CTM Clinical Audit Activity

Colleagues from the Mental Health team were acknowledged for their involvement in clinical audit activity and awarded certificate for their poster presentation. The audit reviewed the quality of documentation for DNACPR in Older Persons Mental Health. The prize was awarded jointly by the Royal College of Psychiatrists, the Welsh Psychiatric Society and the National Centre for Mental Health in 2021 and a re-audit has since been conducted which highlighted improvements in the quality of DNACPR documentation.

News from the Team

Let's wish Carol a Happy Retirement!

Carol Williams, Clinical Audit Facilitator, based at RGH retired in May 2022 after 20 years of being an integral part of the team, expertly facilitating key national audits such as COPD, Heart Failure and TARN, plus local audit activity with Therapies, Mental Health and Paediatrics over the years.
Carol will be missed by friends and colleagues.
Happy Retirement Carol!
Good luck and best wishes for the future.

Congratulations Amelia

Amelia Wills, Clinical Audit & Mortality Review Facilitator based at PCH was successfully awarded a First Class Honours Degree (BSc Information Communication Technology) from the University of South Wales in June 2022.

New MS Teams Channel for Clinical Audit

Looking for the latest Clinical Audit info or some guidance on your clinical audit – **join the Clinical Audit Teams Channel via your Microsoft Teams app**

New National Clinical Audit Reports

National Cancer Audit Annual Reports:
National Paediatric Diabetes Audit (NPDA)
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)
National Audit of Breast Cancer in Older Patients
SSNAP: Acute Organisational Audit 2021 Sentinel Stroke National Audit Programme (SSNAP)
NMPA Clinical report 2022 National Maternity and Perinatal Audit

Quarter 1. Releases

'A Picture of Health (2022)?' (NCEPOD)
National Diabetes Foot Care Audit
National Diabetes Audit, 2020-21
Children and Young Person Asthma 2021
Organisational Audit: Summary report
National Cardiac Audit Programme (NCAP) reports: Heart Failure, MINAP, Cardiac Rhythm Management

AMaT Audit Management & Tracking software is being used to hold national clinical audit reports and our local action plans. Multidisciplinary meetings are being scheduled to discuss the audit findings and develop CTM action plans that support positive improvement in the quality patient care.

Clinical Audit Awareness Week 2022

Clinical Audit Awareness Week took place from 13th – 17th June, the week was marked by a number of informative sessions organised by HQIP, Stephen Ashmore & Tracey Ruthven at the Clinical Audit Support Centre and Suzanne Henderson from Meantime, the information technology specialists behind AMaT.

Looking ahead

Clinical Audit, NICE & Effectiveness (CANE) Group Meeting to be held on Tuesday 27th September 2022, all audit leads to attend or nominate a deputy.

For further information on Clinical Audit contact Lauren Dyton, Clinical Effectiveness Manager:
Lauren.Dyton@wales.nhs.uk

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

NATCAN

National Cancer Audit Collaborating Centre

National Audit of Primary Breast Cancer & National Audit of Metastatic Breast Cancer
breastcanceraudits@rcseng.ac.uk

Newsletter | March 2023 | Issue 2023 (1)

Highlights

1. Scoping survey for new audits
2. ABS Conference 15-16 May
3. Meet the team and find out more

Help shape the new audits – scoping survey now live

The scoping survey that will help inform the new National Audit of Primary Breast Cancer and National Audit of Metastatic Breast Cancer is now live. We are asking stakeholders from across the breast cancer care community – including both healthcare professionals and patients/patient advocates – to share your thoughts on where we should prioritise our efforts.

The short survey will take a **maximum of 5 minutes** to complete.

Please feel free to share the survey with your networks to ensure we consult as widely as possible on the focus of the audits. Your contribution to th… important and appreciated.

Take the survey

ABS Conference, 15-16 May

Join us at the ABS Conference to hear about progress and plans for the two new breast cancer audits. We will also be presenting on breast cancer drug recording in routine data and on re-excision rates based on data from NABCOP.

ABS ASSOCIATION OF BREAST SURGERY

Find out more and book your place

On behalf of the National Breast Cancer Audits Project Teams
For more information on this HQIP-funded project within the National Clinical Audit and Patient Outcomes Programme contact us on:
020 7869 6610 | breastcanceraudits@rcseng.ac.uk

The National Breast Cancer Audits are part of the National Cancer Audit Collaborating Centre (NATCAN). Find out more about NATCAN:
bit.ly/3JJ5tNd | @NATCAN_news

NLCA National Lung Cancer Audit

Issue 2023 (1)
nlca@rcseng.ac.uk
020 7869 6606
@NLCA_uk | www.lungcanceraudit.org.uk

NLCA Newsletter, April 2023

Newsletter highlights

1. State of the Nation Report 2022
2. Data completeness
3. Patient and Public Involvement
4. New cancer audits

1. State of the Nation Report 2022

The National Lung Cancer Audit Project Team is in the final stages of producing the first 'State of the Nation' report for patients diagnosed with lung cancer between 1 January and 31 December 2021 in England and Wales.

The report will be published in April 2023, in advance of the 21st Annual Conference of the British Thoracic Oncology Group. For the first time, we report on the impact of the Covid-19 pandemic on lung cancer care in Wales during 2020, as well as giving insight into the care of patients with lung cancer NHS services in England and Wales during 2021.

We thank all NHS Trust and Health Board teams for your outstanding efforts in submitting data to the National Cancer Registration and Analysis Service (NCRAS) and the Wales Cancer Network (WCN) throughout the Covid-19 pandemic.

Save the date!
The publication date of the first NLCA State of the Nation report is 13 April 2023*, supporting materials (such as an NHS organisation data viewer) will also be published.
*subject to clearance and sign off.

21st BTOG Annual Conference - session 9, 10am on Friday 28 April - presentation on the NLCA State of the Nation report, by Dr Neal Navani, NLCA Senior Clinical Lead.

2. Data completeness

Improving data completeness is essential for the NLCA to measure the care and outcomes of patients with lung cancer. Please continue to submit key routine COSD data items to the National Cancer Registration and Analysis Service (NCRAS) and the Welsh Cancer Network (WCN). Here is a link to the NLCA Minimum Dataset

We are currently exploring more frequent (quarterly) reporting using rapid cancer registration data which is available to the team 3 – 6 months following diagnosis.

3. Patient and Public Involvement

A public and patients' version of the NLCA State of the Nation report will be available from 13 April 2023. The NLCA is in the early stages of setting up a Patient and Public Involvement forum and will be working with the Roy Castle Lung Foundation to recruit patients.

4. New national cancer audits

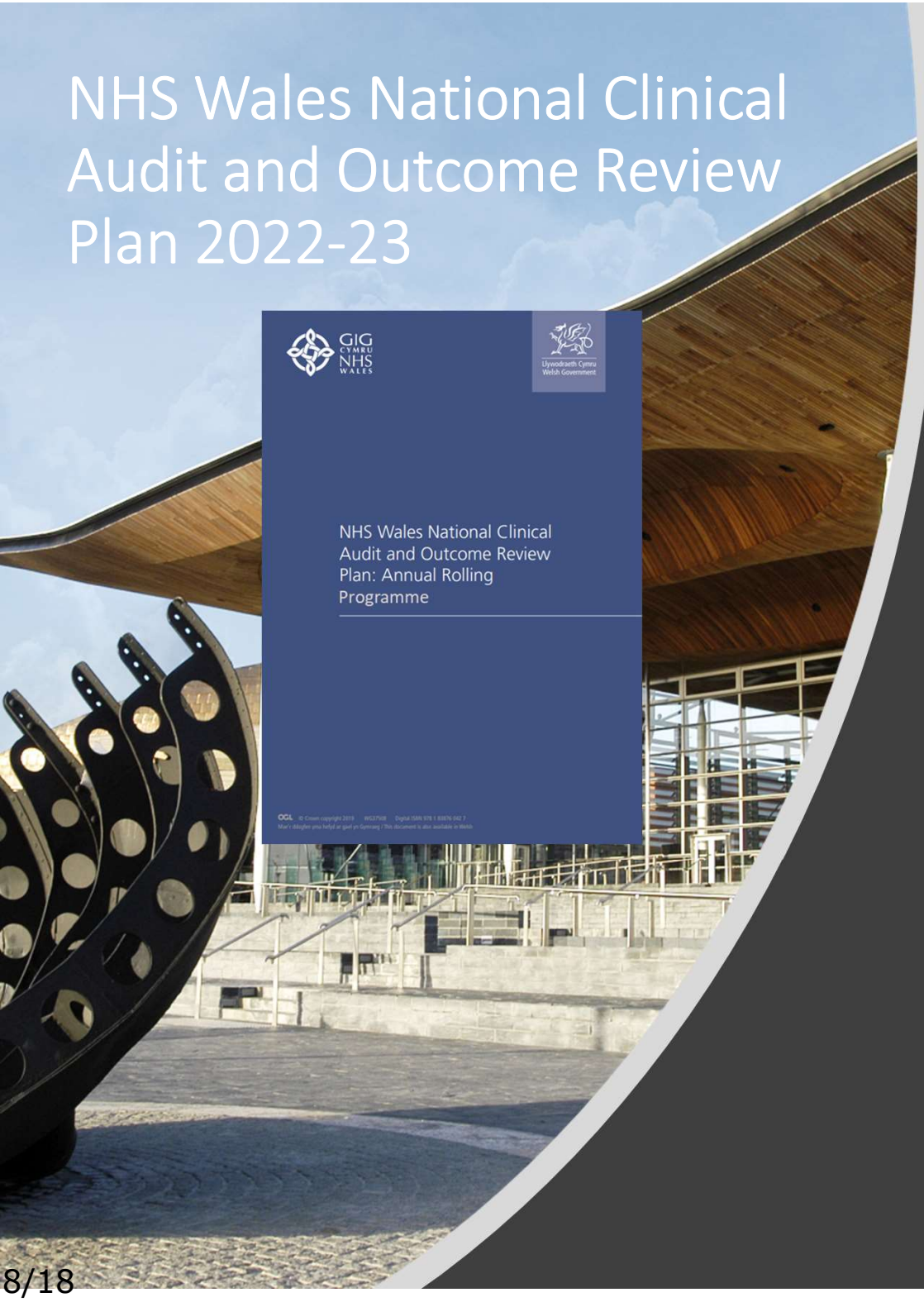
The Royal College of Surgeons of England has been commissioned to create a National Cancer Audit Collaborating Centre (NATCAN) by the Healthcare Quality Improvement Partnership on behalf of NHS England and the Welsh Government. This includes new audits in breast, ovarian, pancreatic, and kidney cancer as well as non-Hodgkin lymphoma. To receive information about these audits, please email natcan@rcseng.ac.uk, indicating which audit you are interested in.

NATCAN

On behalf of the NLCA Project Team
Please contact us or visit our website for more information about the NLCA.
T: 020 7869 6606 @NLCA_uk
E: nlca@rcseng.ac.uk
W: www.lungcanceraudit.org.uk

In addition, national audit newsletters are available to disseminate learning from clinical audits

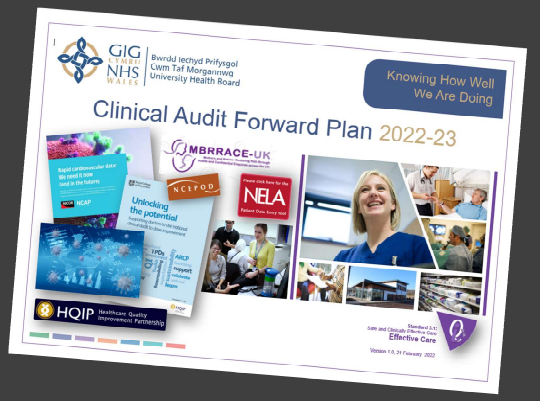
NHS Wales National Clinical Audit and Outcome Review Plan 2022-23



All organisations in Wales are required as part of their Quality Strategy to have an annual Clinical Audit Forward Plan in place to fully participate in all relevant national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.

The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan identifies all of the clinical audit projects from the National Clinical Audit and Outcome Review Plan for 2022-23 that must be undertaken by CTMUHB.

Clinical audit is a fundamental component of the



organisations quality assurance process, based on transparency and candour. Quality assurance provides a systematic approach to maintaining consistently high quality by constantly measuring and reporting on effectiveness, highlighting the need for improvement and enabling the sharing of good practice.

The CTMUHB Clinical Audit Forward Plan sets out a programme of prioritised continuous improvement activities, including clinical audit, and is designed to help to embed the above principles into the everyday working practice of individuals and clinical teams to improve clinical outcomes for patients, through focused and structured work. The plan for 2022-2023, was determined at both corporate, locality and directorate level based around priority categories established by the Healthcare Quality Improvement Programme (HQIP) and defined as:

1. External "must do" - Externally monitored audits that are driven by commissioning and quality improvement are treated as the priority and appropriate resources are provided to support these. Failure to participate or deliver on these externally driven audits may carry a penalty for the Health Board

2. Internal "must do" - Based on the classic criteria of high risk or high profile identified by health board management. They may include national initiatives with health board-wide relevance, but no penalties exist for non-participation. Many of these projects will emanate from Health Board governance issues or high-profile local initiatives.

The 11th annual National Clinical Audit and Outcomes Review Plan was delayed due to the transfer of responsibilities for the NHS Wales National Clinical Audit & Outcome Review Plan (NCA&ORP) from Welsh Government to Digital Health and Care Wales.

Clearly identified responsibilities and timeframes for completion of audit work and continuous monitoring of progress against the plan has ensured the improved compliance position for CTMUHB. The weekly national audit monitoring of compliance that was introduced in April 2019 and the implementation of the Clinical Audit & NICE Compliance Management system from April 2020 has ensured that the organisations has maintained compliance with all national audits.

Pages **10** to **14** of this report provide some examples of the national audits undertaken by the organisation as part of the CTMUHB Clinical Audit Forward Plan. A full list of national audits that the organisation participates in can be found in the published **CTMUHB Clinical Audit Forward Plan 2022-23**.

TARN

THE TRAUMA AUDIT & RESEARCH NETWORK

Every year across England and Wales, 12,500 people die as a result of a serious injury. It is the leading cause of death among children and young adults of 44 years and under. There is also significant amount of evidence available to show that patients who suffer a major trauma have a greater chance of survival and recovery if they are treated within a Major Trauma Network (MTN).

In March 2018, CTMUHB as part of the South Wales region was approved for the establishment of **Major Trauma Centres (MTC)** at the Princess of Wales and Prince Charles hospitals, with the aim of enhancing clinical care and patient experience through introduction of specialist teams and a major trauma pathway.

TARN is the national clinical audit for traumatic injury and forms part of the **National Clinical Audit and Outcome Review Plan** for Wales. CTMUHB participates in the TARN audit that informs the major trauma programme of work.

The team are responsible for ensuring that all TARN cases are identified and input onto TARN within 28 days of discharge from hospital.

Compliance with TARN quarterly reporting deadlines has not been achieved in 2022-23 due to long term sickness, vacancies and budgetary constraints for the period reducing the overall TARN audit cover.

National Joint Registry
www.njrcentre.org.uk
Working for patients, driving forward quality

NJR is described as a global exemplar of an implantable medical device registry, which covers England, Wales, Northern Ireland, the Isle of Man and Guernsey continues to be the largest orthopaedic registry in the world, with an international reputation and holds over 3 million procedure records to provide timely warnings of issues relating to patient safety.

The registry's purpose is to record patient information and provide data on; the performance and longevity of replacement joint implants; the surgical outcomes for the hospitals where these operations are carried out; and on the performance outcomes of the surgeons who conduct the procedures.

NJR Quality Data Provider
for commitment to patient safety through the National Joint Registry
2022/23
CERTIFICATION FOR DATA SUBMISSION & QUALITY

Head of service recognised that *"this was the 4th year in a row that the team have received the NJR Data Quality award, very proud of the high standards the team have maintained evidenced by this continued recognition."*

The award offers public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission.

National Paediatric Diabetes Audit (NPDA) Annual report 2020-21 (Published in April 2022)

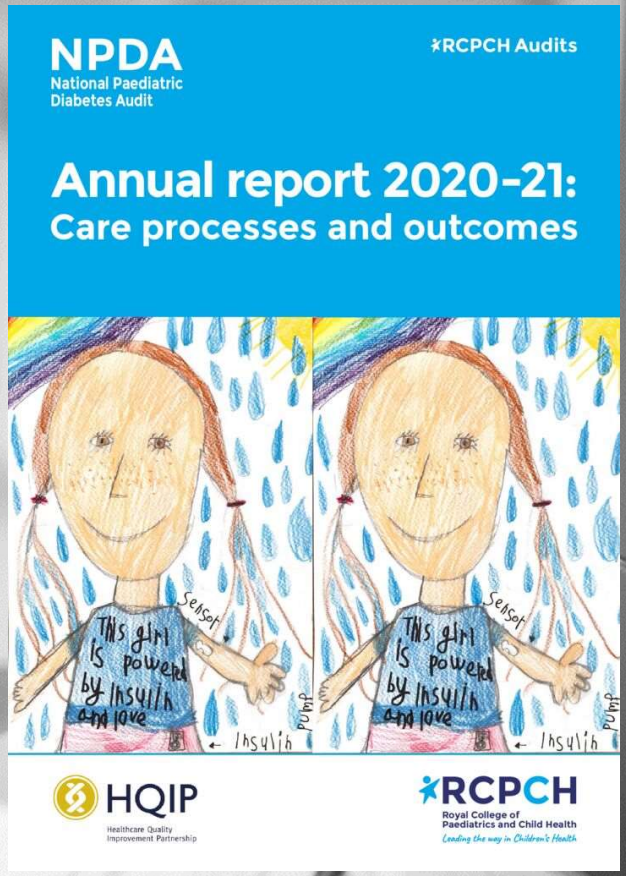
The audit covers the health checks and outcomes for children and young people with diabetes who have attended PDUs (paediatric diabetes units) between 2013/14-2019/20.

Findings

The NPDA annual report found the incidence of Type 1 diabetes increased significantly in 2020/21 amongst those aged 0-15, from 25.6 new cases per 100,000 in 2019/20 to 30.9 in 2020/21 – an increase of 20.7%. Other key national findings include:

- The number of children and young people with Type 2 diabetes being managed within a PDU increased from 866 in 2019/20 to 973 in 2020/21, with the numbers diagnosed within the audit year having increased from 201 in 2019/20 to 230 in 2020/21.
- An increase in the use of real time continuous glucose monitors from 19.4% in 2019/20 to 27.9% in 2020/21 was found, with increases observed across all deprivation quintiles and ethnic groups.
- The impact of the COVID-19 pandemic on paediatric diabetes care can be seen in lower completion rates of all recommended health checks and the smaller percentage of children and young people starting insulin pump therapy if diagnosed in 2020/21, compared to previous years.

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health



National Maternity and Perinatal Audit (NMPA): Clinical report 2022 The NMPA is based on births in NHS maternity services between 1 April 2018 and 31 March 2019 in England and Wales, the report presents information about care and outcomes, and highlights areas of potential service improvement.

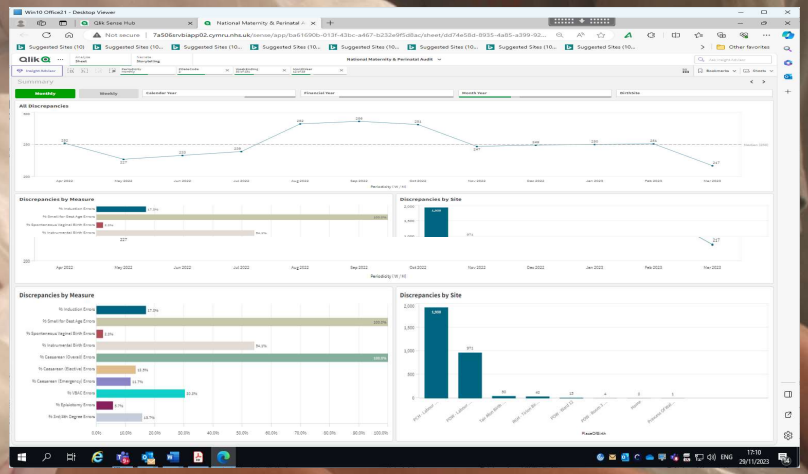
The report captures 89% of eligible births, finding that one third of women and birthing people with singleton pregnancies at term underwent an induction of labour.

Other key national findings include:

- Of those experiencing an instrumental birth by forceps, as many as 1 in 20 did so without an episiotomy; of these, 31% experienced a third- or fourth-degree tear.
- Of those opting for a vaginal birth after a previous caesarean birth, the proportion who went on to experience a vaginal birth was 61% (over 10 percentage points lower than that in national guidance, namely 72–75%).
- Around half of babies born small for gestational age (SGA) were born after their due date. This is in contrast to national guidance recommending earlier induction be offered if there are concerns about a baby being small.

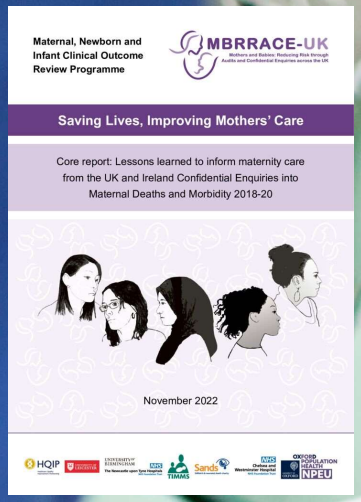
NMPA
National Maternity & Perinatal Audit

A clinical dashboard has been developed by CTMUHB Clinical Audit department in collaboration with the Performance and Information department to identify discrepancies in the data gathered for the NMPA. This will enable the early detection and correction of errors and improve the quality of this essential clinical data for clinical decision making.



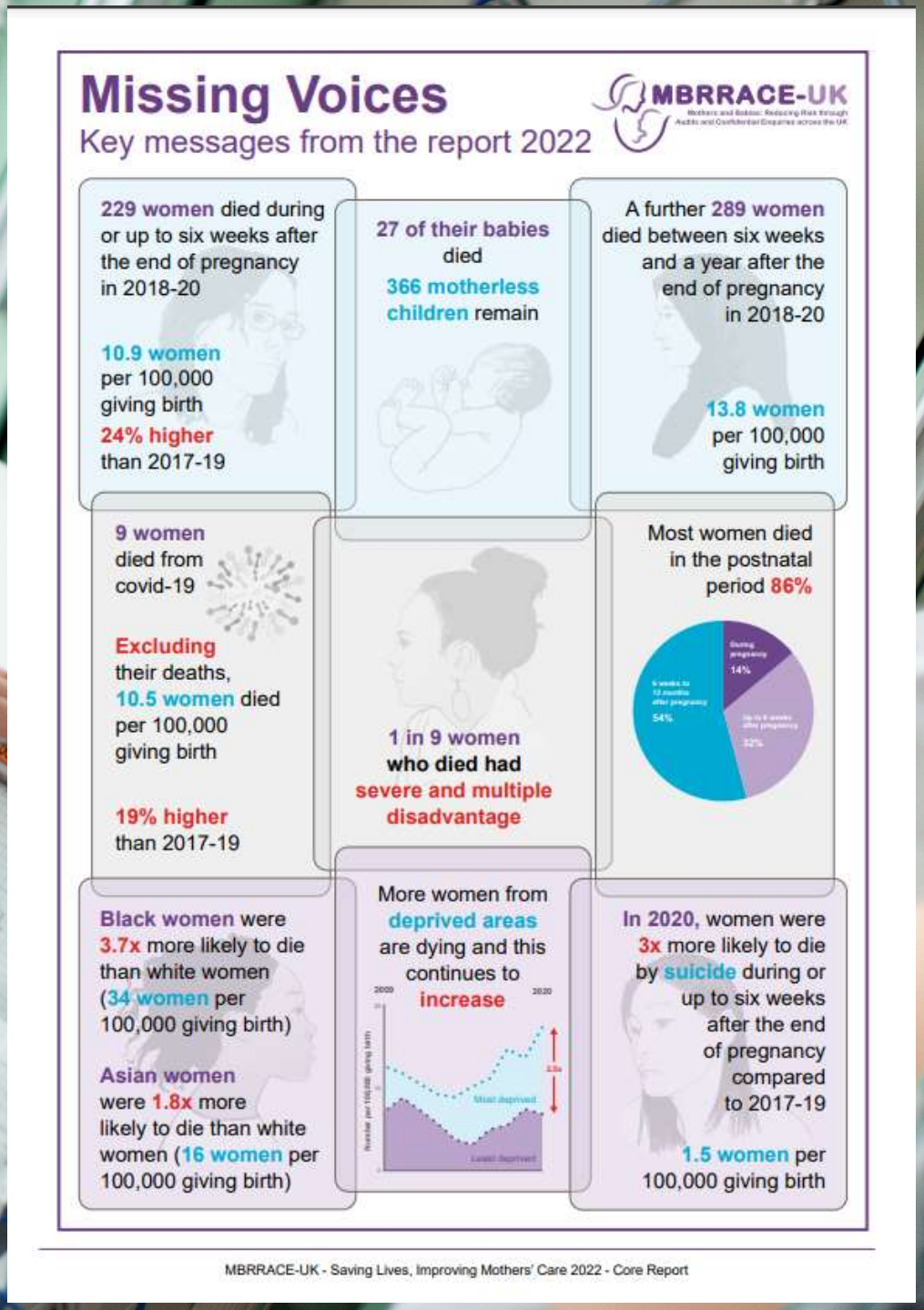
MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

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.



Ward & Community Team real-time clinical audits

The AMaT ward and area module has been implemented across more than 200 clinical locations.

During 2022-23 the rollout has focused on Emergency, Mental Health and Therapy departments.

Audit overview

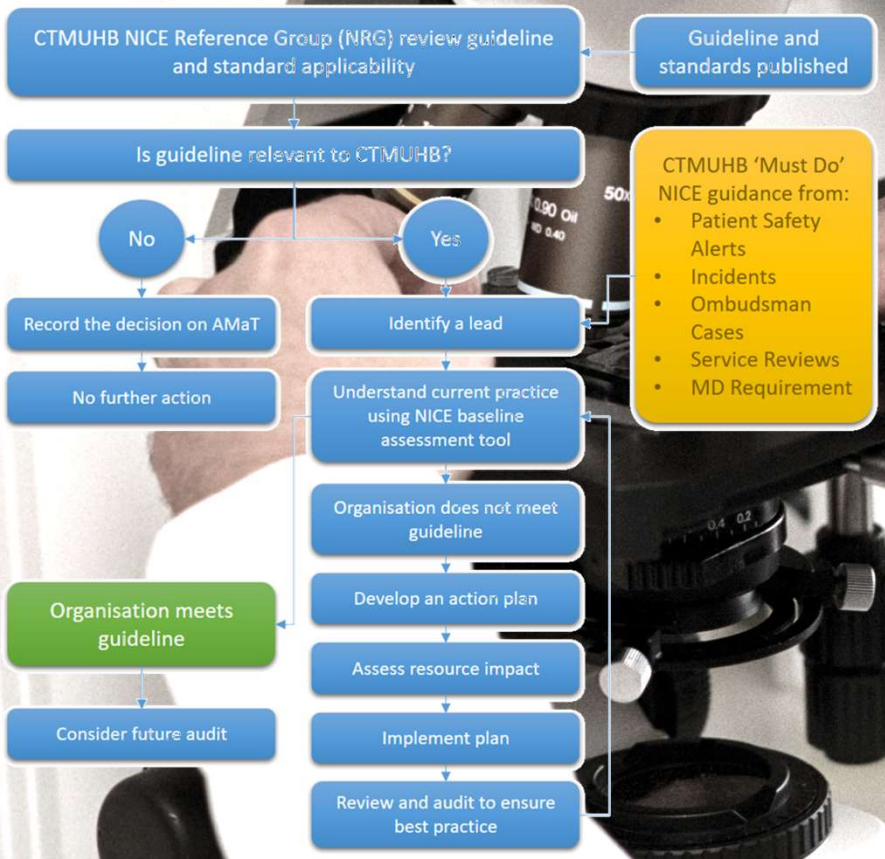
Audit	Frequency	Compliance over last 6 periods						Current	Improvement	Overdue actions	View
POINT REVIEW: Presentation (uniform) audit	M	97.7%	98.2%	98.6%	98.0%	98.3%	98.2%	98.6%	➤	6	CHART INSIGHT
POINT REVIEW: Hand hygiene and bare below the elbow audit	M	97.5%	96.8%	97.0%	98.1%	97.4%	97.0%	96.9%	➤	3	CHART INSIGHT
POINT REVIEW: PVC bundle compliance audit	M	91.5%	93.2%	91.4%	92.6%	84.5%	86.6%	87.3%	▼	8	CHART INSIGHT
POINT REVIEW: Urinary catheter bundle compliance audit	M	92.1%	91.8%	92.9%	93.9%	95.5%	91.9%	93.5%	▲	11	CHART INSIGHT
POINT REVIEW: Controlled drug medicines and storage audit	M	96.8%	97.8%	98.0%	97.7%	98.2%	98.1%	97.2%	▲	5	CHART INSIGHT
POINT REVIEW: Documentation and Record Keeping Audit (V5)	M	86.8%	87.6%	89.4%	90.9%	90.3%	89.8%	88.1%	▲	17	CHART INSIGHT
POINT REVIEW: Glucose Monitoring Audit	M	98.5%	97.6%	96.1%	98.9%	98.0%	97.3%	96.2%	➤	2	CHART INSIGHT
POINT REVIEW: Infection Prevention & Control audit, & Environmental Audit (V1)	M	94.5%	94.2%	94.1%	94.0%	94.0%	93.9%	94.1%	➤	24	CHART INSIGHT
POINT REVIEW: Wristband audit (V2)	M	96.6%	97.3%	97.7%	97.4%	96.8%	97.9%	98.1%	➤	0	CHART INSIGHT

Nine core organisation wide audits have been established to provide assurance around infection prevention control, medicines management, documentation and patient safety. In addition, a range of speciality specific audits are under development.

AMaT Audit Management and Tracking

NICE
National Institute for Health and Care Excellence

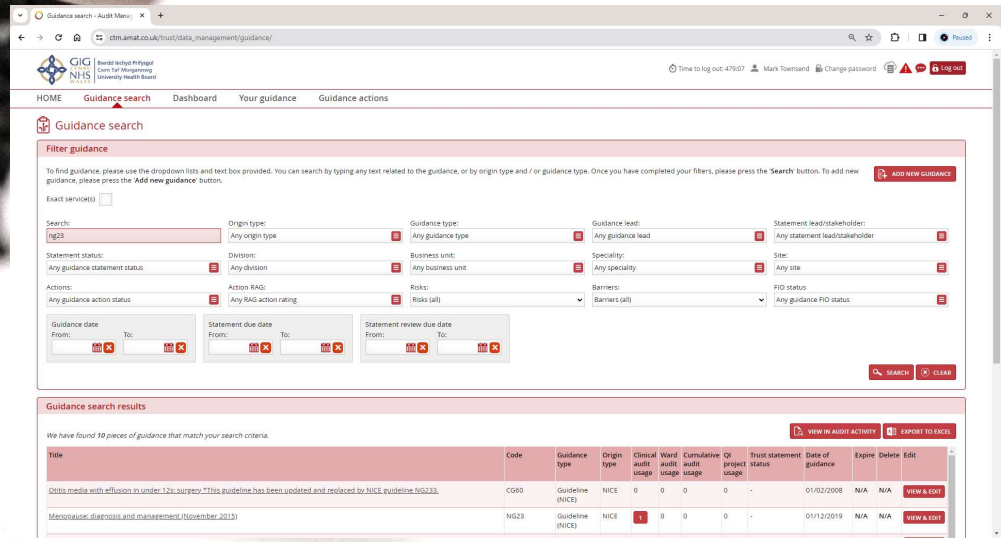
NICE Implementation Process Model



The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB remain the responsibility of the, Care Groups, directorates and individual clinical leads.

The clinical audit team continue to work collaboratively across Wales with the NICE Implementation Facilitator for Wales through regular meetings and by helping to lead subgroups of the Welsh NICE Health Network.

The AMaT system enables the online recording of compliance against NICE guidelines and standards.

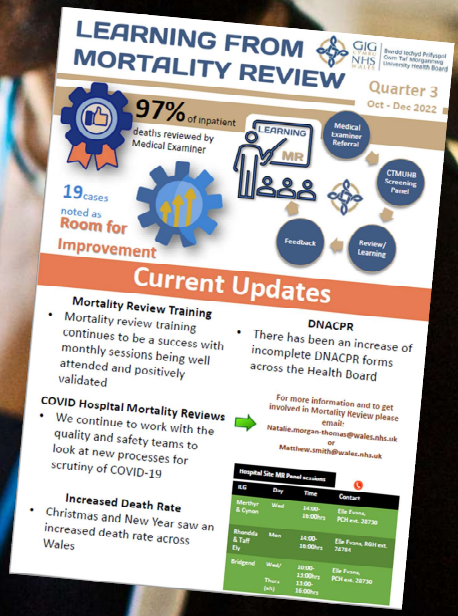


Learning from Mortality Reviews

The introduction of Medical Examiners across NHS Wales has provided an opportunity to look at how mortality reviews can be conducted to identify themes and trends, maximise learning, prevent future harm and improve the experience of patients, families and NHS staff.

The Mortality Review Framework for Wales aims to provide a co-ordinated and systematic all Wales approach to the mortality review process to enable local and national implementation of learning, targeted clinical audit and quality improvement work.

Every stage of the mortality review process provides an opportunity for learning and recognizing notable practice. The learning captured is shared via a quarterly newsletter. Immediate make safe cases are instantly communicated to the directorates / Care Groups and Director of nursing if required. Going forward the mortality review module within DATIX will assist the capturing of this information in a more systematic way and each learning point will have an action plan assigned to it.



In 2022-23 CTMUHB Mortality Review achievements include:

- Quarterly Learning from MR Newsletters that identify key themes and trends, MR process performance and identified learning.

- Monthly Mortality Review (MR) training has been led by the Lead Nurse for Clinical Effectiveness and Medical Examiner. The aim to update clinicians on the new MR process nationally and locally within CTMUHB.

  In addition, the training aims to provide clinicians with the knowledge on how to undertake a Hospital mortality review.

Clinical Audit and Effectiveness
Annual Report 2022-23

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

Clinical Audit &
Quality Informatics Department

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.1

ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
5.3.2	19/04/2023	Medical Rostering Progress Report – The next update report should report on progress towards a board-wide medical rostering policy underpinned by a single IT system with the aim of providing a single reliable source of information regarding the deployment of the medical workforce. Medics Rostering Policy to be presented to the People & Culture Committee for formal approval.	Medical Director	October 2023 **Now December 2023**	**In progress** Report due to be presented to the October 2023 meeting. Now deferred to the December 2023 meeting – **On agenda**
4.1.1	21/06/2023	National Fraud Initiative Progress and Outcomes - Future reports to include an opening paragraph which explained the purpose of the national fraud initiative and what the process means for the Health Board	Head of Local Counter Fraud	Next report due February 2024	**In progress** The Head of Local Counter Fraud has suggested that the Committee receives bi-annual update son this matter, with the next report to be presented to the February 2024 Audit & Risk Committee.

5.2	21/06/2023	Audit Recommendations Tracker - Lead officers to be asked for rationale to be provided as to why they were proposing a change to the implementation date.	Head of Corporate Governance & Board Business	16 August 2023 Now October 2023 **Now December 2023**	**In Progress** Rationale for changes to implementation dates has been captured against some updates provided. Work will continue to ensure rationale is provided for all future updates.
4.4	24/10/2023	Changes to the Welsh Risk Pool Agreement - Report to be shared with the Planning, Performance & Finance Committee for information only.	Head of Corporate Governance & Board Business	27 February 2024	**In progress** This report has been shared with the Committee Secretariat for the Planning, Performance & Finance Committee for inclusion on the February 2024 agenda.

Completed Actions					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
4.2	16/08/2023	Procurement and Scheme of Delegation Report – Review to be undertaken in relation to the specific circumstances regarding the single tender action waiver regarding Honeywell Building Solutions to determine whether this had been missed off the original tender	Deputy Director of Finance	24 October 2023	**Completed** Review undertaken and response shared with Members by email on 18 October 2023
4.4	16/08/2023	Learning From Events Reports – Confirmation to be provided outside the meeting as to how many blank LFER's were still outstanding	Deputy Director of Nursing	24 October 2023	**Completed** As of the 9 October 2023, the Assistant Director of Quality & Safety has confirmed that there are five blank LFER's that are in the process of being addressed.
5.1	16/08/2023	Organisational Risk Register – Update to be sought outside the meeting in relation to the reduction of the fire safety risk regarding compartmentalisation at Prince Charles Hospital	Assistant Director of Governance & Risk	24 October 2023	**Completed** Update against this risk was received from the Assistant Director of Health, Safety & Fire and was circulated to members

					by email on 8 September 2023
5.2	16/08/2023	Audit Recommendations Tracker – Update to be included in the next iteration of the report in relation to recommendations relating to the Patient Pathway Appointment Process.	Head of Corporate Governance & Board Business	24 October 2023	**Completed** Updates have been provided against the recommendations relating to the Patient Pathway Appointment Process.
4.3	24/10/2023	Post Payment Verification Mid Year Update - Report to be amended given the error contained within it regarding revisits completed and re-circulated to Members	Post Payment Verification Manager	19 December 2023	**Completed** Report amended an re-uploaded to Admincontrol
2.1.3	24/10/2023	Amendment to Standing Financial Instructions - Cover report produced for Board outlining the changes made to the Standing Financial Instructions to be shared with Committee Members.	Assistant Director of Governance & Risk	24 October 2023	**Completed** Members received the revised report within a copy of the Board papers presented to the November 2023 Board meeting
2.2.2	24/10/2023	Audit & Risk Committee Forward Work Programme - Discussion to take place at the next Board meeting as to whether it would be more appropriate to discuss JAG Accreditation/Endoscopy issues at the Quality & Safety Committee moving forwards.	Audit & Risk Committee Chair	30 November 2023	**Completed** This was included within the alert/escalate section of the Highlight report that was submitted to the Board in November 2023. A further discussion has been held at Quality & Safety Committee agenda

					planning where it was agreed that an initial update on Endoscopy issues would be included in the Unscheduled Care Group Highlighted report being presented to the January 2024 Quality & Safety Committee and also agreed that a Spotlight Presentation (with associated Listening & Learning Story would be shared at the March 2024 Quality & Safety Committee.
5.2	16/08/2023	Audit Recommendations Tracker - Confirmation to be provided as to whether funding for the Business Case referred to in relation to Princess of Wales Fire Safety had already been included in the current plan	Head of Corporate Governance & Board Business	24 October 2023 Now November 2023	**Completed** Fees funding has already been provided to develop the business case and the Welsh Government capital team are receiving regular updates on progress. Funding cannot be confirmed until a business case is submitted and appropriately scrutinised however Welsh Government are aware of the consequences of not addressing the fire enforcement notice and

					that this requires capital investment.
3.1	24/10/2023	Audit & Risk Committee Action Log - Organisational Risk Register to be updated to reflect the current position in relation to the Princess of Wales Fire Safety risk	Assistant Director of Governance & Risk	19 December 2023	**Completed** Please refer to the November update in the Organisational Risk Register - Datix Risk ID 3993 - "Fire Enforcement Notice - POW Theatres" – Row 39.
5.1	24/10/2023	Organisational Risk Register - Cover report to be amended to include the rationale for closing the risk.	Assistant Director of Governance & Risk	19 December 2023	**Completed** Rationale for risk closure is now captured in the cover paper which accompanies the Organisational Risk Register.
5.4.1	24/10/2023	Internal Audit Progress Report - Discussion to be held at the Executive Leadership Group in relation to issues being received regarding timely submission of Management Responses.	Director of Corporate Governance	19 December 2023	**Completed** Performance against the charter for the timely submission of management responses was discussed at the Executive Leadership Group on the 13th November 2023. Director of Corporate Governance has also discussed the position with Internal Audit Colleagues and is planning to introduce a further trigger point to the process so that the Quality

					Compliance & Assurance Team are aware when a report is issued and response due, which the Director of Corporate Governance will raise as a routine item at the weekly ELG meetings as appropriate.
5.4.2	24/20/2023	Internal Audit Review – Interventions Not Normally Undertaken - Response to be provided outside the meeting as to the practicalities involved in setting up an individual patient funding request panel, to include how this would be implemented, what would trigger a panel to meet and the scale of the process.		19 December 2023	**Completed** Response received and shared with Members by email on 7 December 2023

Agenda Item
4.1

Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CFS Wales	Counter Fraud Service Wales
FI	Financial Investigator
LCFS	Local Counter Fraud Specialist
LPE	Local Proactive Exercise
NHS CFA	NHS Counter Fraud Authority

1. Situation /Background

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

2. Specific Matters for Consideration

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

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Not Applicable
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

6. Next Steps

6.1 Further update reports will be brought to Audit Committee in line with the Committee's work plan.

Agenda Item 4.1

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 19 December 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	48	43
Ensuring that anti-crime measures are embedded at all levels across the organisation		
Inform and Involve	118	66
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.		
Prevent and Deter	130	132
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.		
Hold to Account	320	165
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.		
TOTAL	616	406

4. STRATEGIC GOVERNANCE

The Head of Counter Fraud Services attended a NHS Wales Counter Fraud Steering Group meeting where discussions were held around the paper previously presented to Directors of Finance Forum regarding counter fraud arrangements in NHS Wales. The discussions concluded with an agreement to pursue wider consultation with the NHS Counter Fraud community and other stakeholders via engagement workshops. The intent is to develop a 5 year vision for NHS Counter Fraud Services alongside an achievable roadmap.
This presents an opportunity to shape the Counter Fraud provision within NHS Wales to ensure the service remains able to respond to emerging fraud risk in an

evolving environment. The wider consultation is being led by the Director of Finance at DCHW and is welcomed by the NHS Counter Fraud Community.

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

5. INFORM AND INVOLVE

The Counter Fraud Team participated in International Fraud Awareness Week which ran 13-19 November. Articles and communications around NHS fraud risk were disseminated before, during, and after the week.
The Counter Fraud Team also conducted site visits to deliver promotional materials and demonstrate visibility to staff during the week.

6. PREVENT AND DETER

The Counter Fraud Team have completed field work for the proactive exercise around the Fraud Prevention Notice issued relating to impersonating a medical professional.
A review of the existing risk assessment and previous proactive exercise relating to pre-employment checks has been completed. Physical ward visits have also been undertaken to assess compliance with completion of agency worker induction forms and ID checks carried out at ward level.
Alongside this work a data matching exercise is being undertaken. This exercise seeks to identify overlapping start/finish agency shifts relating to individual agency workers within a 6 month period across 6 NHS Wales Health Boards. This work has reviewed 196154 individual shifts resulting in identification of 1050 shifts which overlap between different Health Boards as well as 362 shifts which overlap within the same Health Board. Further analysis is being undertaken to assess these 1412 shifts currently categorised as ‘high risk’. Reasons other than fraud which may give rise to the same individual being recorded as completing shifts at the same time in different places may be the ‘block booking’ of shifts by agencies who then allocate another individual to attend one of the shifts or incorrect NHS records as to completion of shift i.e. a late replacement of individual which is not recorded on system.
It is intended that a findings report be brought to February’s Audit Committee meeting around this work.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 to this report. A summary of basic investigation KPI data is presented at outset of the appendix.
Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table.

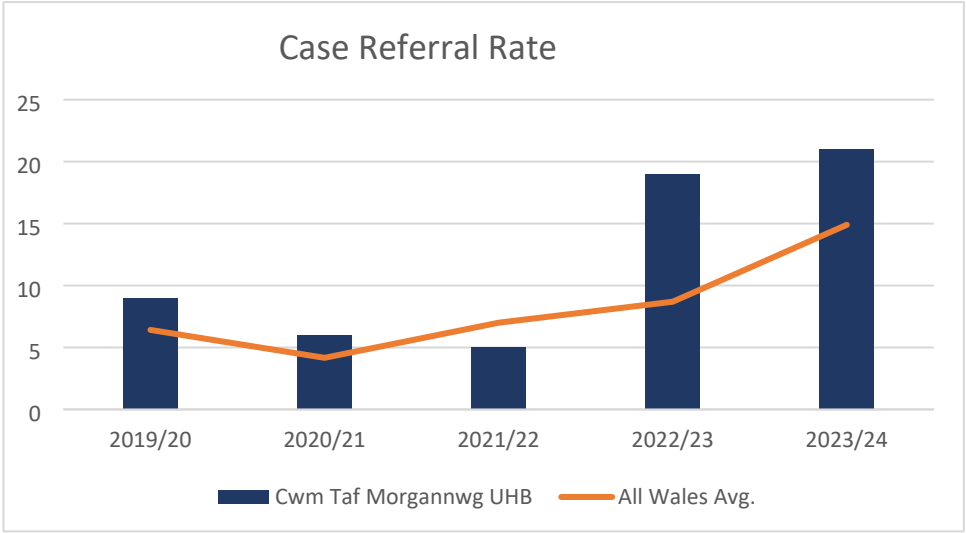
The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries.
A table of Closed Cases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

Item 4.1 – Appendix 1

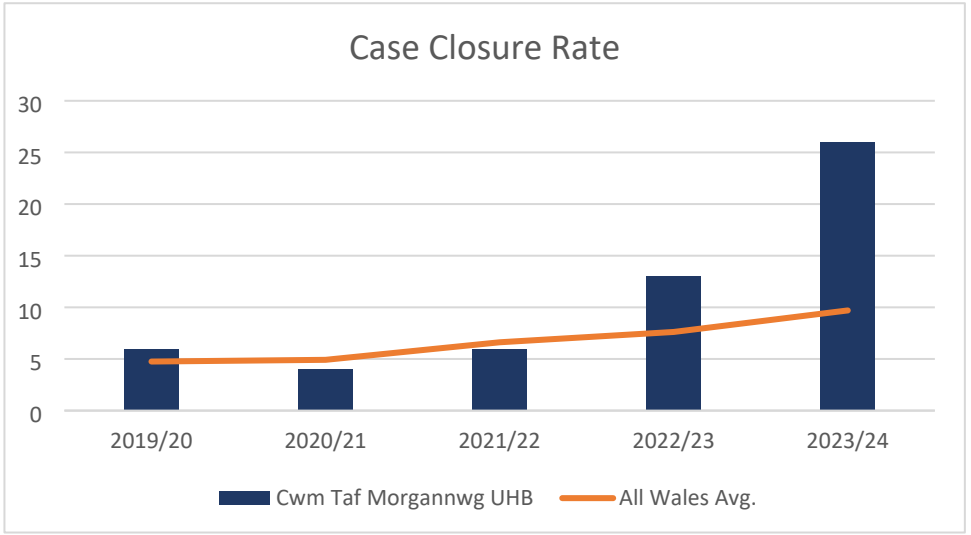
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Half Year

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	9	6.4
2020/21	6	4.2
2021/22	5	7.0
2022/23	19	8.7
2023/24	21	14.9



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	6	4.8
2020/21	4	4.9
2021/22	6	6.6
2022/23	13	7.6
2023/24	26	9.7



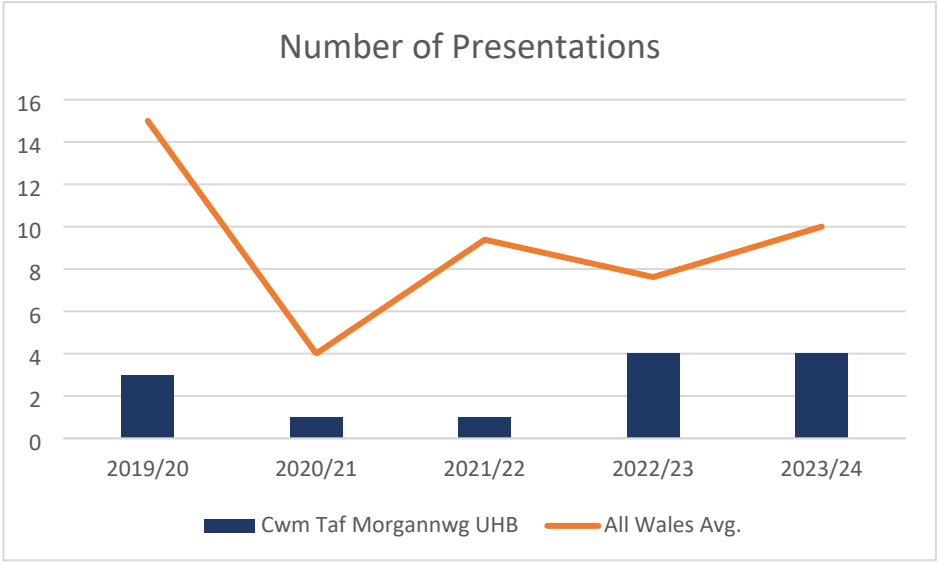
Counter Fraud Benchmarking Statistics – Half Year

Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2019/20	11	9	6	14
2020/21	18	6	4	20
2021/22	13	5	6	12
2022/23	11	19	13	17
2023/24	13	21	26	5

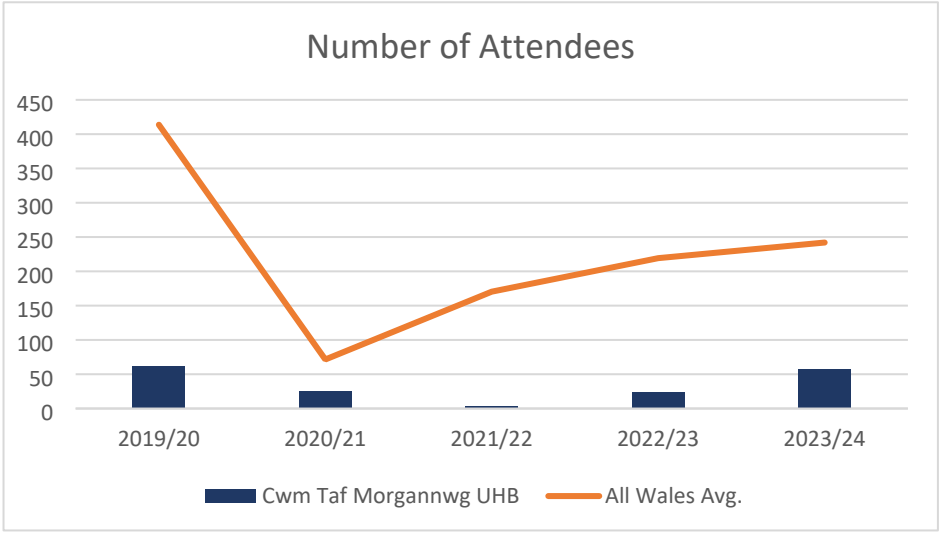
Sanctions	2019/20			2020/21			2021/22			2022/23			2023/24		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	0	1	1	0	1	1	1	0	6	0	0	4	0	1	2
All Wales Avg.	0.6	1.4	1.6	0.3	1.0	1.2	0.3	2.3	1.6	0.3	1.4	2.1	0.4	1	2
All Wales Total	7	17	19	4	12	14	4	30	21	4	18	27	5	13	27

Counter Fraud Benchmarking Statistics – Half Year

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	3	15
2020/21	1	4
2021/22	1	9
2022/23	4	8
2023/24	4	10

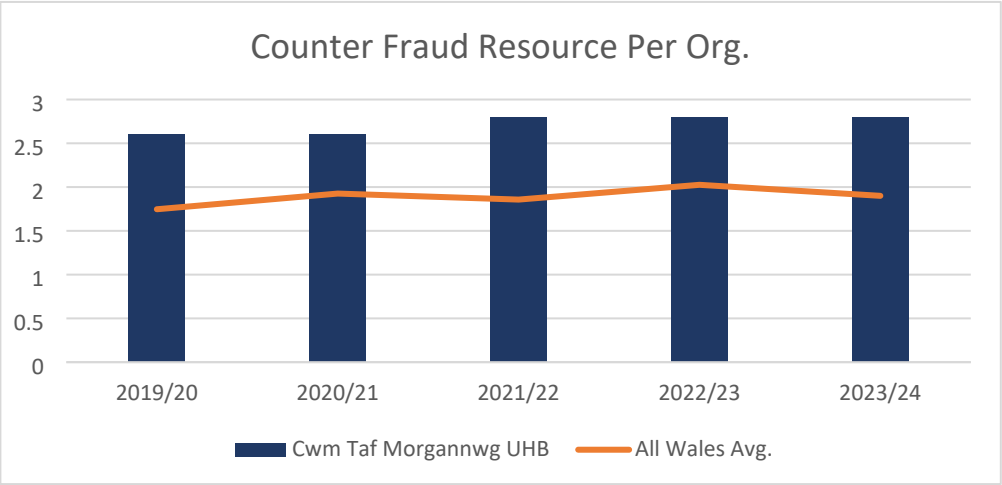


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	62	414
2020/21	25	72
2021/22	3	170
2022/23	24	219
2023/24	57	242

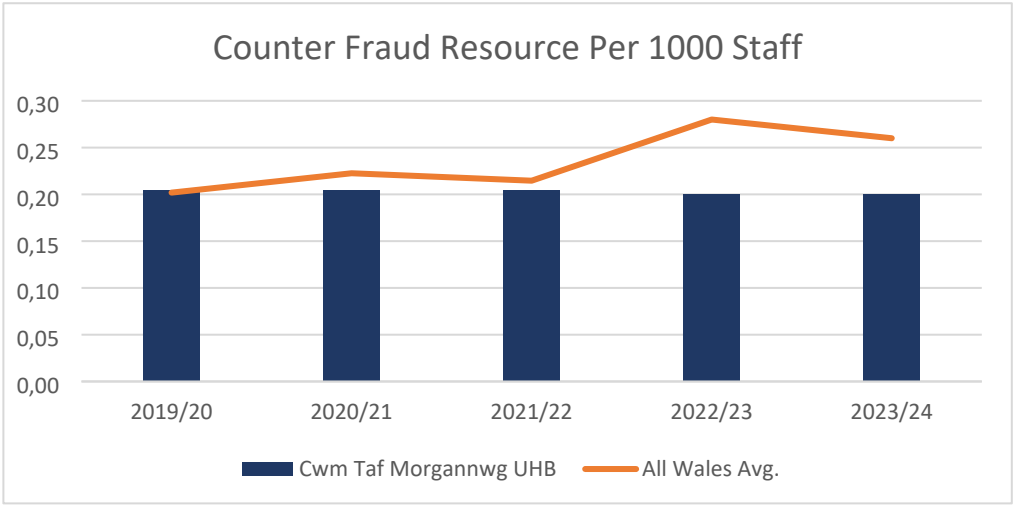


Counter Fraud Benchmarking Statistics – Half Year

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



Counter Fraud Resource Per 1000 Staff	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	0.20	0.20
2020/21	0.20	0.22
2021/22	0.20	0.21
2022/23	0.20	0.28
2023/24	0.20	0.26



Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Item 4.1 – Appendix

Counter Fraud Investigations Update Report

19 December 2023

Summary

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

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

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

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

Case Status

Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2023/24
7	1	29

Case Rates

Referrals Received 2023/24	Cases Under Investigation for Over 12 Months
20	1

Sanctions/Outcomes

Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	3	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	The subject in this case has entered a not guilty plea to 9 counts of dishonesty offences relating to deceit around gaining employment in the NHS. Trial preparation hearings have been set and trial is expected to be in June 2024. There has been press interest in this case with TV and print media coverage. Further interest anticipated at trial. A communication plan was in place and continues to be maintained with support from the Health Board's Communications Dept and NHS CFA Communications Team. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are awaiting outcome of criminal case.
INV/23/01232	27/06/2023	False Overtime	Allegation received that staff are not completing overtime hours or not attending at all and claiming full day overtime payments. Allegation states that supervisors are aware of this. Enquiries are ongoing but made more difficult by allegation that managers are aware of and allow conduct limiting investigative approaches. A senior manager contact has been identified and approached in efforts to progress investigation.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/01588	01/08/2023	Timesheet Fraud	Information received following concerns established during disciplinary process. Allegation that staff member has not been completing contracted hours and is in deficit. Enquiries have sought data of Outlook account, IT logins, system logins, and ESR. This has been measured against fob data to established working hours. Enquiries have established a small deficit which would not be proportionate to seek prosecution. Findings have been shared with disciplinary process which is proceeding with investigation phase concluded.
INV/23/02142	29/09/2023	Recruitment Fraud	Allegation received via Fraud and Corruption Reporting Line that an applicant failed to declare an ongoing investigaiton at employer at point of application. Subject was traced as being successfully appointed at another NHS Health Board. Given that the subject did not successfully gain employment with Cwm Taf Morgannwg UHB and therefore no loss was realised investigation is better placed with other Health Board. An approach has been made to seek transfer of investigation.
INV/23/02268	11/10/2023	Overpayment of Salary	A former staff member continued to be paid for a period of 16 months following leaving Health Board employment. This resulted in a gross overpayment of £14k. Enquiries are underway to establish if any contact has been made by subject to any Health Board or Payroll staff regarding the overpayment and to establish how overpayment occurred.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/02269	11/10/2023	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Staff member alleged to be absent due to sickness but providing the same services fulfilled in substantive NHS role within their own private clinic. Investigation commenced to establish background to sickness absence and work completed within the private clinic during absence period.
INV/23/02311	16/10/2023	Contractor Prescription Fraud	A dispensing GP Practice is alleged to have been dispensing cheaper medications but endorsing prescriptions for more expensive brands. Initial enquiries have established that CFS Wales have undertaken a previous investigation in this area. The case file from this previous investigation has been gained and is being reviewed in conjunction with new evidence.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/23/02008	18/09/2023	Procurement Fraud	Allegation received that the person providing contracted services to other public sector organisation is related to the staff member responsible for the decision making in procuring these services. Case was allocated to CFS Wales due to potential corruption / bribery aspect. Investigation reviewed the procurement process and established that the named staff member was not involved in the process for procuring these services. Further evidence was established that the staff member had previously declared this particular interest in line with the Health Board's Standards of Behaviour Policy and this was considered before the commencement of the procurement process examined.
INV/23/02207	05/10/2023	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Allegation received via Fraud and Corruption Reporting Line that staff member has been working for a private healthcare provider whilst absent due to sickness from substantive role. Initial enquiries have been unable to identify the subject as a Health Board Employee. Enquires were undertaken with neighbouring Health Boards and subject traced. Investigation was subsequently transferred to that Health Board for review.
INV/23/02305	16/10/2023	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Investigation established that the subject was employed by Cwm Taf Morgannwg UHB and had a secondary role with another NHS Wales Health Board. It was

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			established that the subject was absent from CTMUHB due to an injury which prevented performance of role. The injury did not impact performance of secondary role however which is performed on a work from home basis. Enquiries found that managers were aware of the parallel absence/continued working and were content with this given the reason for absence. No dishonesty could therefore be established.

Agenda Item
4.2

Audit & Risk Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James - Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
OJEU	Official Journal of the European Union
FCPs	Financial Control Procedures
SoD	Scheme of Delegation
PSPP	Public Sector Payment Policy

1. Situation /Background

1.1 Procurement Matters

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

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

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

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

d) Summary of contracts over £500,000

e) Free of charge services

f) Retrospective orders

g) Consultancy contracts

h) No PO No Pay summary

This report provides details of any such transactions within the period 01.10.23 to 30.11.23.

1.2 Purchase to Pay (PSPP)

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 2023-24.

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

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 01.10.23 to 30.11.23.

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

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

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Tables A and B** below provides details of such actions during the period 01.10.23 to 30.11.23

Table A – Single Tender Actions 01.10.23 to 30.11.23

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1685	CAP	Estates	Removal of the DRAX system at POW and upgrade of existing BMS	BCML	£75,000	(b)	27/10/23
1686	Rev	ICT	Carepartner Mental health System Licences & Maintenance	Imosphere	£63,758	(c)	08/11/23
1687	Rev	Theatres	Maintenance contract for OPMI Lumera 700 OCT Ceiling Microscope	Karl Zeiss	£10,537	(b)	07/10/23

1701	Rev	Radiology	Year Maintenance contract following warranty expiry Secureview-DX	Hologic	£273,950	(c)	05/12/23
1702	Rev	Catering	Repair and replacement of evaporation coil for the blast freezer	Cool Therm	£40,028	(a)	24/11/23

Reasons for approval:

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

b) Compatibility issue

c) Genuine 1 provider

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

Table B - Single Tender Actions- Retrospective

There are no retrospective Single Tender Actions for this reporting period.

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

There were no contracts requiring Ministerial approval in this reporting period.

d) Summary of contracts awarded over £500,000

Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. Below is a retrospective summary of contracts awarded between 01.10.23 to 30.11.23:

There were no contracts awarded over £500,000 in this reporting period.

e) Free of Charge Services

Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit

itself to a single provider or longer term commitment. Below is a summary of free of charge services that have been provided between 01.10.23 to 30.11.23:

Supplier	Directorate	Service being provided
KPMG	People Services	Ongoing review currently being undertaken for Retinue

f) Retrospective orders

Top 3 areas for retrospective orders over the last period:

Supplier	Areas	Number of retro orders	Value of retro orders	Comments
Blue Arrow	559148_Houskeeping YCC 544063_LLW DOM TOP B 533928_RGH CAT STORE	52	£79,761	Agency Staff
The Real Wrap Co	555184 PCH CATERING DEPARTMENT(BY MATERNITY ENTRANCE) 555179 Keir Hardie Coffee Shop 555109 PCH CATERING	29	£13,047	Catering Supplier
BOC LTD	555100 PCH PHARMACY 533044_DENTAL BRIDGEND CLINIC 534131_POW DERMATOLOGY UNIT (WARD 17)	28	£13,415	Medical Gases

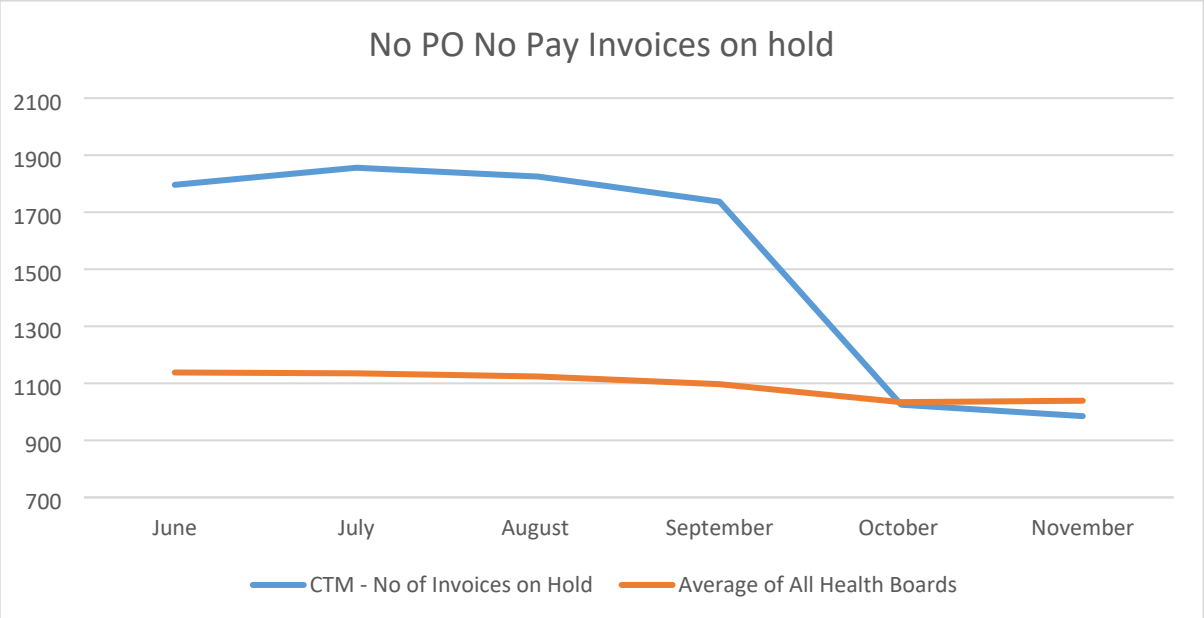
g) Consultancy Contracts

There have been no consultancy contracts awarded over the reporting period.

h) No PO No Pay Summary

Below shows the trend of number of No PO No Pay holds over the past 6 months. Previously the number of invoices on hold for CTM was tracking significantly above the average of all Health Boards at c1,800 invoices on hold. In October 2023 a process of clearing old invoices not paid was undertaken which significantly improved the number of invoices of No PO No Pay invoices on hold, and are now tracking at around the average number across other welsh health

boards. Work is continuing to target suppliers with high quantity and value invoices on hold.



Top 5 invoices on hold by supplier by quantity:

Supplier Name	No of invoices on hold
CULLIGAN (UK) LTD TA ANGEL SPRINGS	171
CANON (UK) LTD	73
KONICA MINOLTA BUSINESS SOLUTIONS (UK) LTD	55
PHS GROUP LTD	38
SYNNOVIS GROUP LLP	37

Note that the top 5 suppliers account for 38% of the total number of invoices on hold.

2.2 Purchase to Pay (P2P)

The PSPP figures are reported for the second quarter to 30th November 2023.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 7 2023-24 achieving 97.1% (value 95.1%). This compares to 93.9% (value 93.8%) to Month 7 2022-23.

	0 - 30 Days		Total		%	
	Number	**Value**	**Number**	**Value**	**Number**	**Value**
Apr-23	15,571	38,586,322	16,298	43,991,964	95.5	96.0
May-23	23,465	69,816,166	23,924	76,960,512	98.1	97.9
Jun-23	22,974	35,244,677	23,533	39,126,216	97.6	95.2
Jul-23	31,044	54,058,760	31,830	56,526,210	97.5	95.6
Aug-23	18,381	34,149,207	18,973	36,983,288	96.9	92.3
Sep-23	19,722	46,960,932	20,740	51,217,771	95.1	91.7
Oct-23	22,915	39,801,116	23,334	41,882,427	98.2	95.0
YTD	**154,123**	**318,669,421**	**158,683**	**335,278,996**	**97.1**	**95.1**

The NHS invoice position continues to be challenging and shows that 80.3% (number) and 93.7% (value) of invoices were paid within 30 days to month 7 2023-24. (85.6% (number) and 97.1% (value) for the same period in 2022-23).

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

In October 2019 the Scheme of Delegation for 'Quotations and Tenders' was updated following approval by Audit & Risk Committee. Following review of Standing Financial Instructions (SFIs) it has been noted that the "waivers, or exceptions to tender rules" in the current Scheme of Delegation (version 19) do not comply to the SFIs, and the delegation for authorisation of Single Tender Actions needs to be amended.

Appendix A details the changes required which are to be endorsed by the Audit & Risk Committee to the Board for Approval. In summary the following is required for Single Quotation Applications or Single Tender Applications:

"Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance

must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit & Risk Committee."

3. Key Risks / Matters for Escalation

3.1 Audit & Risk Committee are requested to endorse the updated Scheme of Delegation as detailed in Appendix A to Board for approval.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No impact
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Audit & Risk Committee is asked to:

NOTE the position on procurement matters for the period 01.10.23 to 30.11.23;

NOTE the update regarding Purchase to Pay and achievement of PSPP target to the end of October 2023;

ENDORSE the updated Scheme of Delegation to the board for approval.

6. Next Steps

6.1 If endorsed the update of the Scheme of Delegation will be taken to the next board meeting for approval

Proposed changes to the Additional delegations linked to the SFIs **Appendix A**

SoD version 19 Ref.	SoD version 19 Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing		Cwm Taf Morgannwg proposed	
				Limits	Waivers, or exceptions to tender rules	Limits	Waivers, or exceptions to tender rules
11 C	27	Non Pay expenditure	Quotations and tenders	Up to £5k	Head of Department	Up to £5k	Head of Department
				£5k to £24.9k	Head of Procurement	£5k to £24.9k	Single tender action authorised by Director of Finance following consultation with Procurement services
				£25k to OJEU threshold for supplies and services £25k to £1m for Works	Single tender action authorised by Director of Finance	£25k to OJEU threshold for supplies and services	Single tender action authorised by Chief Executive AND Director of Finance following consultation with Procurement services
				OJEU threshold for supplies and services to £1m	Single tender action prohibited	OJEU threshold for supplies and services to £1m	Single tender action prohibited
				Above OJEU threshold for works	Single tender action prohibited	Above OJEU threshold for works	Single tender action prohibited
				Over £1m (Other than D4L)	Welsh Government	Over £1m (Other than D4L)	Welsh Government

Agenda Item
4.3

Audit & Risk Committee

Losses and Special Payments 01.08.23 to 31.10.23

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Daxa Varsani – Financial Accountant
Cyflwynydd yr Adroddiad / Report Presenter	Sally May - Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
NWSSP – legal services and Risk Pool Stephanie Muir, CTMUHB Assistant Director Claims & Concerns	Click or tap to enter a date.	NOTED

Acronyms / Glossary of Terms	
WRP	Welsh Risk Pool
NWSSP	NHS Wales Shared Services Partnership
VER	Voluntary Early Release
DEL	Departmental Expenditure Limit
L&R	Legal & Risk

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

1. Situation /Background

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

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

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

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

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

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

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

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

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

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

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

2. Specific Matters for Consideration

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

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

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

a) Provision and Creditors as at 31 October 2023

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

Table 1

	31.10.23	31.07.23	31.03.23	31.03.22	31.03.21
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs (Note 1)	92,048	70,203	72,198	65,127	86,029
Redress Medical Negligence claims/costs	419	399	385	235	269
GP Indemnity (Note 2)	113	0	0	0	0
Personal Injury claims/costs	646	805	701	611	436
Recoverable from Welsh Risk Pool	(100,323)	(82,182)	(83,623)	(93,074)	(114,863)
Net claim provision	**(7,097)**	**(10,775)**	**(10,339)**	**(27,101)**	**(28,129)**
Permanent Injury Benefit	4,162	4,002	4,077	6,201	6,320
Net Provision	**(2,935)**	**(6,773)**	**(6,262)**	**(20,900)**	**(21,809)**
Number of live cases on losses system (LaSPaR)					
	31.10.23	**31.07.23**	**31.03.23**	**31.03.22**	**31.03.21**
Medical Negligence claims	340	351	334	299	309
Redress Medical Negligence claims	251	254	230	213	168
GP Indemnity claims	21	21	18	7	0
Personal Injury claims	115	132	129	113	110

Note 1: Increase in Medical Negligence provision is due to 10 new cases requiring provision and 28 existing cases requiring provision due to change in probability for settlement from Possible to Certain. This is reflected in increase in WRP provision for the reimbursement of monies.

Note 2: GP Indemnity provision of £113k is fully reimbursable by WRP as such no net impact to the Health Board's Budget.

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

b) Expenditure incurred for the year to 31 October 23

This is shown in table 2 below, together with equivalent figures for the last three complete financial years and last reporting period to the Audit & Risk Committee (31.07.2023).

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

Table 2

	Year to	Year to	Year ended	Year ended	Year ended
	31.10.23	**31.07.23**	**31.03.23**	**31.03.22**	**31.03.21**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs (Note 1)	23,237	(437)	17,386	1,945	13,110
Redress Medical Negligence claims/costs	217	108	711	170	305
GP Indemnity	117	3	6	1	0
Personal Injury claims/costs	391	269	822	772	316
Recoverable from Welsh Risk Pool	(22,482)	769	(16,858)	(1,210)	(12,449)
Net claim expenditure (Note 2)	**1,480**	**712**	**2,067**	**1,678**	**1,282**
Permanent Injury Benefit	312	37	(1,707)	286	470
Other	126	34	1,427	570	609
Total Net expenditure	**1,918**	**783**	**1,787**	**2,534**	**2,361**

Note 1: The reasons for the increase in Medical Negligence is explained above in Table 1.

Note 2: The annual budget for net claim expenditure for 2023-24 is £1,785k (year to date £1,041k), actual expenditure for the year to date is £1,480k, therefore an overspend of £439k to October 2023. This overspend has a direct impact on the in-year position of the health board.

c) Cash Write-Offs made for the period 1 August 2023 to the 31 October 2023

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

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

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

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

Table 3

Cash write-offs made during 23/24

	01.08.23 - 31.10.23 £000	Previous Months	Total 2023-24 £000
Medical Negligence (Appendix 1)			
Claims	1,228	990	2,218
Costs	461	335	796
Defence Fees	141	232	373
Medical Negligence Totals	1,830	1,557	3,387
Redress Medical Negligence (Appendix 2)			
Claims	58	49	107
Costs	13	16	29
Defence Fees	18	28	46
Redress Medical Negligence Totals	89	93	182
GP Indemnity (Appendix 3)			
Defence Fees	2	3	5
GP Indemnity Totals	2	3	5
Personal Injury (Appendix 4)			
Claims	70	82	152
Costs	175	45	220
Defence Fees	36	39	75
Personal Injury Totals	281	166	447
Permanent Injury Benefit (Appendix 5)	115	112	227
Permanent Injury Benefit Totals	115	112	227
Other (Appendix 6)			
Ex-Gratia	66	31	97
Debt Write Off	0	0	
WRP Penalty Charge	0	17	17
Ombudsman	6	3	9
Employment Matter/Other	3	0	3
Other Totals	75	51	126
Total	2,392	1,982	4,374
Recovered from Welsh Risk Pool	(5,111)	(671)	(5,782)
Net Cash Write-Off	(2,719)	1,311	(1,408)

WRP Risk Sharing Agreement

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

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

3. Key Risks / Matters for Escalation

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Growing Well Living Well Ageing Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15)	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim	
Enw da / Reputational	Yes (Include further detail below)	
	As noted within Quality Impact Assessment section above, reputational risk is managed via the reporting hierarchy.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments.	

5. Recommendation

5.1 The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 August 2023 to 31 October 2023.

- **NOTE** the increase in the Medical Negligence provision due to increase in number and value of claims highlighted in Table 1. Note the consequent overspend on net claim expenditure and the impact of this on the in-year revenue position highlighted in Table 2. This expenditure is charged to the Patient Care & Safety revenue position.

6. Next Steps

6.1 The Audit & Risk Committee is requested to note the information provided in this report and regular updates will be provided to the Committee as required by the Governance arrangements.

Medical Negligence Payments 01/08/2023 - 31/10/2023							Appendix 1
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RRSMN0039	0	0	20	0	20	119	139
10RYLMN0014	57	2	0	-1,423	-1,365	1,473	108
10RYLMN0065	30	0	0	0	30	66	96
10RYLMN0078	0	0	0	-415	-415	440	25
12RYLMN0035	0	5	0	0	5	1,378	1,383
13RYLMN0005	0	0	0	0	0	24	24
15RYLMN0049	40	0	0	0	40	358	398
15RYLMN0106	30	0	50	0	80	41	121
15RYLMN0199	0	2	0	0	2	3	5
16RYLMN0073	0	0	0	-428	-428	453	25
16RYLMN0074	0	0	0	33	33	-8	25
16RYLMN0098	0	0	0	-44	-44	115	71
17RYLMN0122	0	0	0	-454	-454	479	25
18RYLMN0016	0	2	0	0	2	0	3
18RYLMN0029	0	0	1	0	1	0	1
18RYLMN0030	0	1	0	0	1	5	5
18RYLMN0056	0	0	0	-127	-127	152	25
18RYLMN0064	0	0	0	-909	-909	934	25
18RYLMN0078	0	0	0	0	0	13	13
18RYLMN0085	0	3	7	0	9	211	221
18RYLMN0109	0	2	0	0	2	25	27
18RYLMN0114	0	0	0	-68	-68	93	25
19RYLMN0087	0	0	0	-64	-64	89	25
20RYLMN0018	0	0	0	0	0	13	13
20RYLMN0021	-10	0	0	0	-10	158	148
20RYLMN0023	0	0	0	-17	-17	42	25
20RYLMN0033	0	1	0	0	1	16	17
20RYLMN0099	0	2	0	0	2	8	9
20RYLMN0108	0	7	0	0	7	0	7
20RYLMN0109	1	0	0	0	1	241	242
20RYLMN0112	0	2	0	0	2	6	7
20RYLMN0116	9	0	0	0	9	422	431
20RYLMN0121	0	0	0	-529	-529	554	25
20RYLMN0125	0	1	0	0	1	10	11
20RYLMN0129	55	11	920	0	986	228	1,214
20RYLMN0163	0	0	0	-46	-46	71	25
20RYLMN0170	0	1	0	0	1	10	11
20RYLMN0171	0	0	0	-93	-93	118	25
20RYLMN0197	0	-3	-7	0	-9	9	0
21RYLMN0014	9	0	0	0	9	0	9
21RYLMN0016	21	0	0	0	21	57	78
21RYLMN0020	0	0	0	-23	-23	48	25
21RYLMN0035	0	3	0	0	3	6	9
21RYLMN0060	0	4	0	0	4	2	6
21RYLMN0077	0	17	53	0	70	154	223
21RYLMN0100	0	0	0	-41	-41	66	25
21RYLMN0118	0	0	0	-63	-63	88	25
21RYLMN0119	0	0	0	0	0	19	19
21RYLMN0131	0	0	0	-27	-27	52	25
21RYLMN0135	0	0	0	-47	-47	72	25

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
21RYLMN0147	0	1	0	0	1	46	47
21RYLMN0149	0	2	0	0	2	0	2
21RYLMN0160	0	3	0	0	3	6	9
22RYLMN0007	0	0	55	0	55	7	62
22RYLMN0040	28	0	0	0	28	42	70
22RYLMN0069	0	0	0	-19	-19	44	25
22RYLMN0073	0	0	0	0	0	7	8
22RYLMN0094	0	0	0	-7	-7	32	25
22RYLMN0153	0	0	60	0	60	0	60
22RYLMN0157	0	1	0	0	1	6	7
22RYLMN0159	0	2	0	0	2	2	4
22RYLMN0162	0	1	0	0	1	0	1
22RYLMN0166	0	1	0	0	1	38	38
22RYLMN0174	0	7	0	0	7	0	7
22RYLMN0182	0	1	0	0	1	9	9
23RYLMN0034	38	0	0	0	38	45	83
23RYLMN0037	4	1	0	0	5	53	58
23RYLMN0040	0	1	0	0	1	12	13
23RYLMN0044	25	0	0	0	25	32	57
23RYLMN0046	0	1	0	0	1	27	28
23RYLMN0049	28	1	0	0	28	13	41
23RYLMN0051	0	1	0	0	1	8	9
23RYLMN0052	0	2	0	0	2	2	3
23RYLMN0064	0	1	0	0	1	0	1
23RYLMN0075	40	0	14	0	54	9	63
23RYLMN0076	0	0	0	0	0	3	3
23RYLMN0079	0	4	0	0	4	2	6
23RYLMN0093	12	0	0	0	12	26	38
23RYLMN0095	25	0	20	0	45	1	46
23RYLMN0096	0	1	12	0	13	0	13
23RYLMN0098	0	3	0	0	3	6	9
23RYLMN0117	0	2	0	0	2	0	2
23RYLMN0118	15	0	0	0	15	5	20
23RYLMN0127	0	3	0	0	3	0	3
23RYLMN0140	0	6	0	0	6	5	10
23RYLMN0141	0	1	0	0	1	8	9
23RYLMN0143	0	4	0	0	4	4	8
23RYLMN0158	0	1	23	0	24	7	31
23RYLMN0180	0	6	0	0	6	0	6
23RYLMN0193	0	4	0	0	4	0	4
23RYLMN0196	0	0	0	0	0	0	0
23RYLMN0202	0	3	0	0	3	2	4
23RYLMN0235	0	2	0	0	2	6	8
23RYLMN0239	0	4	0	0	4	0	4
23RYLMN0246	0	7	0	0	7	0	7
24RYLMN0030	0	3	0	0	3	0	3
24RYLMN0061	6	1	0	0	7	0	7
24RYLMN0065	0	1	0	0	1	0	1
24RYLMN0081	0	0	0	0	0	0	0
Total 01/08/2023 - 31/10/2023	**461**	**141**	**1,228**	**- 4,813**	**- 2,983**		
Total						**9,448**	**6,465**

Redress Payments 01/08/2023 - 31/10/2023							Appendix 2
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLMN0050	0	0	0	-23	-23	25	2
19RYLMN0109	2	0	0	0	2	8	9
20RYLMN0051	0	0	0	0	0	2	2
20RYLMN0065	0	0	0	-23	-23	25	2
20RYLMN0096	0	0	0	-11	-11	11	0
20RYLMN0142	0	0	0	-1	-1	3	2
20RYLMN0161	0	0	0	-15	-15	17	2
20RYLMN0183	0	0	0	0	0	3	3
20RYLMN0191	0	1	0	0	1	10	11
21RYLMN0001	0	0	0	-17	-17	19	2
21RYLMN0046	0	0	0	-2	-2	4	2
21RYLMN0096	0	0	0	-2	-2	2	0
22RYLMN0003	0	3	0	0	3	0	3
22RYLMN0025	0	0	0	-13	-13	14	2
22RYLMN0032	2	0	24	0	26	3	28
22RYLMN0061	0	0	0	-2	-2	2	0
22RYLMN0062	0	6	0	0	6	0	6
22RYLMN0063	2	0	3	0	5	0	5
22RYLMN0082	0	2	0	0	2	0	2
22RYLMN0085	0	0	0	-3	-3	3	0
22RYLMN0107	0	0	0	-22	-22	23	2
22RYLMN0125	0	0	0	-23	-23	25	2
22RYLMN0128	0	0	1	0	1	0	1
22RYLMN0184	2	0	1	0	3	19	21
23RYLMN0002	0	3	0	0	3	11	13
23RYLMN0003	0	0	0	-25	-25	25	0
23RYLMN0012	0	3	0	0	3	0	3
23RYLMN0030	2	0	1	0	3	0	3
23RYLMN0054	2	0	2	0	4	0	4
23RYLMN0058	0	0	3	0	3	8	10
23RYLMN0087	0	0	0	-6	-6	8	2
23RYLMN0106	0	0	0	-2	-2	2	0
23RYLMN0114	0	0	0	-4	-4	5	2
23RYLMN0213	2	0	4	0	6	0	6
23RYLMN0225	0	0	0	-3	-3	4	2
23RYLMN0229	2	0	1	0	2	0	2
24RYLMN0001	0	0	14	0	14	0	14
24RYLMN0075	0	0	5	0	5	0	5
Total 01/08/2023 - 31/10/2023	**13**	**18**	**58**	**-195**	**-105**		
Total						**276**	**171**

GP Indemnity Payments 01/08/2023 - 31/10/2023						
Case Reference	**Costs £000**	**Defence Fee £000**	**Claims £000**	**WRP reimbursement £000**	**Total £000**	**Previous Write Offs £000**
23RYLMN0233	0	1	0	0	1	2
23RYLMN0204	0	1	0	0	1	0
24RYLMN0072	0	0	0	0	0	0
Total 01/08/2023 - 31/10/2023	**0**	**2**	**0**	**0**	**2**	
Total						**2**

Appendix 3
Cumulative £000
3
1
0
4

Personal Injury Payments 01/08/2023 - 31/10/2023							Appendix 4
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLPI0010	0	0	0	-24	-24	49	25
18RYLPI0031	0	0	0	-0	-0	25	25
19RYLPI0026	1	-1	0	0	0	11	11
20RYLPI0022	0	4	0	0	4	16	19
20RYLPI0050	0	5	0	0	5	9	14
20RYLPI0054	5	0	5	0	10	0	10
20RYLPI0055	1	0	0	0	1	0	1
20RYLPI0059	0	1	0	0	1	0	1
20RYLPI0061	22	0	0	0	22	74	95
21RYLPI0007	63	4	0	0	67	8	75
21RYLPI0011	0	0	0	-10	-10	35	25
21RYLPI0020	7	1	2	0	9	0	9
21RYLPI0022	0	1	0	0	1	0	1
21RYLPI0023	0	2	0	0	2	0	2
21RYLPI0025	0	1	0	0	1	0	1
21RYLPI0032	0	-3	0	0	-3	14	11
21RYLPI0042	0	0	0	-69	-69	94	25
22RYLPI0002	0	1	0	0	1	1	2
22RYLPI0003	0	1	0	0	1	6	6
22RYLPI0005	7	1	25	0	33	2	34
22RYLPI0014	2	0	5	0	7	1	9
22RYLPI0015	0	0	0	0	0	1	1
22RYLPI0022	0	0	0	0	0	1	2
22RYLPI0023	26	7	0	0	33	17	50
22RYLPI0026	0	0	0	0	0	1	1
22RYLPI0030	10	1	10	0	21	6	27
22RYLPI0037	0	0	0	0	0	1	2
22RYLPI0038	2	0	2	0	5	1	6
22RYLPI0040	0	0	0	0	0	1	1
22RYLPI0041	15	-0	0	0	15	7	22
22RYLPI0042	0	0	0	0	0	1	1
22RYLPI0044	0	0	0	0	0	2	2
23RYLPI0001	0	0	0	0	0	2	3
23RYLPI0003	0	0	0	0	0	1	1
23RYLPI0004	0	0	0	0	0	1	1
23RYLPI0006	11	0	12	0	22	2	24
23RYLPI0009	1	0	2	0	3	1	4
23RYLPI0015	0	0	0	0	0	2	2
23RYLPI0016	0	1	0	0	1	1	1
23RYLPI0017	0	0	0	0	0	1	1
23RYLPI0018	0	0	0	0	0	0	1
23RYLPI0020	0	0	0	0	0	1	1
23RYLPI0021	0	0	0	0	0	2	2
23RYLPI0026	0	0	1	0	1	1	2
23RYLPI0027	1	0	2	0	3	0	4
23RYLPI0028	0	0	0	0	0	1	1
23RYLPI0029	0	0	0	0	0	2	2

23RYLPI0033	2	0	4	0	6	1	7
23RYLPI0034	0	0	0	0	0	0	1
23RYLPI0035	0	0	0	0	0	0	1
23RYLPI0038	0	0	0	0	0	1	1
23RYLPI0039	0	0	0	0	0	0	1
23RYLPI0041	0	0	0	0	0	0	1
23RYLPI0045	0	0	0	0	0	0	0
23RYLPI0048	0	0	0	0	0	0	0
23RYLPI0049	0	0	0	0	0	0	1
23RYLPI0050	0	0	0	0	0	0	0
23RYLPI0051	0	0	0	0	0	0	0
23RYLPI0052	1	0	0	0	1	0	1
24RYLPI0003	0	0	0	0	0	0	0
24RYLPI0004	0	0	0	0	0	0	0
24RYLPI0005	0	0	0	0	0	0	0
24RYLPI0006	0	0	0	0	0	0	0
24RYLPI0012	0	0	0	0	0	0	0
Total 01/08/2023 - 31/10/2023	**175**	**36**	**70**	**-103**	**178**		
Total						**403**	**580**

Permanent Injury Benefit 01/08/2023 - 31/10/2023			Appendix 5
Laspar Number	**In period Payments £000**	**Previous Write-Offs £000**	**Cumulative £000**
01RRSPI0020	4	249	253
02RVEPI0001	2	71	73
02RVEPI0003	3	182	185
02RVEPI0004	2	125	127
03RRSPI0020	14	889	903
03RVEPI0028	4	272	275
04RRSPI0009	4	242	246
04RRSPI0024	3	169	172
05RRSPI0020	2	83	85
05RRSPI0021	4	200	204
05RVEPI0033	5	307	312
05RVEPI0034	2	90	92
08RVEPI0009	4	199	203
10RYLPI0070	2	113	115
11RYLPI0065	6	260	266
12RYLPI0059	2	79	81
13RYLPI0020	1	41	42
13RYLPI0050	4	152	156
98RVEPI0005	0	7	7
19RYLPI0022	12	341	353
20RYLPI0032	3	46	49
20RYLPI0033	1	19	21
20RYLPI0034	2	31	33
20RYLPI0035	6	91	97
20RYLPI0036	4	63	67
20RYLPI0037	1	21	23
20RYLPI0038	3	51	54
20RYLPI0039	3	38	41
20RYLPI0040	6	95	102
20RYLPI0041	4	64	68
20RYLPI0042	2	31	33
Total 01/08/2023 - 31/10/2023	**115**		
Total		**4,621**	**4,736**

Other Payments 01/08/2023 - 31/10/2023			Appendix 6
Case Reference	**Type**	**Details**	**Amount £000**
24RYLMN0002	Ombudsman	Damages	0.38
24RYLMN0007	Ombudsman	Damages	5.75
24RYLEG0094	Ex-Gratia	Loss of Personal Effects	0.41
24RYLEG0095	Ex-Gratia	Loss of Personal Effects	0.28
24RYLEG0096	Ex-Gratia	Loss of Personal Effects	0.25
24RYLEG0125	Ex-Gratia	Compensation for Loss of Office Furniture relating to Covid Vacination Centre Facilities	52.10
24RYLEG0126	Ex-Gratia	Loss of Personal Effects	1.00
24RYLEG0127	Ex-Gratia	Poor Service	0.50
24RYLEG0128	Ex-Gratia	Tyre Damage	0.41
24RYLEG0057	Ex-Gratia	Retirement Vouchers	-0.35
24RYLEG0090	Ex-Gratia	Retirement Vouchers	-0.39
23RYLEG0132	Ex-Gratia	Retirement Vouchers	-0.21
23RYLEG0147	Ex-Gratia	Retirement Vouchers	-0.20
23RYLEG0220	Ex-Gratia	Retirement Vouchers	-0.39
23RYLEG0055	Ex-Gratia	Retirement Vouchers	-0.40
24RYLEG0097	Ex-Gratia	Retirement Vouchers	0.34
24RYLEG0098	Ex-Gratia	Retirement Vouchers	0.46
24RYLEG0099	Ex-Gratia	Retirement Vouchers	0.31
24RYLEG0100	Ex-Gratia	Retirement Vouchers	0.25
24RYLEG0101	Ex-Gratia	Retirement Vouchers	0.32
24RYLEG0102	Ex-Gratia	Retirement Vouchers	0.39
24RYLEG0103	Ex-Gratia	Retirement Vouchers	0.34
24RYLEG0104	Ex-Gratia	Retirement Vouchers	0.33
24RYLEG0105	Ex-Gratia	Retirement Vouchers	0.28
24RYLEG0106	Ex-Gratia	Retirement Vouchers	0.27
24RYLEG0107	Ex-Gratia	Retirement Vouchers	0.26
24RYLEG0108	Ex-Gratia	Retirement Vouchers	0.43
24RYLEG0109	Ex-Gratia	Retirement Vouchers	0.34
24RYLEG0110	Ex-Gratia	Retirement Vouchers	0.34
24RYLEG0111	Ex-Gratia	Retirement Vouchers	0.23
24RYLEG0112	Ex-Gratia	Retirement Vouchers	0.38
24RYLEG0113	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0114	Ex-Gratia	Retirement Vouchers	0.23
24RYLEG0115	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0116	Ex-Gratia	Retirement Vouchers	0.42
24RYLEG0117	Ex-Gratia	Retirement Vouchers	0.32
24RYLEG0118	Ex-Gratia	Retirement Vouchers	0.42
24RYLEG0119	Ex-Gratia	Retirement Vouchers	0.36
24RYLEG0120	Ex-Gratia	Retirement Vouchers	0.24
24RYLEG0121	Ex-Gratia	Retirement Vouchers	0.36
24RYLEG0122	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0123	Ex-Gratia	Retirement Vouchers	0.27
24RYLEG0124	Ex-Gratia	Retirement Vouchers	0.32
24RYLEG0129	Ex-Gratia	Retirement Vouchers	0.35
24RYLEG0130	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0131	Ex-Gratia	Retirement Vouchers	0.35
24RYLEG0132	Ex-Gratia	Retirement Vouchers	0.34

24RYLEG0133	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0134	Ex-Gratia	Retirement Vouchers	0.21
24RYLEG0135	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0136	Ex-Gratia	Retirement Vouchers	0.25
24RYLEG0137	Ex-Gratia	Retirement Vouchers	0.27
24RYLEG0138	Ex-Gratia	Retirement Vouchers	0.21
24RYLEG0139	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0140	Ex-Gratia	Retirement Vouchers	0.33
24RYLEG0141	Ex-Gratia	Retirement Vouchers	0.25
24RYLEG0142	Ex-Gratia	Retirement Vouchers	0.29
24RYLEG0143	Ex-Gratia	Retirement Vouchers	0.39
24RYLLC0002	Penalty	Late Payment Charge for NHS Pensions Agency Invoice	1.40
24RYLLC0003	Penalty	Late Payment Charge for NHS Pensions Agency Invoice	1.33
Total 01/08/2023 - 31/10/2023			**74.82**

Agenda Item
5.1

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	October / November 2023	RISKS REVIEWED
Operational Management Board	1st November 2023	ENDORSED NEW RISKS FOR ELG
Executive Leadership Group (ELG)	13th November 2023	MANAGEMENT SIGN OFF RECEIVED
Digital & Data Committee (Public and Private Session)	14th November 2023	REVIEWED ASSIGNED RISKS
Quality & Safety Committee (Public Session)	21st November 2023	REVIEWED ASSIGNED RISKS

Acronyms / Glossary of Terms	

1. SITUATION/BACKGROUND

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

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

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

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

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams) continue. **525** members of staff trained to date (Since January 2022). Focussed sessions to discuss risk has also been undertaken with Care Group Leads during June 2023.

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

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 **NEW RISKS**

Care Group – Diagnostics, Therapies, Pharmacy and Specialties (DTPS)

- Datix Risk ID – 5590 - Radiopharmaceutical Business Interruption. New risk escalated November 2023 with a risk score of 20.
- Datix Risk ID -5602 - Door security in pharmacy department at Ysbyty Cwm Rhondda hospital. New risk escalated November 2023 with a risk score of 20.
- Datix Risk ID – 5579 - Lack of Children and Young Persons Weight Management Service. New risk escalated November 2023 with a risk score of 16

3.2 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period

Care Group - Unscheduled Care

- Datix ID 3826 - Emergency Department (ED) Overcrowding. With the recent onset of winter pressures the risk rating has been increased from a 16 to a 20, with the likelihood score changing from a 4 to a 5.

- Datix ID 1133 - Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). This risk was re-escalated to the Organisational Risk Register in November 2023 as risk reviewed and score increased from a 12 to a 20.

b) Risks where the risk rating DECREASED during the period
Care Group – Diagnostics, Therapies, Pharmacy and Specialties (DTPS)

- Datix Risk ID 5304 - The Air Handling Unit (AHU) for the pharmacy aseptic production suite, risk relating to the need for repairs and upgrades has been reduced in terms of scoring this period. Following an independent review of the AHU in July 2023, recommended repairs / upgrades were actioned in October 2023. In light of this mitigation the risk likelihood score has now reduced from a 4 to a 3. This risk is now scoring as a 12 (from 16) and has been de-escalated from the organisational risk register.

Central Function – Corporate Governance

- Datix Risk ID 4922 - Covid-19 Inquiry Preparedness (Information Management), in light of progress in relation to the appointment of a Covid-19 Information Manager and the development of a system for creating a Health Board timeline and archive repository, the risk score has been reduced in terms of likelihood from a 5 to a 4 and therefore the risk has reduced to score of 16 from 20.

Central Function – Finance

- Datix ID 5425 - Failure to achieve financial balance in 2023/24 and 5427. The risk score has been updated to 16 and reflects the risk surrounding the delivery of the £8m stretch savings target. The key action is to now allocate the £8m stretch target to Care Groups and to develop robust savings plans for the Care Groups to deliver a £8m improvement from their recent M6 Forecast year end overspends.

- Datix ID 5427 - Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24. The risk score has been updated to

16 and reflects the risk surrounding the delivery of the £8m stretch savings target and securing the £51m recurrent funding, which is conditionally dependent on delivering the break-even Control total target for 23/24.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Care Group – Diagnostics, Therapies, Pharmacy and Specialties (DTPS)

- Datix Risk ID 5036 - Pathology services unable to meet current workload demands. This risk has been discussed internally and DTPS Care Group have reduced the risk score to reflect current Pathology service provision. DTPS Care Group have taken the decision to close this overarching Pathology risk as department specific risks and mitigations are recorded on the Pathology risk register to capture any remaining resource and capacity issues. Where high risk is identified the risk will be escalated accordingly. Current consideration on the escalation of risk 5115 and 3567 risks in relation to cell Path is underway and these risks will be escalated if required.

- Datix Risk ID 5364 - Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage, risk review undertaken with the support of the Head of Safeguarding and considered that this risk had been scored too highly and required updating in terms of the risk assessment and mitigating action. This risk (5364) was closed and a new risk opened (Datix Risk ID 5528 - Merthyr Cynon band 6 SCPHN's shortage) which has been scored as a 12. Due to the closure of risk 5364 and the level of risk score now applied to the new risk this no longer requires escalation to the Organisational Risk Register.

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

Consequence						
	5			4253 3337 4768 3993 4887 4080	4664 5276	
	4				4337 3008 4906 4809 4753 3131 4671 5477 4908 5462 5404 5427 5425 4152 3133 4752 4922 4417 5374 5254 4798 4348 4907 5602	4491 4071 4103 4841 4827 4780 2713 3826 1133 5579 5590
	3					3638 4691 4732 4699 4928 4650 4672 4691 2808 5040 4732
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 Matters to Note

- The Assistant Director of Transformation is currently developing a new risk for escalation relating to the Community Brain Injury Service in Bridgend. It is anticipated that this risk will be escalated to the January 2024 iteration of the Organisational Risk Register.

- In response to discussions at the Population Health and Partnerships Committee on the 7th November 2023, the Interim Executive Director of Public Health is developing a new risk in relation to vaccination uptake.

4. IMPACT ASSESSMENT

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
	Not Applicable

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf futuregenerations.wales)*	A Resilient Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the Organisational Risk Register.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail for each risk	
Effaith Adnoddau	Yes (Include further detail below)	

(Pobl /Ariannol) / **Resource Impact** *(People / Financial*	See detail for each risk.

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.

6. Next Steps

6.1 The Organisational Risk Register will be submitted to the relevant Board and Committees.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	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
2	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	**IF**: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. **THEN** patients will not receive the necessary imaging **RESULTING IN** delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Discuss with Radiologists other scan options.	Quality & Safety Committee	20	C4xL5	4 C4xL1	New risk escalated November 2023	23.10.2023	06.11.2023	31.12.2023
3	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	IF there is consistent backlog of Radiology reports THEN there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes RESULTING IN deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Review allocation of reporting and productivity. All further mitigations would require financial resource. WLIs options being considered. Mitigating actions have been discussed through Operational Management Board, Planned care recovery Operational group and have discussed some further options with the Assistant Director of Transformation, Strategic and Operational Planning, Executive Director of Strategy and Transformation and the Chief Operating Officer. Risk score increased and therefore this risk has now been escalated to the Organisational Risk Register due to the current increase in reports outstanding, particularly for MR, USC and concerns raised from internal colleagues and patients. The score is now 20 based on risk being held within the service. Risk reviewed November 2023 - no change to risk score.	Quality & Safety Committee Planning Performance & Finance Committee	20	C4xL5	4 C4xL1	↔	08.02.2017	03.11.2023	11.12.2023
4	4348	Chief Operating Officer	Central Support - Facilities Function	Assistant Director of Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Compliance to the PUWER (Provision and Use of Work Equipment) Regs 1998, MHRA compliance, Wales Duty Of Quality Statutory 2023	If: The Health Board fails to deliver a robust and sustainable Clinical Engineering function. Then: Due to the quantity and complexity of medical devices being purchased the Health Board would not be able to provide a full service in terms of advice, maintenance & repair and compliance with relevant legislation and regulations. Resulting In: Non-compliance with the legislation / regulation such as PUWER, MHRA (Medicines and Healthcare Products Regulatory Agency) Managing Medical Devices 2021 guidance and Wales Duty Of Quality Statutory Guidance 2023.	All calls and responses are being prioritised according to service risk and need. Some overtime is being utilised to cover some planned maintenance. Service contracts in place for life support Anaesthetics Equipment (a cost pressure) as a result of vacant B6 Technologist post.	Update November 2023 - Recruitment exercise completed and new staff are starting training period. Risk remains unchanged until new starters are fully trained and up to speed. Review risk again in 3 months with a view to close/reduce risk. Review date: 29.12.23	Planning, Performance & Finance Committee	20	C4xL5	4 C4xL1	↔	23.07.2010	16.10.2023	29.12.2023
5	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.	Update November 2023. This risk has been discussed at LDP 19.10.2023, the outcome of the discussion was to keep this risk on the organisational risk register for now. There is a LIMS Programme Board meeting scheduled end of November where the overall RAG rating for the program may be reduced to amber/green. Providing the RAG status is downgraded, we would then look to de-escalate this risk in preparation for the Jan 24 risk submission deadline.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	19.10.2023	01.12.2023
6	4780	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training Then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to Incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tontieg is on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role.	Update November 2023 24/10/2023 - Business case has been approved for funding although the full funding has not been provided by finance. Discussions have taken place around the shortfall and it has been noted there will be a cost pressure which is unfunded going forward. Posts for this business case will be advertised shortly. It is anticipated these posts will be in place by the end of the year to provide additional Manual Handling Training across the Health Board.	Health Safety & Fire Sub Committee	20	C4 x L5	4 C2xL2	↔	06.08.2021	24.10.2023	31.12.2023
7	4827	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses e.g. Covid, flu, etc.; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	Update November 2023 24/10/2023 - Business case has been approved for funding although the full funding has not been provided by finance. Discussions have taken place around the shortfall and it has been noted there will be a cost pressure which is unfunded going forward. Posts for this business case will be advertised shortly. It is anticipated these posts will be in place by the end of the year to provide fit testing across the Health Board.	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	24.10.2023	31.12.2023
8	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update July 2023 - The financial Planned Care Recovery package agreed in June 2023 and the schemes are now in motion which is resulting in a positive impact on backlogs and ongoing demand. The Health Board has trajectories in place for planned and cancer targets which is monitored weekly by the Planned Care Director and their wider team. Clinical strategy work is ongoing which will serve to strengthen the Health Boards ability to create more capacity within the system. The Health Board is also starting to look at a Demand Management Plan as currently referrals to CTM are higher than pre-Covid levels. In order to sustain performance the Health Board needs to tackle this issue along with Primary Care colleagues and in this regard have produced a heat map to identify those practices that the Health Board needs to work collaboratively with as a priority. In addition the Six Goals Plan was agreed in June 2023 and the plans to increase Same Day Emergency Care (SDEC) plans across CTM are in motion. The Health Board is now focussing on its outcome matrices to ensure it captures investment return effectively. Update November 2023 - due to ongoing pressures risk reviewed and score and mitigation remains unchanged. The following updates are however noted in terms of the Six Goals Plan: 1. Capital work underway in Prince Charles Hospital for Same Day Emergency Care (SDEC) unit completion January 2024. 2. Acute frailty established in Princess of Wales Hospital and Royal Glamorgan Hospital, recruitment completed for service in Prince Charles Hospital awaiting start dates 3. Navigation hub screening calls from nursing homes and pulling proactively from WAST stac (Ambulance demand). Next review 30.11.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	31.10.2023	30.11.2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	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
9	4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update November 2023 - Risk now sits with Planned Care and substantive Director in post. Mitigation work continues, with an increase in straight to test and streamlining of pathways, leading to a small reduction in numbers waiting, a slight improvement in performance	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	03.11.2023	15.12.2023
10	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF:** The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: 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 (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews Update November 2023 - No changes made to scoring or mitigation.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	06.11.2023	30.11.2023
11	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	November update new governance arrangements will provide a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • First Board meeting held and monthly meetings to follow from September onwards. • Operational Group being established with first meeting in September with a focus on the performance and actions for improvement. • Consultant recruitment still problematic and as such alternative options being explored re SAS doctors to provide an increased level of robustness. • Brainomix implementation continues. • USC group engaging with stroke regional programme, exploring alternative models of acute stroke care between Cardiff & Vale and CTM. Behind this there is significant modelling work which will feed into review of the whole stroke pathway. • Directorate teams exploring feasibility of developing further stroke ANP roles. • CTM have undertaken a review of the historical action plan aligned to the stroke strategy group where many of these actions have been closed. Membership and terms of reference have also been reviewed with the Director of Therapies and this will be discussed during the next stroke operation group. Risk Remains 20, C4 C5 Review date 31/12/2023. - Pan CTM ESD Service - Staff are coming into post and being inducted and pathways being written, and engagement with key stakeholders. The service will start taking patients when all staff in post.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	02.11.2023	31.12.2023
12	5462	Executive Director of Therapies and Health Sciences.	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update November 2023 - risk reviewed and risk updates with progress - no change to score 20/10/23 - AWMS Monitor Capacity and Demand Monthly and Review with DHoS. Progressing and first group delivery due to be held. Waiting list continues to increase. Working with Digital Team to identify solution for self referral which will support prudent use of resources and validation for waiting lists to support better C and D management. Timeframe: 11.12.2023 Review NICE Technical Guidance and complete SBAR to consider impact for CTM UHB if applied. Timeframe: 11.12.2023 Review AWMS pathways - 24.10.23 - group now in pilot stage. Evaluation agreed with Research team. Evaluation will take up to 18 months and so local evaluation also planned after first few groups. Next action update to include ongoing plan for groups and likely impact on capacity. Timeframe 09.01.2024.	Quality & Safety Committee People & Culture Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	24.10.2023	31.12.2023
13	4664	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	Redacted. Due to business sensitivities this will be considered in Private Session.			Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26/05/2021	22.09.2023	29.12.2023
14	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients in excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	November update: Unscheduled Care Senior Management Team reviewed risk and met with Emergency Department (ED) leadership teams across CTM, in response to concerns raised including overcrowding. While many of the causes of overcrowding relate to the whole of the acute site, there are actions within ED to help manage risk. The ED teams have for example been asked to develop a protocol for management of an ambulatory stream. This remains an ongoing risk for all three sites and will be reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With the recent onset of winter pressures, risk rating to be increased to 20. C4, likelihood 5. New review date 31/12/2023.	Quality & Safety Committee Planning & Performance Committee	20 ↑ 16	C4xL5	12 (C4xL3)	↑ Risk Increased from a 16 to a 20 in November 2023	24.09.2019	02.11.2023	31.12.2023
15	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update November 2023 - risk re-escalated to the Organisational Risk Register in November 2023. November 2023 update: Senior Management Team risk reviewed, nurse establishment review continues in RGH Emergency Department, to support additional capacity within the department. Submitted a full winter pressure plan, decision awaited by the Executive Leadership Group. Risk rating increased C4 & L5, therefore risk now 20. Review date 31/12/23	Quality & Safety Committee. People & Culture Committee - Workforce aspect	20	C4xL5	8 (C4xL2)	↑ Risk re-escalated to the Organisational Risk Register in November 2023	20.02.2014	02.11.2023	31.12.2023
16	5579	Interim Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Children and Young Persons Weight Management Service	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	The options appraisal was presented to the Improving Care Board on the 18th Oct 2023 resulting in full support to progress to development of a full business case.	Population Health & Partnerships Committee	16	C4xL4	8 C4xL2	New risk escalated November 2023	13.10.2023	01.11.2023	20.12.2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	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
17	5602	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Redacted. Due to business sensitivities this will be considered in Private Session.				Heath, Safety & Fire Sub Commitee	16	C4xL4	8 (C4xL2)	New risk escalated November 2023	31.10.2023	6.11.2023	31.12.2023
18	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	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 team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2023 Risk Score remains the same. Backlog remains for redress cases: Team Lead triaging backlog of cases, to ensure that cases are prioritised appropriately. Duty of Candour continues to be an area of increased activity. New 'Invest to Save' bid is in final stage of development, prior to submission.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	06.11.2023	31.12.2023
19	5425 (Replacing 5153)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2023/24. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 23/24 Context: The context is that the draft financial plan for 22/23, . This planned deficit is also dependent on the delivery of efficiency savings of £27.3m which is a significant step up in savings compared to recent years.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper was submitted to WG on 31 May but the forecast deficit for 23/24 remains at £79.6m. Update October 2023- Additional allocations of £72m (£51m Conditionally recurrent and £21m Non recurrent) have been notified by WG, together with a stretch savings target of £8m. As a result CTM has been issued with a break- even Control Total target for 23/24. The risk score has been updated to 16 and reflects the risk surrounding the delivery of the £8m stretch savings target. The key action is to now allocate the £8m stretch target to Care Groups and to develop robust savings plans for the Care Groups to deliver a £8m improvement from their recent M6 Forecast year end overspends.	Planning, Performance & Finance Committee	16 ↓ 20	C4xL4	12 C4 x L3	↓ risk score reduced from a 20 to a 16 in November 2023	28.04.2023	31.10.2023	31.12.2023
20	5427 (Replacing 5154)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper was submitted to WG on 31 May but the forecast deficit for 23/24 remains at £79.6m. Update October 2023- Additional allocations of £72m (£51m Conditionally recurrent and £21m Non recurrent) have been notified by WG, together with a stretch savings target of £8m. As a result CTM has been issued with a break- even Control Total target for 23/24. The risk score has been updated to 16 and reflects the risk surrounding the delivery of the £8m stretch savings target and securing the £51m recurrent funding , which is conditionally dependent on delivering the break-even Control total target for 23/24. The key action is to now allocate the £8m stretch target to Care Groups and to develop robust savings plans for the Care Groups to deliver a £8m improvement from their recent M6 Forecast year end overspends.	Planning, Performance & Finance Committee	16 ↓ 20	C4xL4	12 C4 x L3	↓ risk score reduced from a 20 to a 16 in November 2023	28.04.2023	31.10.2023	31.12.2023
21	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2023 All Claims Investigations Officers have returned to full compliment. Reconciliation of inquest data is currently being undertaken. A Learning Event was undertaken between CTM Legal Services staff and NHS Wales Shared Services Legal & Risk team. The aim of the event was to improve communication and management of legal cases. A meeting has also taken place between senior members of CTM Legal Services and HM Coroner's Office to discuss ways improvements in management of inquest cases. To improve communication, regular meetings between the CTM Legal Services team and Coroners' officer team have been reinstated.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	06.11.2023	31.12.2023
22	4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 Inquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update November 2023 - the system for the timeline is now in place and population of information linked to the repository has commenced. The resource implications are significant and therefore it will take some time for the Health Board to map and archive all information. However, in light of progress the risk score has been reduced in terms of likelihood from a 5 to a 4.	Quality & Safety Committee	16 ↓ 20	C4xL4	8 (C4xL2)	Risk score decreased from a 20 to a 16 in November 2023	23.11.2021	18.10.2023	31.12.2023
23	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	IF: the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. THEN: There will be delays in performing and reporting autopsies. RESULTING IN: * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update November 2023 Draft escalation plan currently being approved by FT - this will provide guidance on communication and escalation at various levels of occupancy. This will provide support for escalation throughout the winter months. Awaiting feedback form Paper submitted outlining challenges in PM service/after death service flows. Meeting Coroner weekly to assess situation. Further Winter/Christmas Planning meeting with MES scheduled for end November. Additional staffing requirements to manage winter pressures submitted. Awaiting feedback from Paper submitted outlining challenges in PM service/ after death service flows. Next review 30.11.2023.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	27.10.2023	30.11.2023
24	4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	**If** the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), **Then:** the critical service will be unable to meet the need of patients requiring therapy, **Resulting in:** significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response.	November 2023: The funding released in June 2023 has enabled Speech and Language Therapy (SLT) staffing to be recruited to across all sites, with the Princess of Wales SLT role taking up their post in late October, and the Prince Charles Hospital and Royal Glamorgan Hospital post holders due to commence in November and December. Gaps in funding other Allied Health Professionals (AHPs) remain. The AHP workforce required to address these gaps has been captured within the Critical Care reconfiguration board business case (AHP workforce features as appendix 5 of the business case).	Quality & Safety Committee	16	C4xL4	C4xL2	↔	20.08.2021	16.10.2023	27.12.2023

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1	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
25	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update November 2023 - Draft escalation plan currently being approved by FT - this will provide guidance on communication and escalation at various levels of occupancy. This will provide support for escalation throughout the winter months. Awaiting feedback form paper submitted outlining challenges in PM service/after death service flows. Next review 30.11.2023	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	27.10.2023	30.11.2023
26	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update October 2023 The OCP has not been fully implemented. The Legal Services team are prioritising other areas of work which have risk of penalties i.e. LFERs and Inquests New invest to save bid has been prepared and due to be submitted.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	07.11.2023	31.12.2023
27	5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Estate/ Infrastructure	Fulfilling our environmental and social duties	**IF:** the health board's decisions fail to reflect our values or consider the long term environmental or social impact **Then:** we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles **Resulting in:** negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases - CTM representatives attend the Welsh Government Green meeting - Update of the DAP by March 2024 - Board and Committee cover papers also now include environmental impact against SRs.	Update November 2023 - Update to the Decarbonisation Action Plan (DAP) to be completed by March 2024. No further updates or changes to risk score at this time. Next review January 2024.	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	02.11.2023	31.01.2024
28	3008	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 6. Ask other HB`s their MH requirements SBUHB online training package to be shared. 7. Directorate will Seek out any opportunities for online updating to support current practice 8. 2 registered nurses to undertake train the trainer and initially cascade to community midwifery staff, commencing Sept 2022. 9. Staff member identified to action monthly module B training to facilitate improvement in knowledge and skills- agreed 11.10.22 10. In agreement with MH team 2 midwives to undertaken 5 day TTT course for manual handling in July. Meeting arranged with MH team to arrange bespoke 3 hour course for all midwives to be implemented 2023/2024 for 100% compliance in 12 months.	Organisational plan for compliance training. Update April 2023 - Risk reviewed. Bespoke training module in development and ready for roll out 2023. Risk score will be adjusted once numbers trained increases. Update June 2023 - risk reviewed by AD Health, Safety & Fire 27.6.2023 - No Changes made. Update requested from Care Group and will be added to the Organisational Risk Register once received.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	27.6.2023	31.08.2023
29	3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update October 2023: Progress made with e-learning ESR package for med gas training to be available via an All Wales agreement, however until attendance/compliance increases significantly, the risk cannot be reduced. Was also raised at MDG Group in September 2023, training compliance provided to Nursing for appropriate circulation. Review again in 3 months(CM/WG 02/10/2023)	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	06.10.2023	29.12.2023
30	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. PCR funding bid for 2 biochemists - FITT testing - new vetting criteria Update November 2023: Continued monitoring of waiting lists. Review of demand. Radiology workforce planning.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	3.11.2023	11.12.2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	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
31	4337	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	**If:** The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers **Then:** The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	**Key Controls** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems, the ABHB Clinical Workstation or Local Authority system Numerous delays in NHS Wales progressing open architectural approach which results in CTM UHB being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Integrate Bridgend ICT Systems within CTM - 22/09/2023 - SLA Aligned to Infrastructure has been arranged to move to CTM in the majority as of October. Further work on the standalone systems has been made and a scheduled defined. Timeframe: 29.12.2023 Additional Funding for ICT Integration of Bridgend - WPAS funding for resource, workstream started Nationally led. estimated timescales arrive at 2025. Next review scheduled for 29.12.2023	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	22.09.2023	29.12.2023
32	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Module D PMVA Training Provision / Programme Delivery - Timeframe 22.12.203. Addition training needs to be acquired to meet the increasing demand as highlighted in the Training Needs Analysis. The present training programme will not meet specified compliance targets. Timeframe 31.12.2023 Update November 2023 risk reviewed and position has not changed since last update. Review timeframe 31.12.2023.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	06.09.2023	31.12.2023
33	4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	Update October 2023: Risk Score remains unchanged. LFER status is regularly monitored in: - Weekly Patient Safety, Complaints and Legal Services data meeting, - Weekly Executive Patient Safety Meeting and Quality & Safety Committee. Weekly meeting to review and monitor all deferred LFERs has been set up and will continue. Members of Quality & Safety team and Legal Services attend this meeting. This meeting has provided support to Care Groups in relation to evidence required for LFERs. This has provided an increase in number of deferred LFERs the Health Board has submitted and approved by the WRP. This process will continue for deferred LFERs. In addition to the Weekly review meetings, noted above, LFER Scrutiny Panels will take place monthly from December 2023, to ensure evidence submitted meets the appropriate standard required to demonstrate learning and provide assurance to the WRP Learning Advisory Panel.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	06.11.2023	31.12.2023
34	4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update November 2023 The Deputy COO (MH and PC&C) has started the process of undertaking a UHB wide review of access and egress to all sites. An initial meeting has taken place with appropriate parties for an approach to be agreed that will consider the identification all appropriate areas, agreement on a process of risk assessment which builds of information already gathered and identifies the action needed. Once that has been agreed then a programme will be agreed with timescales and an assessment of the capital implications. The next meeting will be held in the coming six weeks and colleagues from this committee will be made aware of progress on what is a considerable task at their next meeting.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	02.11.2023	31.12.2023
35	4671	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	Redacted. Due to business sensitivities this will be considered in Private Session.			Digital & Data Committee	16	C4 x L4	9 (C3xL3)	↔	03.05.2021	07.09.2023	29.12.2023
36	4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	November Update: Senior Management Team reviewed, following clarity of ask from executive team. USC will hold responsibility for Consultant orthogeriatrician to be working with the wider COTE team on each site. Funding to be released to create these posts, from T&O budgets. Nursing/junior medical work force to remain responsibility for planned care group. Risk rating to remain unchanged this period, however, will be reviewed once funding released and solutions implemented.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	7.11.2023	31.12.2023
37	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	Update August 2023: Medical Workforce Productivity Programme is fully established. Within this programme are a range of initiatives which are interrelated and mitigate each associated risk one part at a time. Within the initiatives/workstreams, financial aspects are fully considered. Collaborative discussions have been ongoing for CTMUHB to align rates with Aneurin Bevan UHB's rate card. This has been discussed at Executive level and financial controls have been considered. An updated paper is due to be received at Executive Leadership Group in September for formal approval. Update November 2023 - the Health Boards Non Consultant Rate Card is now active. Medical Workforce Productivity Programme continues as detailed in the August update above and at this point risk score remains unchanged. Risk score will be reviewed in January 2024.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	31.10.2023	31.01.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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38	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 1.0 wte Psychiatrist (clinical lead role, Uplift from 8a to 8b 0.6 wte Pharmacist, 1.0 wte Band 3 admin & 0.6 wte Band 3 HCSW - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred. Meetings scheduled to bid for funding via Regional Partnership Board. Timeframe 29.9.2023 Update November 2023: Consideration required for further investment in the service - Timeframe 31.3.2024 NDIP Award for funding until 31.3.2025: - B5 Psychology Assistant recruitment - Timeframe for action 31.3.2024. - Speech and Language Therapy post recruitment - Timeframe for action 31.3.2024. - NDIP funding provided 0.8 wte nurse until 31/03/2024 - Timeframe for action 31.3.2024.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	03.10.2023	01.03.2024
39	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update June 2023 -options for decant remains under strategic review and is proposed for discussion at Improving Care Board on 27th June. If this is the agreed way forward this will be discussed at a formal review with Welsh Government, likely to be late July. If approved then the contractor can be re-engaged and works commence on procuring the decant solution and developing the design for the theatre department works for inclusion in a business case. Further funding will need to be applied for to develop the business case. Once approved then the decant will need to be installed. Likely to require a further extension on the Fire enforcement notice which is due to expire on 31st December 2023. Update September 2023 - Project board established and at the July meeting discussed all options for earliest decant from POW theatres, including some that have not previously been considered. Full options appraisal is under development for presentation at a future meeting. Review end of October. Update November 2023 - October Programme Board agreed a preferred option, this option requires significantly less capital. The option has been presented to Welsh Government Capital Team, however, there are revenue elements to the option which require further exploration with Welsh Government.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	31.10.2023	31.01.2024
40	4672	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	**IF:** The Health Board is not able to record information accurately and reliably, with complete and up to date information **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update as at November 2023: External provider contract has finished and all day forward scanning continues to be undertaken in house by the Health Board scanning team in Williamstown. The Health Board is consistently maintaining the 48 hour turn around target for all scanning but legacy scanning has now been paused due to the end of the contract with the supplier. Longer term strategy now in early development stages to agree way forward for remaining paper notes across the organisation. The foundational building blocks which will enable the use of clinical e-forms interoperable with our integrated care record have developed well, with DHCW starting to enable integration to the record they hold. Clinical coding improvement programme has progressed strongly, with over 95% of episodes being coded within the month, and 25000 coding rules now built into the autocoder. The preparation for e-forms and ontologies is now under development. Data quality and completeness remains sub-optimal, with the intelligence suggesting that insufficient allocation of clinical resource and admin support to the maintenance of the record being the key contributory factors There remains a requirement for a fundamental change in the clinical information model, which is starting to be considered at the national level. The digital and data team have ppraised the risk and would ask that it remains at a15 for now. Review date: end of December 2023.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	07.11.2023	31.12.2023
41	5040	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	**IF:** The Health Board can not integrate new applications into its digital architecture in a timely fashion **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered **Resulting in:** delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity {much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC} and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	Update August 2023 - SLA discussions with key providers have articulated a requirement for APIs to be made available far more rapidly. Whilst there is a commitment of all partners towards opening up the architecture and ability for data to flow across the NHS there appears to be fundamental constraints within NHS Wales in having the capacity and capabilities to do so. November update: no change to risk score - next review date 30.12.2023.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	01.09.2023	30.12.2023
42	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify 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. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update November 2023: WCCIS Programme Board held on the 7th November and further discussion and exploration required in terms of implementation for MHLD Care Group. Further update to be provided in January.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	7.11.2023	31.12.2023
43	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	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 and extended lengths of stay.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case to be prepared and submitted to Welsh Government Inpatient Improvement Programme has been established - April 2023.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. SON completed to support strategic and systematic review of inpatient development opportunities. 3. Develop a strategic outline business case following no.2 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Update September 2023 - Statement of Need (SON) completed to support strategic and systematic review of inpatient development opportunities. Develop a strategic outline business case following SON completion. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Review 31.10.2023. Update November 2023 - linked to September update. Feedback is awaited from Planning Colleagues and therefore risk remains unchanged with a review date extended until 30.11.2023.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	30.10.2023	30.11.2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	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
44	4699	Director of Digital	Central Support Function - Digital & Data (Information Governance)	Chief Information Officer	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	**IF:** The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care **Then:** There will be a loss of trust and confidence in the Health Board from its patients, population, staff and 'care providing partners' and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. **Resulting in**: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	**Key Controls:** - Adoption and implementation of All Wales IG and Data protection policies, - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc) - Mandatory training in Information Governance with auditing functionality (such as NIIAS) built in to monitor compliance, - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI -Professional (clinical) training and approach to maintain an accurate and timely medical record **Gaps in Controls:** 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom if Information and Subject Access Requests	Cyber and Data Protection Improvement Plans being taken forward. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking with other organisations in Wales undertaken. Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Update November 2023 - Head of Information Governance in post, and recruitment is being progressed for the wider IG Team roles. In response to the ICO letter, evidence is to be collated and submission to the ICO audit team by December 2023 with a final follow up meeting arranged for January 2024. Ongoing challenges in meeting minimal operating requirements in IG, with numerous members of staff acting down to maintain an operational service, and an inability to make inroads into the improvement plan Risk score currently remains unchanged and will be reviewed at the end of December.	Digital & Data Committee	15	C3xL5	12 C3xL4	↔	18.06.2021	03.11.2023	31.12.2023

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
5304	Chief Operating Officer	Improving Care	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU is over 20 years old and is at risk of malfunction. If: the air handling unit malfunctions Then: the aseptic unit will not be able to function Resulting in: patients not being able to receive certain drug therapies.	The room pressures are being monitored on a daily basis. The estates department maintain the AHU regularly. Monthly in-house QC testing of air quality provided by AHU. 6 monthly external testing of air quality provided by AHU. Contingency plan in place if the AHU does malfunction.	An independent assessment of the unit took place end of July 2023. The review in July recommended repairs / upgrades which have been actioned in October 2023. The risk likelihood score has now reduced.	Quality & Safety Committee	12 Reduced from a 16 in November 2023	4 (C4xL1)	Likelihood score reduced from a 4 to a 3 in November 2023, in light of the repair works that have been completed in October 2023. Risk now de-escalated from Organisational Risk Register and will be monitored via medicines management which is part of the DTPS Care Group.

	A	B	C	D	E	F	G	H	I	J	K
1	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
2	5036 Link to RTE 5155	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Update November 2023 This risk has been discussed internally and DTPS Care Group have reduced the risk score to reflect current Pathology service provision. DTPS Care Group have taken the decision to close this overarching Pathology risk as department specific risks and mitigations are recorded on the Pathology risk register to capture any remaining resource and capacity issues. Where high risk is identified the risk will be escalated accordingly. Current consideration on the escalation of risk 5115 and 3567 risks in relation to cell Path is underway and these risks will be escalated if required.	Quality & Safety Committee	Nov-23	Update November 2023 This risk has been discussed internally and DTPS Care Group have reduced the risk score to reflect current Pathology service provision. DTPS Care Group have taken the decision to close this overarching Pathology risk as department specific risks and mitigations are recorded on the Pathology risk register to capture any remaining resource and capacity issues. Where high risk is identified the risk will be escalated accordingly. Current consideration on the escalation of risk 5115 and 3567 risks in relation to cell Path is underway and these risks will be escalated if required.
3	5364	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage	IF we are unable to recruit SCPHN School Nurses into vacant caseloads. THEN there will not be enough SCPHN's to deliver the School Nursing Framework and Welsh Government priorities. In addition increased pressure on existing staff. RESULTING IN – the school nursing service being unable to fulfil all of its statutory obligations to safeguarding, optimise immunisation uptake rates, support CYP with their emotional health and compliance with the CMP. It is also predicted that there will be increased levels of staff sickness and impact on recruitment and retention of staff.	Vacancies to be advertised as required. Development of a SCPHN SN bank Team Leader and CNS safeguarding to support staff to ensure safeguarding statutory duties are met. Plan in place to prioritise, Immunisations, CMP, SEHS. Where possible, Team Leader to protect SCPHN time to hold drop in sessions within schools. Vacant caseload policy has been activated. Letter send to Directors of Education and Head Teachers regards reduced SN service capacity. Development plan in place for junior staff to complete SCPHN training and ensure succession planning of future SCPHN workforce. Cross cover support from School Nursing staff across the HB. Extra hours have been offered throughout the team. Team leader review workforce capacity as required and escalate to Senior Nurse when required. Skill mix approach by MC team to deliver school nursing service Senior Nurse to escalate to senior management as required.	Update November 2023 - Risk owner undertook a review with the support of the Head of Safeguarding and considered that this risk had been scored too highly and required updating in terms of the risk assessment and mitigating action. This risk (5364) was closed and a new risk opened (Datix Risk ID 5528 - Merthyr Cynon band 6 SCPHN's shortage) which has been scored as a 12. Due to the closure of risk 5364 and the level of risk score now applied to the new risk this no longer requires escalation to the Organisational Risk Register.	Quality & Safety Committee People & Culture Committee	Nov-23	Update November 2023 - Risk owner undertook a review with the support of the Head of Safeguarding and considered that this risk had been scored too highly and required updating in terms of the risk assessment and mitigating action. This risk (5364) was closed and a new risk opened (Datix Risk ID 5528 - Merthyr Cynon band 6 SCPHN's shortage) which has been scored as a 12. Due to the closure of risk 5364 and the level of risk score now applied to the new risk this no longer requires escalation to the Organisational Risk Register. New risk 5528 will be monitored via the Children & Families Care Group.

Agenda Item
5.2

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Emma Walters, Head of Corporate Governance & Board Business
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

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

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

2. Specific Matters for Consideration

2.1 Internal Audit (NWSSP)

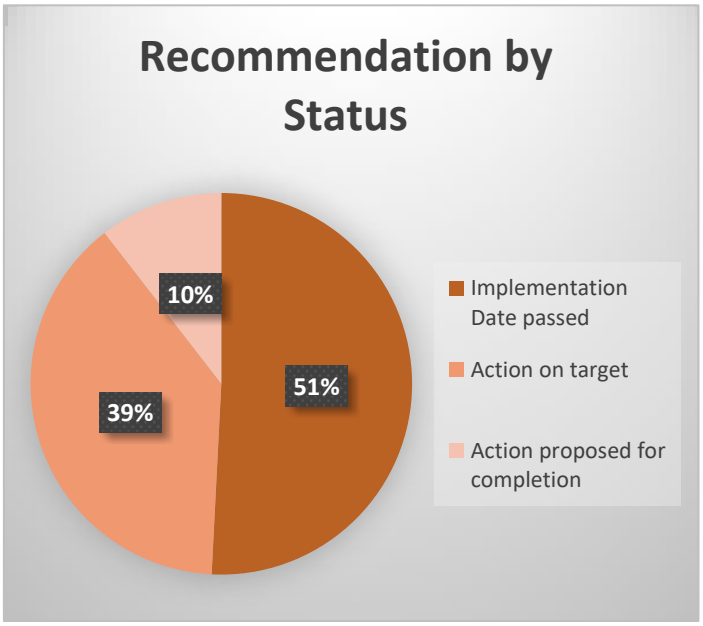
2.1.1 Since the last meeting the following changes and updates are noted:

- **3 NEW** Internal Audit Reviews have been added to the Audit Recommendations Tracker:
  - Interventions Not Normally Undertaken – Eight recommendations;
  - Facilities Systems Follow Up Review – Eight recommendations;
  - IT Infrastructure – Seven recommendations;

- **13** Internal Audit recommendations have been completed and are proposed for **CLOSURE**, these are:
  - Medical Variable Pay 2.2, 3.1, 3.2, 5.1, 6.1;
  - Facilities Systems Follow Up Review 3.2;
  - Bridgend Transfer of Informatics Services Follow Up Review 1.1;
  - National Incident Framework 5.1;
  - IT Infrastructure 5.1;
  - Radiology Service Review 4.1;
  - Prince Charles Hospital Programme Redevelopment 1.1, 2.1;
  - Concerns Follow Up Review 9.0.

2.1.2 **Current Position**

The tables below provide a summary of the current position in relation to Internal Audit Recommendations, noting that the proportion of red status recommendations has improved slightly to 51% compared to the October position which was at 54%.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High	**30**	16	8	6
Medium	**79**	40	33	6
Low	**15**	7	7	1

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Finance	**21**	18	1	2
Chief Operating Officer	**42**	22	18	2
Director of Nursing	**23**	1	20	2
Director of Digital	**9**	2	5	2
Director for People	**4**	2	2	0

Director of Strategy & Transformation	**18**	17	1	0
Medical Director	**7**	1	1	5

Implementation Date Extended by					
Priority	**TOTAL**	More than 24 Months	18-24 Months	12-18 Months	6-12 Months
High	**13**	1	1	8	3
Medium	**44**	21	5	7	11
Low	**6**	3	0	2	1

2.2 External Audit (Audit Wales)

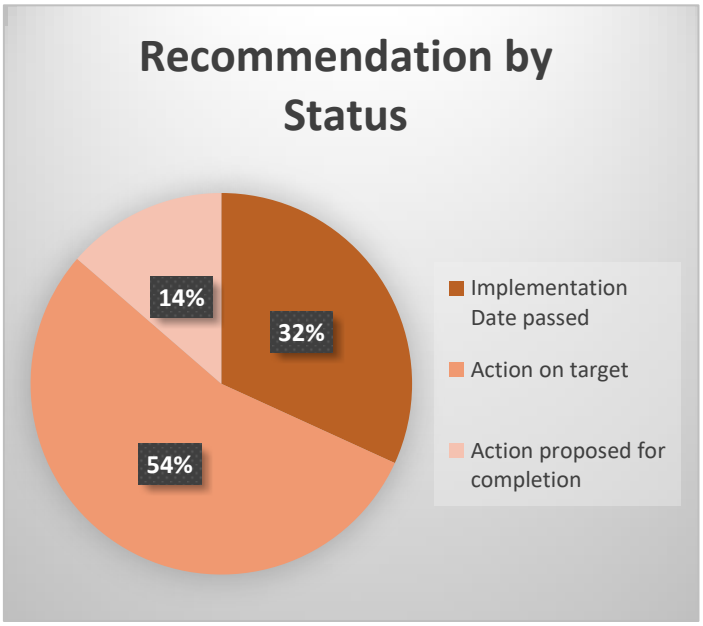
2.2.1 Since the last meeting the following changes and updates are noted:

- No new External Audit Reviews have been added to the Audit Recommendations Tracker.

- **3** external audit recommendations have been completed and are proposed for **CLOSURE**, these are:
- Audit Wales/HIW Quality Governance Follow Up Review R2.3, R7.7b and R8.6.

2.1.3 Current Position

The tables below provide a summary of the current position in relation to External Audit Recommendations. You will note that the percentage of recommendations whereby the implementation date has now passed has improved very slightly to 32% compared to the 33% reported to the October 2023 meeting.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High/Medium/Low	**22**	7	12	3

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**1**	1	0	0
Director of Strategy & Transformation	**8**	2	6	0
Chief Operating Officer	**3**	0	3	0
Director of Digital	**1**	0	1	0
Director of Nursing	**5**	2	1	2
Director for People	**2**	1	1	0

Medical Director	1	0	0	1

Implementation Date Extended by					
Priority	TOTAL	More Than 24 Months	18-24 Months	12 - 18 Months	6 -12 Months
High/Medium/Low	13	4	0	6	3

3. Key Risks / Matters for Escalation

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

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	There may be an adverse effect on the organisation if CTMUHB does not fully implement learning and improvements identified as part of Audit arrangements.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

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.

CTM Interna [date]

Red -
Orange -
Yellow -
Green - Action
Blue - Action

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Update provided for Previous meeting
Patient Pathway Appointment Management Process Follow Up 1.1	Jun-22	Limited	Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	Chief Operating Officer	ILG Directors of Operations / Head of Information	Aug-22	Now December 2022 Now January 2023 Now April 2023 Now June 2023 Now October 2023 Now December 2023 given renewed focus on actions Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.
Patient Pathway Appointment Management Process Follow Up 1.3	Jun-22	Limited	On receipt of the outcome reports, management within the CSGs should ensure that they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data or making the errors. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action.	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023 Now June 2023 Now October 2023 Now December 2023 given renewed focus on actions Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.
Patient Pathway Appointment Management Process Follow Up 1.5	Jun-22	Limited	Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	High	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023 Now June 2023 Now October 2023 Now December 2023 - given focus on making progress in other areas. Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 Update - opinion sought from Performance.
Patient Pathway Appointment Management Process Follow Up 2.1	Jun-22	Limited	Management should ensure that the correct data detailed within the closed pathway reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023 Now June 2023 Now October 2023 Now December 2023 given changes with OCP Phase 2 and renewed focus on audit. Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.
Patient Pathway Appointment Management Process Follow Up 2.2	Jun-22	Limited	Management should ensure that closed pathway reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that the patients are put onto an open pathway. In addition, closed pathways reports should be sent on a regular basis to staff within Bridgend ILG, or checks should be made to ensure managers are accessing this data for themselves.	High	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Aug-22	Now December 2022 Now February 2023 Now June 2023 Now October 2023 Now December 2023 given renewed focus and impact of phase 2 OCP Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 Update - email has gone from Deputy COO to all Operations Directors asking for validation to be undertaken. In addition, targeted email going to Ops Directors and Service Group Managers as appropriate, with circulation lists and areas of greatest concern outlined. In addition, discussion has taken place with Internal Audit and have asked colleagues within Performance for areas of greatest concern to inform the above. Specific Bridgend information also requested.
Patient Pathway Appointment Management Process Follow Up 2.3	Jun-22	Limited	On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action	Chief Operating Officer	ILG Acute Services General Managers	Aug-22	Now December 2022 Now February 2023 Now June 2023 Now October 2023 Now December 2023 as a consequence of further detailed work needed. Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.

CTM Interna [date]

Red -
Orange -
Yellow -
Green - Action
Blue - Action

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Update provided for Previous meeting
Patient Pathway Appointment Management Process Follow Up 2.4	Jun-22	Limited	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Sep-22	Now February 2023 Now June 2023 Now October 2023 Now December 2023 as a consequence of further focused work needed. Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.
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	Now October 2023		Completed	December 2023 Update - The new Non Consultant Rate Card has been agreed with Execs. This has now been launched. The first report on adoption and impact will be on 23rd November 2023. There will be a new governance/reporting system for any breaches of these rates.	October 2023 Update - A new Non Consultant Rate Card has been agreed with Execs. This will be launched on 19th October. There will be a new governance / reporting system for any breaches of these rates. These rates are more than those set by the WG cap of 2019.
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	Now October 2023		Completed	December 2023 Update - Non Consultant Rate Card has been agreed by Execs. Launch is 19th October 2023. There will be a new governance and reporting system led by both Deputy Medical Directors that the care groups MUST report into if there are any breaches of the rate card.	October 2023 Update - Non Consultant Rate Card has been agreed by Execs. Launch is 19th October. There will be a new governance and reporting system led by both DMDs that the care groups MUST report into if there are any breaches of the rate card.
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	Now October 2023		Completed	December 2023 Update - Rate Card has now been launched. First review due in end of Nov 2023.	October 2023 Update - Non Consultant Rate Card has been agreed by Execs. Launch is 19th October. There will be a new governance and reporting system led by both DMDs that the care groups MUST report into if there are any breaches of the rate card. The Care Groups can breach up to 10% of the rate however this must be done in extreme circumstances only. The EMD can only authorise over 10% of the rate.
Reasonable Offer Process 5.1	Apr-23	Limited	A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	High	5.1.1 - Identification of WPAS reports to allow for identification of compliance. 5.1.2 - Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements	Chief Operating Officer	Director of Operations Planned Care & Head of Clinical Administration Transformation	July 2023 August 2023	Now December 2023, Now February 2024		In progress	December 2023 Update - as a consequence of the phase 2 OCP process, the position remains the same as that in October 2023. There will be an update in February 2024.	October 2023 Update - In terms of reports this has not changed since previous update as one report on application of RTT rule is not available. In mitigation to this we have agreed that an escalation route through weekly RTT meetings of any identified areas of noncompliance with RTT rules which are identified by performance and reporting team where actions on patients pathways are not inline with guidance.
SLA Arrangements 1.0	Jun-23	Limited	To aid the Health Board in achieving more efficient use of resources, a consistent approach for entering into SLA agreements should be adopted. Guidance should be in place to provide clarity on the roles and responsibilities of the central commissioning team in supporting service managers when SLAs are set up. The development of procedures, guidance and templates should be completed, approved and made available to all staff. Communication with staff should take place, to ensure staff are aware of the Health Board's desired approach and prevent the use of localised procedures and approaches that may not comply with the Scheme of Delegation or allow value for money to be achieved.	High	A project team has been set up to develop the guidance required for development of SLAs. This includes Strategy and Transformation, Finance (Commissioning) leads and will include Procurement and Care Group representatives as the work progresses. This group will: • Develop guidance for the development of SLAs. • Provide templates for SLAs and service specifications. • Ensure all SLAs currently in place are recorded on the register of agreements and have Strategy, Commissioning and Care Group (service) leads. This guidance will be supported by a clear structure of governance supported by meetings with each Care Group to manage and monitor SLAs. Progress already made includes: • A checklist for the development and changes to SLAs has been drafted. • A revised SLA template is being tested for a current SLA development	Director of Strategy & Transformation	Assistant Director of Transformation and project team	Sep-23	Now January 2024		In progress	December 2023 Update - The planning and commissioning team is providing a project team to develop the resources and has collated a draft SLA and service specification template which is being considered by a number of expert teams (e.g. procurement and quality and safety) to ensure that all legal and service requirements are appropriately considered. A checklist has been developed to support SLA cessations and a further checklist is being developed for initiating SLAs. These will be temporary documents pending a more detailed piece of work to establish a policy structure. Links are being made to all Wales peer groups to collaborate with and learn from other NHS organisations in Wales in the approach to commissioning.	

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SLA Arrangements 2.0	Jun-23	Limited	Data in the register of agreements should be checked to confirm its accuracy and completeness. • Once the current completeness and accuracy of the register of agreements has been confirmed, procedures will need to be put in place to ensure that changes are promptly notified so that it remains accurate and up to date. • The register of agreements should be checked before setting up an SLA agreement with a provider to ensure that multiple SLAs are not set up with the same provider for the same service and that no issues have been identified which would suggest that setting up the SLA agreement should not proceed. The columns for end date and review date in the register of agreements should be regularly used to identify when periodic reviews are due and whether they have been completed on schedule.	High	The register of agreements will be reviewed by a process of sharing with all corporate and service (Care Groups) teams for review and supported by a structure of meetings between the Strategy and Transformation Team (Commissioning leads) and the Care Groups to manage and monitor SLAs. All third sector SLAs have been reviewed and the register will be updated to reflect the latest status.	Director of Strategy & Transformation	Assistant Director of Transformation supported by the Commissioning Manager and Planning Assistant	Aug-23	Now January 2024		In progress	December 2023 Update - Commissioning meetings are now in place with all care groups. Care groups have received the register of agreements and are providing updates. All contracts will have confirmed HB contracts for planning/commissioning and service teams and agreed frequencies for monitoring. This work will progress and embed during the next cycles of the commissioning meetings.	
SLA Arrangements 5.0	Jun-23	Limited	Adequate data should be obtained in line with SLA requirements to allow effective performance, quality and financial monitoring of the SLA to take place. The supporting data should be provided in sufficient time before SLA reviews are scheduled to occur so that it can be properly considered at the review. Evidence and supporting data should be retained of the SLA review process.	High	Please refer to action four above, which confirms that information requirements and review frequency will be determined with Care Groups. The capacity of the Strategy and Transformation team's commissioning function has been a limiting factor in the robust development of processes. A Commissioning Support Officer vacancy is being considered by the organisation's scrutiny panel. This post will lead on organisation of the administration of the register of agreements and the meetings with Care Groups. A Head of Commissioning job description has been developed and has been sent for Agenda for Change banding. This post will be recruited to on a fixed-term basis while the Head of Planning post is vacant due to secondment. Should this role provide successful, every effort will be made to structure the team to retain this function, however this will be dependent upon the team budget.	Director of Strategy & Transformation	Assistant Director of Transformation and Commissioning Manager	Sep-23	Now January 2024		In progress	December 2023 Update - Please refer to the update in the Management Action section. Commissioning Support Officer now in place. Meeting schedule is in place with care groups and meetings have commenced. The register of agreements is being updated and will include confirmation of monitoring arrangements.	
Interventions Not Normally Undertaken 1.1	Oct-23	Limited	Key staff, especially those listed as the target audience at the start of the INNU policy, should be made aware of the revised policy and its contents. Where necessary, training should be carried out to ensure staff understand the policy and the application of it	High	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Chief Operating Officer	Executive Medical Director Director of Operations Planned Care	Sep-23			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Interventions Not Normally Undertaken 1.2	Oct-23	Limited	A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	High	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Chief Operating Officer	Head of Plannning and Partnerships Strategic and Operational Planning Director of Operations Planned Care	Jan-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Interventions not Normally Undertaken 2.0	Oct-23	Limited	For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy or within WHSSC guidance has been met. Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	High	Individual patient funding request panel to be re-established to receive INNU intervention requests necessary. Application and outcome to be documented and WPAS to be updated	Chief Operating Officer	Executive Director of Strategy & Transformation	Jan-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Interventions not Normally Undertaken 5.1	Oct-23	Limited	The monitoring mechanisms set out in the INNU policy should be implemented as soon as possible. Appropriate reports should be produced monthly to monitor INNUs at an operational level which are distributed to all relevant stakeholders. These should include totals by month and by specialty/clinician so that trends and anomalies can be easily spotted and investigated. Sample checks back to patient records should be carried out to confirm all criteria had been met. The use of a checklist as recommended in Matter Arising 2 would aid this process. An appropriate mechanism should be in place for addressing any matters identified, so that corrective action can be promptly taken.	High	With the establishment of the recording and monitoring mechanism. Monthly reports will be produced with trends and anomalies highlighted. Any matters that require addressing will be via the Care Group with the service performance meeting structures.	Chief Operating Officer	Chief Operating Officer Directors of Operations and Service Group Directors	Mar-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	

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Facilities Systems Follow Up Review 2.4	Oct-23	Limited	Management should remind staff of the requirement that documentation to support all orders should be retained. Consideration should be given to including information on the retention of documentation to support orders on the action cards. This information should align to any relevant information contained in the FCPs.	High	We have reminded staff of their responsibilities in relation to the requirement that supporting documentation to support all orders should be retained. Further work is required. These procedures require monitoring monthly to ensure compliance. All procedures will be added to the Facilities Key Performance Indicators and will be monitored monthly. An Action Plan Tracker will follow this report which will include specific actions, accountability and completion dates. The Tracker will be submitted in November 2023.	Chief Operating Officer	Head of Technical Services. Divisional Director of Facilities	Feb-24			In progress	December 2023 Update - Required Training is still underway. Over 75% of staff are now trained and several more training sessions planned. The Department is in the process of completing the action tracker and preparing key performance indicators to monitor progress. Date for completion stands.	
Facilities Systems Follow Up Review 6.0	Oct-23	Limited	Management should review and clarify purchasing and budgetary arrangements and responsibilities for Central Facilities Hub and ensure that they align to the Health Board's revised Operational Structure.	High	The Facilities Hub and non-hub no longer exist. Systems are now in place to track and monitor, however further review is required to reduce activity and achieve budget. The services se arears are significantly overspent. Further control measures need to be determined, implemented and monitored.	Chief Operating Officer	Divisional Director of Facilities	Oct-23	Now February 2024		In progress	December 2023 Update - The review was not followed up correctly in October 2023. Preparation is underway to progress the matter accurately. Update will be available at the February Meeting.	
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	November 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.	October 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.
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 Now February 2024		In progress	December 2023 Update - Outline Plan for 2024/25 is in draft and will be presented to the next Health, Safety and Fire Sub Committee in February 2024	October 2023 Update - This recommendation is difficult to achieve due to the changing political and financial position within Welsh Government. Each year the Fire Team bid for Capital Monies to support Fire Management initiatives across the Health Board. As Capital funding has reduced, so has the ability to address the risks that have been requested through the Capital allocation. The Fire Team have received £50k of Capital funding for the current 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 Now October 2023 Now December 2023 as focus has been on validation aspect of this work Now January 2024		In progress	December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.	October 2023 - opinion sought from Performance colleagues.
POW Theatres Fire Safety Works 3.1	Aug-22	Limited	The Health Board should ensure timely completion of contacts.	Medium	Agreed – though in this case, due to the bespoke nature of the contract – a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Director of Strategy & Transformation	Project Director	At future contracts	Now January 2023 Now March 2023 Now June 2023 Now March 2024 Now January 2025		In progress	December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025	October 2023 Update - Work to identify the preferred decant option is ongoing, a further option was considered at the August project Board to be reported on in the November Board. Once this has been confirmed then work can commence on the business case

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POW Theatres Fire Safety Works 4.1	Aug-22	Limited	The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Medium	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Director of Strategy & Transformation	Project Director	At future contract awards	Now January 2023 Now March 2023 Now June 2023 Now March 2024		In progress	December 2023 Update - Preferred option now agreed by the project board . Tender will be completed for the design consultants, discussion to be held with NWSSP SES regarding appropriate procurement process for appointment of modular theatre supplier as Framework is available for direct award.	October 2023 Update - Please see note above this action will be addressed once there is an approved business case in place
POW Theatres Fire Safety Works 4.2	Aug-22	Limited	The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now March 2024 Now January 2025		In progress	December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025	October 2023 Update - As above action remains open pending business case preparation and approval. Only then will a construction contract be let and this can be actioned.
POW Theatres Fire Safety Works 4.3	Aug-22	Limited	The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now March 2024 Now January 2025		In progress	December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025	October 2023 Update - As above this will be required on the next phase of the development
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 Now January 2025		In progress	December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025	October 2023 Update - It is proposed that the SCP contract be ended and this will be discussed on the 21st September 2023 Project Board. If this action is taken then this will be closed if the scheme continues outside of the current framework.
POW Theatres Fire Safety Works 8.1	Aug-22	Limited	Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: • contacted sums; • cash flow budgeted to date; • expenditure to date; • forecast out-turn; and • associated variance commentary.	Medium	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now September 2023 Now February 2024		In progress	December 2023 Update - Now preferred option is agreed the fees required to develop the business case can be developed. Spend against current fee allocation will be reported to the project board once spend commences	October 2023 Update - This will be part pf the formal project Board update - expected to be agreed as a template in September Board and implemented for October Board.
POW Theatres Fire Safety Works 9.1	Aug-22	Limited	Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Medium	Agreed. This will be undertaken at the future procurement.	Director of Strategy & Transformation	Project Director	At confirmation of the preferred option	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now October - December 2023 Now November 2024		In progress	December 2023 Update - Discussions with a Designed for Life Framework Manager confirmed that because the scheme has changed so significantly and the FEN works cost will be below the current D4L limit of £4m the HB are no longer obliged to continue with the SCP. It is considered that better value for money for both the construction costs and design fees to be undertaken via traditional contract routes with a medium sized contractor on an open tender for the smaller scale works. Consequently, the Project Board agreed to terminate the D4L contract and appoint an alternative design team. NWSSP-SES have been informed and the Health Board informed the SCP on 4th October 2023. Procurement route for appointment of modular supplier still to be agreed	October 2023 Update - In the light of the LHP outcome this is not a likely outcome. However it does remain important that value for money is evidenced in any solution as part of the option appraisal.

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POW Theatres Fire Safety Works 10.1	Aug-22	Limited	A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023 Now June 2023 Now September 2023 Now January 2025		In progress	December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025	October 2023 Update - This is part of the Project Board remit and will be a standing item on the Project Board
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 Now December 2023 Now January 2025		In progress	December 2023 Update - Action to be addressed once there is funded project - based on current timeline this is scheduled to be January 2025	October 2023 Update - This will not be a requirement until we have a revised and funded project allocation. As the preferred option is not yet identified this can not be reviewed.
POW Theatres Fire Safety Works 10.3	Aug-22	Limited	Risks should be individually assigned to those best placed to control them, with time parameters for action.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023 Now June 2023 Now September 2023 Now December 2023		In progress	December 2023 Update - Key has been agreeing preferred way forward and pulling together a timeline for the project to present to the fire service , now this has been agreed the risk register will be fully reviewed and updated to address the recommendation	October 2023 Update - The Project Board will oversee the risk register, updates and risk allocation
POW Theatres Fire Safety Works 10.4	Aug-22	Limited	An exception report should be published of targeted risk mitigations not achieved.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now September 2023 Now December 2023		In progress	December 2023 Update - As above this will be actioned as part of project board	October 2023 Update - This will be actioned as part of the Project Board Agenda
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	Now August 2023 Now November 2023		In progress	December 2023 Update - We have now achieved 97% DE across the HB. There are a few remaining non-DEs that were part of agreement before we applied the new rues. These will not be repeated when agreement comes to an end.	October 2023 Update - Planned Care, Primary and Community and DT+S have DE rates of over 98%. The Care Groups that have the most non engaged Doctors are Unscheduled Care and Mental Health. The Unscheduled Care group sent a letter to all agency workers giving them a 6 week period to establish engagement.
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	Now August 2023 Now November 2023		Completed	December 2023 Update - Completed as Direct Engagement now managed	October 2023 Update - Planned Care, Primary and Community and DT+S have DE rates of over 98%. The Care Groups that have the most non engaged Doctors are Unscheduled Care and Mental Health. The Unscheduled Care group sent a letter to all agency workers giving them a 6 week period to establish engagement.

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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	Now October 2023		Completed	December 2023 Update - Completed as process now in place for Care Groups to oversee. This is process going forwards	October 2023 Update - Care Groups given monthly spend broken down into DE rates, ADH and locum agency spend. Divided into specialities and Doctor grades so target areas can be then addressed in Medical Productivity Group. Will need to include once rate card is implemented on number of breaches of the rate card and where specific problems are.
Reasonable Offer Process 1.1	Apr-23	Limited	As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.	Medium	Standard Operating Procedures to be reviewed and updated with approval at OMB and Executive Leadership Group. Once approved, the SOP will be published and issued to all booking teams. Previous versions of the SOP will be removed from the intranet and kept in a historical record.	Chief Operating Officer	Director of Operations Planned Care/Head of Clinical Administration Transformation	End April 2023	Now August 2023 Now October 2023 Now December 2023 given additions to process and need to revisit policy.		In progress	December 2023 Update - Awaiting update from Director of Planned Care following update.	October 2023 update - Following feedback received by the Director of Planned Care and updated guidance from WG on the management of RTT patients this SOP will need to be presented at the next OMB for approval.
Reasonable Offer Process 2.3	Apr-23	Limited	Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	Medium	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Chief Operating Officer	Director of Operations Planned Care/Head of Clinical Administration Transformation	End June 2023	Now August 2023 Now October 2023 Now December 2023 as a consequence of OCP Phase 2 Now February 2024 as a consequence of appointments around OCP 2.		In progress	December 2023 Update - Awaiting the outcome of OCP 2 which has been delayed.	October 2023 Update - This will be completed when Phase 2 of the OCP is complete in December 2023.
Reasonable Offer Process 3.1	Apr-23	Limited	The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Medium	A training needs assessment and compliance sign off will take place post implementation of the agreed SOP. Refresher training to be organised where required for staff identified.	Chief Operating Officer	CSGMs & for all operational/booking team managers/Head of Clinical Administration Transformation	Aug-23	Now October 2023 Now December 2023 given need for update on SOP Now February 2024		In progress	December 2023 Update - Awaiting SOP update from Director of Operations Planned Care.	October 2023 Update - additional work has been required and an update on the SOP Is imminent.
SLA Arrangements 3.0	Jun-23	Limited	When SLAs are agreed the documentation should be completed to include the details of the lead contact for the Health Board. SLAs should be signed on behalf of the Health Board as the commissioning body and by the provider before the start of the period to which it applies to confirm agreement with its terms and conditions.	Medium	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Director of Strategy & Transformation	Assistant Director of Transformation and project team	Sep-23	Now January 2024		In progress	December 2023 Update - Guidance documents are in development. The implementation of commissioning meetings provides a mechanism for testing and assurance of all SLAs pending completion of the guidance document.	
SLA Arrangements 4.0	Jun-23	Limited	SLAs should be reviewed in line with timeframes set out within them and the spreadsheet register kept up to date with renewal dates.	Medium	The meetings to be initiated with Care Groups as described in the actions above and the updating of the register of agreements will include the required performance information for each agreement and frequency of reporting, with the officers responsible for review to be identified.	Director of Strategy & Transformation	Assistant Director of Transformation and Commissioning Manager	Sep-23	Now January 2024		In progress	December 2023 Update - SLA review is a component part of the commissioning meeting structure and the allocation of both service and planning/commissioning leads for each SLA will ensure this is undertaken. The review of the register of agreements that will deliver this is ongoing currently.	

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Interventions not Normally Undertaken 1.3	Oct-23	Limited	The policy, and an associated SOP, should provide greater clarity on whether the IPFR process can be used for those interventions that are listed as 'Do Not Do' and the relevant process to follow.	Medium	Application of the above actions	Chief Operating Officer	Executive Medical Director Director of Operations Planned Care	Jan-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Interventions Not Normally Undertaken 4.0	Oct-23	Limited	A mechanism should be put in place that will allow the Health Board to monitor if activity has taken place against interventions that are classed as DNDs where no clinical code currently exists and the level of activity against the INNU interventions where no clinical code is recorded.	Medium	Data work stream established to look at the recording of INNU's across CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented.	Chief Operating Officer	Executive Medical Director	Mar-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Interventions Not Normally Undertaken 5.2	Oct-23	Limited	Consideration should be given to the need to periodically report compliance / non-compliance at a relevant level within the Health Board.	Medium	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	Chief Operating Officer	Chief Operating Officer Director of Operations Planned Care	Mar-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Facilities Systems Follow Up Review 1.0	Oct-23	Limited	Management should ensure that staff who are yet to attend training sessions identified as a requirement for their role, do so as soon as is practicable.	Medium	A change in the Facilities structure was implemented in September 2023. The hub and non-hub services have merged into one service. The ILG service Managers are no longer accountable for Facilities services. Leadership is new and all facilities services are under review. Training records will be amalgamated. Any employees who have missed the training will receive the recommended training. A total of 77% have completed Qlik Finance system training and 66% have completed P2P Procurement training. Further training to be arranged.	Chief Operating Officer	Quality Assurance, Performance and Compliance/ Divisional Director of Facilities	Feb-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Facilities Systems Follow Up Review 2.2	Oct-23	Limited	2.2a Management should continue to work with Procurement to review arrangements with suppliers where large numbers of retrospective orders continue to be raised, with a view to using 'call off / open' orders instead (where practicable). 2.2b In liaison with Procurement, clear guidance should be developed for when it may be acceptable to use 'call off / open' orders and the process staff need to follow to ensure appropriate controls are in place. The FCP should be updated accordingly.	Medium	2.2a We will continue to work closely with Finance and Procurement colleagues to identify further opportunities for using call of orders instead of using retrospective orders. 2.2b We have developed and issued a new action card to remind staff of their responsibilities for attaching supporting information/documentation in respect to open/call off orders and to provide information on the retention of information/documentation to support orders. Although informative action cards have been designed there is no evidence that the cards are utilised and adhered to. A monitoring procedure will be added to Facilities Key Performance Indicators and will be monitored monthly.	Chief Operating Officer	Head of Technical Services/Divisional Director of Facilities	Feb-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Facilities Systems Follow Up Review 2.3	Oct-23	Limited	Management should clarify the access arrangements to the notes section in Oracle for requisitioning staff, in order for information to be captured on why a retrospective order has been used.	Medium	We have developed and issued a new action card to remind staff on how to access the notes section on Oracle reminding them of their responsibilities in relation to attaching and entering supporting information in respect of retrospective orders and providing the rationale for raising a retrospective order. Although staff have been advised, no monitoring has taken place. There is therefore no evidence that the procedures are being followed. This procedure will be added to the Facilities Key Performance Indicators and will be monitored monthly.	Chief Operating Officer	Head of Technical Services. Divisional Director of Facilities	Feb-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	

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Facilities Systems Follow Up Review 3.2	Oct-23	Limited	As we note in 2.4 above, management should ensure that staff are reminded that documentation to support all orders, including the evidence of quotes, is retained and accessible. Management should ensure that staff who have not had refresher training, receive this as soon as practically possible. Management should consider enhancing the action card prompts that have been developed to remind staff of the quotes and tender thresholds, while ensuring they align to FCPs.	Medium	We have reminded staff that documentation to support all orders, including the evidence of quotes, is retained and accessible. We have developed and issued an action card reminding staff and management of the guidance in relation to the requirement of obtaining three quotes where expenditure for goods and services to be procured will exceed £5k, or where tenders are required.	Chief Operating Officer	Head of Technical Services.	Completed			Completed		
Facilities Systems Follow Up Review 4.0	Oct-23	Limited	The level of ongoing additional support provided by procurement to Facilities should be reviewed with an aim to reducing it over time as more Facilities staff complete training. Facilities staff should reminded suppliers that queries should be directed through 'Action Point' in the first instance, and not directly with the department.	Medium	We have requested the reinstatement of the 'invoices on hold' reports with an agreed frequency from procurement. Reports are generated and distributed	Chief Operating Officer	Head of Technical Services.	Oct-23			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
POW Theatres Fire Safety Works 2.1	Aug-22	Limited	The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Low	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Director of Strategy & Transformation	Project Director	At the business case	Now 2023 Now January 2023 Now March 2023 Now September 2023 Now December 2023 Now October 2024		In progress	December 2023 Update - Preferred option now agreed by the project board and programme updated. Business case is due for submission to WG October 2024. Adequate resources will be factored into the fees requested	October 2023 Update - Delays in the identification of the preferred option will further delay the preparation of the business case and preparation of appropriate resource schedules. This is a future recommendation based on a specific event and the date needs to tie in with the latest proposed business case date
POW Theatres Fire Safety Works 7.1	Aug-22	Limited	The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works	Low	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now September 2023 Now January 2024		In progress	December 2023 Update - This will be discussed with NWSSP in advance of tendering for the works and modular hire	October 2023 Update - Please see note above this will be part of the business case process
Interventions not Normally Undertaken 3.0	Oct-23	Limited	The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing.	Low	Review and update of waiting list 'holding names' to be undertaken.	Chief Operating Officer	Director of Operations Planned Care	Mar-24			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Facilities Systems Follow Up Review 5.0	Oct-23	Limited	Management to ensure that outstanding staff receive QlikView training as soon as practicable.	Low	Additional training sessions will be arranged with Finance colleagues to ensure that the staff who require the training receive it and training records are updated accordingly.	Chief Operating Officer	Quality Assurance, Performance and Compliance	07/10/2023			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Directorate Review Acute Medicine & A&E 13	Aug-20	Reasonable	An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	High	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Chief Operating Officer	General Manager	Apr-21	01/05/2021 August 2021/April 2022 Now September 2022 Now March 2023 Now June 2023 Now December 2023 Now February 2024		In progress	December 2023 Update - position remains the same as a consequence of staffing resource. It is hoped that the resolution of the OCP process will mitigate this situation. Too early to make a commitment - so update will be available for the meeting in February 2024.	October 2023 Update - no further progress to report. Until the vacancies that exist as a consequence of phase 2 of the OCP are filled there will not be the management capacity to undertake this piece of work.

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Financial Systems 8.1	Jun-22	Reasonable	Management should ensure that staff responsible for approving requisitions and processing purchase orders are aware of the correct procurement process as stated in the Requisition of Goods and Services FCPO and the All-Wales No PO No Pay policy.	High	Procurement will increase the training and cascade information relating to the No PO No Pay policy. We will identify the areas of retrospective ordering, implement a plan and ensure bespoke training to these areas.	Director of Finance	Head of Procurement	Jul-22	Now August 2022 Now November 2022 Now January 2023 Now March 2023 Now September 2023 Now End of March 2024		In progress	December 2023 - An update has not been provided against this recommendation on this occasion	October 2023 update - No PO Policy , Communication plan and exemption list on hold, as AW Finance academy have stood down the AW P2P group. As part of monthly P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). What does good Procurement session held with Care groups within Operational Management Board 12th July 2023. Further sessions held in Sept with Pharmacy, Pathology and Primary Care. October sessions booked with Planning and Communication teams, trying to finalise sessions with other Care groups. AW P2P governance group disbanded by Finance Academy. No governance exists, discussions ongoing with NWSSP and Finance academy.
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	Now August 2023 Now October 2023 Now December 2023 (as structure is under review)		In progress	December 2023 update - additional governance support has been provided with a view to review the governance structure. A further update will be provided in December 2023.	October 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including support for the governance role has been submitted to the Executive Board for approval. This post has not been reflected in the OCP document as it cannot be fully funded at present.
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	Now August 2023 Now December 2023		In progress	December 2023 update - ToR have now been produced in draft format. A Site Superintendent has been nominated to lead this work. A further update will be provided in December 23.	October 2023 Update - Initial scoping meeting took place on 13/09/23 with People's Services. An identified sponsor and leads to take this forward established. The leads are currently establishing a ToR and will arrange the T&F working group on completion of ToR.
Welsh Risk Pool 2.1	Jun-23	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes, appropriately recorded on Datix Cymru, and monitoring takes place to ensure compliance with this requirement.	High	In respect of LFER's a new process and SOP is being drafted to ensure timely submission of LFER's. In respect of CMR's there is a process that currently picks up on upcoming CMR's. The process around monitoring CMR's will be solidified by the new dashboard which will allow a more robust monitoring process. Individuals who have missed deadlines will be reminded of importance of CMR deadlines and provided with additional training & support.	Director of Nursing	Head of Claims & Inquest	Jun-23	Now September 2023 Now December 2023		In progress	December 2023 Update The SOP for LFERs has been amended following new Welsh Risk Pool reimbursement procedures - COMPLETED. Final comments received - COMPLETED. Due to go to Weekly Exec meeting for review in December 2023. All actions completed, however awaiting audit to be undertaken by the BI team to provide full assurance. This is due in December 2023	October 2023 Update Standard Operating Procedure for LFERs drafted and re-circulated for final comments. The SOP now includes an escalation process. CMRs and LFERs are already monitored via the weekly reporting process. LFER dashboard has been completed. Further developments are in process to ensure information is available to service areas. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs. Working to improve the CMR monitoring is underway. Rationale for Revised Implementation date: from September to December 2023-New Welsh Risk Pool Procedures came into force in September 2023 and therefore SOP had to be revised. This is now out for review. Audit programme is being developed for the Legal Services function by the BI team. Long term sickness of staff within the team resulted in a delay in progressing all actions
Bridgend Transfer of Informatics Services Follow Up 1.1	Apr-23	Reasonable	Consideration should be given to requesting that services fully quantify the impact of the lack of integration on the delivery of services and service change, with monitoring with reporting at an appropriate committee.	High	Bridgend disaggregation is reported to every Digital & Data Committee. This reporting will be reviewed to ensure it covers integration, service delivery and service change. The programme is currently developing a template which will assess the impact of any of the repatriation. The template is planned to be completed by June 2023.	Director of Digital	Director of Digital / Assistant Director of ICT	Qtr 2 2023/2024	Now end of Qrtr 3 2023/2024		Completed	December 2023 Update: Risks are now reviewed at every Bridgend Transition Board and any risks raised with the Joint Executive Group and the Digital & Data Committee - Propose to close	October 2023 Update - Further work required to complete this activity - propose to close end of Qtr 3 2023/2024
National Incident Framework 5.1	Aug-23	Reasonable	Management should ensure that incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. Management should review the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce the delays. There should be an agreed mechanism in place for ongoing monitoring and reporting of the key stages within the incident life cycle.	High	A process for providing and monitoring data in relation to the timescales for reviewing, investigating and closing of incidents on a weekly basis to be established. Information in relation to Incident Management Timescales to be included as part of the Care Group dashboard development work currently being undertaken. The information will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	Director of Nursing	Head of Concerns & Business Intelligence	01.09.23	Now November 2023		Completed	December 2023 update A baseline review of incident management has been completed. A thematic review of incident management across the DGH sites has been completed. A 12 month programme for the development of dashboards has been developed. Incident management dashboards have been developed for ward managers, Head of Nursing providing information on the incident status for incidents within their area. Incident Data by Care Group is provided to Care Group Leads on a monthly basis. To support this Care Groups dashboards are being developed which will provide live data at source. Open Incident data is included in the Incident Management trajectory slide presented to the Weekly Patient Safety Executive Meeting. Work will continue to evolve and develop incident management metrics.	October 2023 Update A baseline review of incident management is currently being undertaken. This will inform the scope and metrics to be included in the weekly reporting programme. A thematic review of incident management across the DGH sites has been completed. A 12 month programme for the development of dashboards has been developed. Incident management dashboards have been developed for ward managers providing information on the incident status for incidents within their area. Rationale for revised implementation date: From Sept to Nov 23 the plan for development will be finalised by the 01.11.23. Once the plan has been finalised, this action will be complete and the ongoing work required will continue. The information will be presented to the relevant groups from the 01.11.23.

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Performance Reporting Integrated Performance Report 2.1	Aug-23	Reasonable	The Standard Operating Procedure for preparing the performance report should be enhanced to fully set out the process for preparing the report. It should include more comprehensive information on how it is determined, which performance measures are to be reported on, how data should be checked for accuracy and completeness and a detailed monthly timetable for production that allows sufficient time for Executive review.	High	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	Director of Digital	Director of Digital	QTR 3 2023/2024	Now January 2024		In progress	December 2023 Update: Work Ongoing - Performance Framework being updated by end of December 2023 - proposing to take to January 2024 Board	October 2023 Update - Ongoing - work incomplete
Radiology Workforce Follow Up Review 3.0	Aug-23	Reasonable	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. Staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	High	Current compliance as at 10/07/23: • POW 82.5% • RGH 60.8% • PCH 66% Significant improvement noted at PCH with increased compliance from 39%. The team have booked and planned PDRs around incremental dates. All managers have been asked to review and ensure all dates are reflected accurately on ESR. It has been noted that some staff are lacking confidence in completing the new PDR document prior to the planned PDR. Staff are encouraged to engage in the process and work through the document with their line manage during the PDR or seek support prior to the PDR.	Chief Operating Officer	Site Superintendent Radiographers Radiographer Radiology Admin Manager	Ongoing	Now February 2024		In progress	December 2023 update - at the end of September the compliance was reported at 65.07% compliance. A number of staff at POW are now out of compliance and work is being undertaken to address and improve the situation. There will be further a update at the next meeting.	October 2023 update - Current compliance for September 2023 71.93%. Previous compliance for August 2023 71.02%. The team continue to drive performance compliance with site plans.
IT Infrastructure 5.1	Oct-23	Reasonable	Doors to rooms should be locked when not in use, and signage that indicates where equipment is held should be removed. Rooms used to house equipment within PoW, should be assessed to ensure appropriate power and heat protection is in place.	High	This action will be reviewed in detail and prioritised plan will be developed in order to ensure the areas of highest risk are addressed.	Director of Digital	Assistant Director of Digital Delivery	30/11/2023			Completed	December 2023 Update - The detailed plan to assess and remediate high risk areas is being finalised and will be ready by the 30/11/2023. Assessment and remediation work will then be undertaken	
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 Now November 2023 Now January 2024		Part Completed	December 2023 Update - there has been no progress with regard additional Capital resources. Issues with server security certification has delayed further the data migration and was resolved on 24 November 2023 between ICT, DHCW and supplier, therefore no further progress has been noted on this. Target date now for RF-ID migration 15 January 2024 and further information will be available at the next meeting.	October 2023 Update: Capital bid logged on SON system indicating costs for POW and RGH as described previously. Issues experienced with server access for Kinsetsu RF-ID data migration, ICT working on resolution to enable completion and test of data migration. ICT de-segregation work still on-going and therefore no further progress on POW access for cross site systems previously mentioned. Due to these issues, target date now for RF-ID data migration 30/11/2023
Directorate Review Acute Medicine & A&E 04	Aug-20	Reasonable	1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Chief Operating Officer	ILG Directors/ General Manager	September 2020/December 2020	01/04/2021 Now April 2022 Now December 2022 Now February 2023 Now June 2023 Now December 2023 as a consequence of management capacity and vacancies. Now January 2024		Part Completed	December 2023 - situation remains the same as a consequence of lack of resource in staff. Anticipated that the OCP process will resolve this - but too early to make any commitment in this area. Update will be available in January 2024.	October 2023 - no further progress to report. Until the vacancies that exist as a consequence of phase 2 of the OCP are filled there will not be the management capacity to undertake this piece of work.
Sunnyside Health & Wellbeing Centre 01	Aug-21	Reasonable	Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	Medium	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Director of Finance	Head of Capital	Sep-21	Now January 2022 Now 31 March 2022 Now May 2022 Now August 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023 Now January 2024		In progress	December 2023 Update - An addendum to the approved FBC was approved by Welsh Government and a revised funding letter was issued 21st November. The project can now restart and the full meeting structure re established. This was initiated at Project Board on the 23rd November where previous ToR for the subgroups were shared with members for review with updates to be provided before the next meeting for review and sign off	October 2023 Update - An addendum to the approved FBC has been prepared and is due to be submitted to Welsh Government by the 21st September. If this is approved at the October scrutiny panel then the project can be re-started and all documentation and the full meeting structure will restart, this includes steering groups, financial reporting, risk registers etc
Sunnyside Health & Wellbeing Centre 04	Aug-21	Reasonable	Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	Medium	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023 Now November 2023 Now January 2024		In progress	December 2023 Update - Date revised as approval received in November. Contract expected to be signed late November/early December. Provisional sums and contingency values will be reported through the project Board structure when the reporting for the scheme re starts in January 2024.	October 2023 Update - The date has been revised from September to November as there was a delay in the receipt of the final tender and then the tender report. This means that the revised business case can not be submitted until 21st September and earliest approval is going to be mid - late October. The new contract sum as the outcome of the tender process will confirm the provisional sums and contingency values and once these are part of the Welsh Government approved funding sums they can be reported through the project Board structure. If approval is late October it is expected that this reporting can start for the November project Board
Sunnyside Health & Wellbeing Centre 05	Aug-21	Reasonable	Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	Medium	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Director of Finance	Senior Project Manager	Jan-22	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now December 2023 Now March 2024		In progress	December 2023 Update - Business case approved in November, Contract expected to be signed late November/early December. There is unlikely to be a PM/CA report provided covering the December period but this will be restarted in time for return after this which is due in March 2024 (returns are bi monthly)	October 2023 Update - This is on track as long as the business case is approved by late October 2023 and will be part of the new contract expected to be let by December 23 subject to approvals.

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Sunnyside Health & Wellbeing Centre 07	Aug-21	Reasonable	Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	Medium	These are available and will be supplied by the developer.	Director of Finance	Senior Project Manager	Sep-21	Now November 2021 Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Review July 2023 but could be later depending on timings of approvals Now November 2023		In progress	December 2023 Update - As above, funding approved in November, contract due to be signed and then all required documentation will be requested	October 2023 Update - As above if funding is approved then by November the contractor will have to supply all required documentation under the contract
Sunnyside Health & Wellbeing Centre 10	Aug-21	Reasonable	Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	Medium	This will be provided when the project restarts and all design works are completed.	Director of Finance	Senior Project Manager	No Date Identified	01/03/2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023 Now December 2023		In progress	December 2023 Update - Linc are due to enter into contract for the completion of the health centre late November/early December. Once signed the new contractor will agree the form of contract variations and the HB will implement the arrangements for sign off of variations outlined in the updated PEP	October 2023 Update - Again on entering into contract for the completion of the health centre the new contractor will agree the form of contract variations to and the HB will implement the arrangements for sign off of variations outlined in the updated PEP
Sunnyside Health & Wellbeing Centre 11	Aug-21	Reasonable	The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	Medium	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023 Now December 2023		In progress	December 2023 Update - Once the new contract is signed a reminder will be given to the contractor of the requirement for a contractual notification of any delays	October 2023 Update - Once funding is approved and the contractor appointed these reminders will be made
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 Now January 2024		In progress	December 2023 Update - This will form part of monthly reporting to the Board which will restart in full detail from January in contract is signed in Nov/Dec	October 2023 Update - This will be updated monthly as part of the Project Board and steering group reporting on approval of the business case alongside contingency monitoring and reporting referenced above
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 Now January 2024		In progress	December 2023 Update - This will form part of monthly reporting to the Board which will restart in full detail from January in contract is signed in Nov/Dec	October 2023 Update - See above point
Sunnyside Health & Wellbeing Centre 15	Aug-21	Reasonable	The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	Medium	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Director of Finance	Project Leader	Sep-21	Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023 Now December 2023		In progress	December 2023 Update - As soon as new contracts are signed (late Nov/Early Dec) these will be requested from the developer ,reviewed and reported on as appropriate	October 2023 Update - This needs to be deferred to November as can not be implemented until the new contract is entered into. At the moment, subject to WG approval timeframes this is expected to be in late October / early November.
Sunnyside Health & Wellbeing Centre 18	Aug-21	Reasonable	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Medium	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Director of Finance	Primary Care Estates and Development Manager	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now October 2023 Now June 2024		In progress	December 2023 Update - At November Project Board, following confirmation of approved funding , it was agreed that Lease discussions with the GP practices can recommence . Draft Heads of Terms previously were previously shared between solicitors	October 2023 Update - Once the business case is agreed and costs known then Shared Services can re-commence lease discussions with the GP practices and work towards production of signed lease documents.
Sunnyside Health & Wellbeing Centre 19	Aug-21	Reasonable	Management should confirm an agreed service model with measurable outcomes for front line and support services.	Medium	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Director of Finance	Bridgend ILG Community Lead	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now June 2024		In progress	December 2023 Update - This will be led by the Primary and Community Care Group and the relevant steering group. At Project Board on the 23rd November ToR for the subgroups were shared with members for review with updates to be provided before the next meeting for review and sign off. This included as a key responsibility for the relevant group but as recommendation will not be complete until service model is agreed the revised implementation date has been moved to 6 months into the project	October 2023 Update - This will now be led by the Primary and Community Care Group and the relevant steering group will be re-started as soon as business case approval is given.
Sunnyside Health & Wellbeing Centre 20	Aug-21	Reasonable	Objectives at the business case should be measurable.	Medium	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023 Now February 2024		In progress	December 2023 Update - Benefits will be periodically reviewed as part of the Project Board agenda. The frequency of this will be discussed in February 2024 as there are other significant agenda items in Dec/Jan	October 2023 Update - This will be part of the Project Board agenda alongside review of the risk register

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Sunnyside Health & Wellbeing Centre 21	Aug-21	Reasonable	Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	Medium	Please see response above .	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023 Now February 2024		In progress	December 2023 Update - Benefits will be periodically reviewed as part of the Project Board agenda. The frequency of this will be discussed in February 2024 as there are other significant agenda items in Dec/Jan	October 2023 - Please see above
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 Now December 2023 - as no response received, has now been chased specifically with Finance colleagues. Now February 2024		In progress	December 2023 Update - Following a lack of progress, a meeting has been set up in December with Finance Colleagues to finish draft and work towards finalising the Financial Control Procedure.	October 2023 Update Sian Lewis liaised with Finance on 03.10.23 to advise this is the only outstanding item left from our Audit. Finance will look into this and provide us with an update of a completion date.
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 Now August 2023 Now October 2023 Now January 2024		In progress	December 2023 Update - The non-consultant rate card launched on the 19th October 2023. As per the previous update work is progressing to develop the Consultant Rate Card ready for launch in early 2024.	Update October 2023 - Following approval by the Executive Leadership Group the non-consultant rate card will be launched on the 19th October 2023. Work is now underway to develop a comparable proposal regarding a Consultant Rate Card. This will require the development of a proposal, Executive approval and engagement with key stakeholders.
Welsh Risk Pool Claims 1.1	Jun-22	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes and monitoring takes place to ensure compliance with this requirement.	Medium	1.1a Legal Services SOPs to be reviewed and updated. 1.1b Monitoring process to be implemented in respect of deadlines for various paperwork submissions. 1.1c Spot check audit to be undertaken bi-monthly on paperwork submissions against deadlines i.e. CMRs, LFERs etc.	Director of Nursing	Legal Services Manager	1.1a Dec 2022 1.1b June 2022 1.1c August 2022	Now February 2023 Now May 2023 Now July 2023 Now September 2023 Now December 2023		In progress	December 2023 update actions completed. All drafted. Audit tool undertaken to provide full assurance. Awaiting audit to be	October 2023 Update Staff are aware of the importance of completing all required fields in Datix Cymru during the weekly team meeting. An audit tool is in draft form. Baseline validation exercise of open claims currently being undertaken. Spot check audit planned for the end of the year. Rationale for revised implementation date from Sept to Dec 23: Audit programme is being developed for the Legal Services function by the BI team Long term sickness of staff within the team resulted in a delay in progressing all actions
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 Now July 2023 Now September 2023 Now December 2023		In progress	December 2023 Update Management agreed actions completed. CRM report being undertaken by the BI Team. Thus providing further assurance for the monitoring process.	October 2023 Update Standard Operating Procedure for LFERs drafted, consultation with staff, with changes made and out for final comment. Deep dive review being undertaken facilitated by the BI Team, to ensure that CMRs have been appropriately triggered. Thus providing further assurance for the monitoring process. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs
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) Now November 2023 pending AW P2P group		In progress	December 2023 - An update has not been provided against this recommendation on this occasion	October 2023 update - Alternative methods of payments being reviewed as part of AW PO exemption list T&F group. First meeting held 15th September 2023. AW T&F group being led by Head of Corporate finance and Head of Procurement, good output from initial group actions being agreed virtually but no overarching Governance group as AW finance academy disbanded the group.

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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 Now November 2023		In progress	December 2023 - An update has not been provided against this recommendation on this occasion	October 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly
Financial Systems 8.4	Jun-22	Reasonable	Documentation to support all orders should be retained made available if required	Medium	Documentation will be made available via SharePoint.	Director of Finance	Head of Procurement	Mar-23	Now May 2023 Now June 2023 Now September 2023 Now November 2023		In progress	December 2023 - An update has not been provided against this recommendation on this occasion	October 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 November 2023. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB.
Medical & Dental Rostering Follow Up Review 3.1	Aug-22	Reasonable	The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff.	Medium	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	Medical Director & Director for People	Head of workforce productivity and E-Systems	Nov-22	Now February 2023 Now March 2023 Now June 2023 Now September 2023 Now December 2023		In progress	December 2023 Update - Pending December 2023 LNC meeting - aim to have completed	October 2023 Update - The paper went to LNC and returned with some feedback in which we are working with and amending the policy. This will be discussed at the December LNC for further review with said amendments.
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	December 2023 Update: Started to colocate some of the Records staff at Bridgend but this is a significant piece of work which will run through 2024/2025	October 2023 Update - Work Ongoing New Assistant Director of Digital Transformation - with responsibility for the Medical Records team has now commenced in post. Core part of their role will be to take this work forward
Radiology Service Review 2.1	Dec-22	Reasonable	a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	Medium	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancelation the members will review the agenda to assess whether there are any urgent matters that require action and re arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	Chief Operating Officer	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads	30-Nov-22	Now March 2023 Now April 2023 Now August 2023 Now October 2023 Now December 2023 (as a consequence of Phase 2 and decisions to be taken).		In progress	December 2023 update - additional governance support has been provided to facilitate a review of the governance structure. A further update will be provided in December 2023.	October 2023 update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager. A management structure including the governance role has been submitted to the executive board for approval. This is not reflected in new structure in OCP document as it cannot be fully funded at present. ToR established and Vice Chair appointed.

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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 Now August 2023 Now October 2023 Now December 2023 (as a consequence of Phase 2 and decisions to be taken).		In progress	December 2023 update - additional governance support has been provided to facilitate a review of the governance structure. A further update will be provided in December 2023.	October 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including the governance role has been submitted to the executive board for review in Phase 2. This post has not been included in the OCP document as it cannot be fully funded at present.
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	Now October 2023		Completed	December 2023 Update - All staff members outstanding have been contacted. This action is now closed.	October 2023 Update - Request made for list of Radiology staff who would need to have signed the DOI is complete. If incomplete the Care group will encourage individuals to complete asap. Those listed have been contacted in September to complete their DoI submission. The two Radiographer staff have been actioned. The 3 M&D staff have been contacted.
Welsh Risk Pool 1.1	Jun-23	Reasonable	1.1a Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases. 1.1b Regular monitoring of the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported	Medium	1.1a Staff will be reminded of importance in next meeting in respect of closure. A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team. A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required. 1.1b In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	Director of Nursing	Head of Claims & Inquest Legal services Manager Head of Concerns & Business Intelligence	Jun-23	Now September 2023 Now December 2023		In progress	December 2023 Update A checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. An SOP to support the training has been developed. Training has been delayed due to long term sickness within the team. This is now due to take place December 2023 Monthly audits will commence in 12th December 2023. A final audit is due by the end of the year, which should show compliance and therefore enabling this action to be closed.	October 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. A draft checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. An SOP to support the training has been developed, further guidance regarding stages is in the process of being completed. Monthly audits will commence when guidance and training has been completed. A final audit is due by the end of the year, which should show compliance and therefore enabling this action to be closed. Rationale for revised implementation date: from Sept to Dec 23-Long term sickness of staff within the team resulted in a delay in training and therefore a delay to the commencement of the audit programme
Welsh Risk Pool 2.2	Jun-23	Reasonable	Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	Medium	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	Director of Nursing	Legal services Manager Head of Concerns & Business Intelligence H	Jun-23	Now September 2023 Now December 2023		In progress	December 2023 update All actions are complete. Audit programme of new, closed and ongoing claims planned for December 2023	October 2023 update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. Validation of LFER is completed as part of the production of the weekly report. A cross reference of all deferred LFERs against WRP information was completed at the beginning of July 2023. Audit programme of new, closed and ongoing claims planned for December 2023. Rationale for revised implementation date: from Sept to Dec 23 Long term sickness of staff within the team resulted in a delay in training and therefore a delay to the commencement of the audit programme.
Concerns Follow Up Review 3.1	Jun-23	Reasonable	3.1a Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes. 3.1b A training programme should be put in place to deliver the identified concerns training requirement. 3.1c A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward.	Medium	3.1a Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training 3.1b Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board 3.1c Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	Director of Nursing	Head of Concerns & Business Intelligence	3.1a August 2023 3.1b October 2023 3.1c October 2023	Now January 2024		In progress	December 2023 Update The Incident Management Framework and Concerns Policy & Procedures are currently being reviewed. To support the implementation of these documents a training strategy is being developed. Once these documents have been finalised a training needs analysis will be undertaken in conjunction with the Care Groups. A rolling 12 month training programme will established to support the robust management and investigation of concerns.	October 2023 Update The Incident Management Framework and Concerns Policies & Procedures are currently being reviewed. To support the implementation of these documents a training strategy is being developed. Once these documents have been finalised a training needs analysis will be undertaken in conjunction with the Care Groups. A rolling 12 month training programme will be established to support the robust management and investigation of concerns. Rationale for revised implementation date: From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.

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Concerns Follow Up Review 4.1	Jun-23	Reasonable	The information within the draft Early Resolution SOP in relation to re-classification of cases to PTR status should be reviewed to provide greater clarity on the exact timeframe and process to be followed.	Medium	Early Resolution SOP to be reviewed in line with the updated PTR Guidance, with more clarity around timeframes and process.	Director of Nursing	Concerns Manager	Jun-23	Now September 2023 Now December 2023		In progress	December 2023 Update A standard operating procedure for the management of early resolution complaints is in place. Further review will be required following the release of the updated Putting Things Right Guidance	October 2023 Update A standard operating procedure for the management of early resolution complaints is in place. Further review will be required following the release of the updated Putting Things Right Guidance. Rationale for revised implementation date: From Sept 23 to Dec 23 Finalisation of this action has been impacted by the review of Putting Things Right.
PCH Programme Redevelopment 1.1	Aug-23	Reasonable	The Planning, Performance and Finance committee will receive a regular update/ assurance on the PCH Refurbishment Programme	Medium	Agreed. In line with Audit Wales recommendation regular reporting will be provided to the Planning, Performance & Finance Committee and the Board.	Director of Finance	Director of Finance/ Head of Capital	Aug-23			Completed	December 2023 Update - Capital Update Provided to PPF on the 31st October and then to Board on the 30th November. Now added to the cycle of business to report every 3 months in this way	
PCH Programme Redevelopment 2.1	Aug-23	Reasonable	A timeline will be agreed for the reintroduction of monitoring of those community benefits suspended during the covid pandemic.	Medium	Agreed. A recent appointment within Supply Chain Partner has seen an improved engagement on community benefits.	Director of Finance	Responsible Officer PCH Programme	Aug-23	Now December 2023		Completed	December 2023 Update - All measures are now being reported on at the monthly Site Progress meeting and in the subsequent Project Manager's report.	October 2023 Update - Of the 9 measures temporarily suspended during the Covid period, 2 have re-commenced reporting and the remaining 7 have been instructed to recommence. The implementation date will need to change to the next reporting period as the data will take time to collate
Decontamination 1.0	Aug-23	Reasonable	The decontamination policy should be reviewed and updated to reflect the most up to date guidance and practices. The revision should ensure that the updated policy reflects the current decontamination monitoring arrangements, the roles and responsibilities of Decontamination Officer and the role and purpose of the Local Decontamination Groups. The policy should also reflect the impact of the Health Board's new operating model. Once revised and approved, the policy should be made available to relevant staff.	Medium	1a Update the Decontamination of Reusable Medical and Surgical Devices Policy (IPC 27). 1b Present the updated policy to the appropriate oversight committee for ratification. 1c Implementation of the updated policy to include appropriate team briefing and advisory support.	Director of Nursing	Deputy Lead IPCN/ Decontamination Lead	1a Sept 2023 1b Oct 2023 1c Nov 2023	1a October 2023 1b December 2023 to Decontamination Committee/ IPCC January 2024 1c January 2024 1a October 2023 Out for Comment 1b December 2023 to Decontamination Committee/ IPCC January 2024 1c January 2024		In progress	December 2023 Update The Decontamination Policy has been updated and is currently out for comment prior to it being presented at the next Decontamination Committee meeting on the 5th December 2023 prior to going to IPC Committee in January 2024	October update 2023- The Decontamination Policy is being reviewed and will be presented at the next Decontamination Committee meeting on the 5th December 2023 prior to going to IPC Committee in January 2024 Rationale for revised implementation date from Nov 23 to Jan 24 - Policy was not ready to be presented to last Decontamination committee which has delayed the approval process.
Decontamination 2.0	Aug-23	Reasonable	A review of locally held decontamination procedures should be carried out to ensure standardised approach to the quality, content and approval.	Medium	2a Audit tools for approval in the next Decontamination Committee meeting (see action 5.1). 2b Audit programme to be carried out across all appropriate areas within CTM to inform local SOP status and revisions where required (see action 5.2). 2c All local SOPs are to have been reviewed and ratified for ongoing implementation.	Director of Nursing	Deputy Lead IPCN/ Decontamination lead	2a Sept 2023 2b July 2024 2c September 2024			In progress	December 2023 Update Audit tools finalised and audit programme commenced. A SOP template for decontamination has been developed and will be presented at the Decontamination Committee meeting in December 2023.	October 2023 Update 04/10/23 - The Endoscopy, sterile service department and theatre audit tools were agreed in the Decontamination meeting on the 21/09/23. The audit programme has commenced. A SOP template for decontamination will be developed and presented at the Decontamination Committee meeting in December 2023 for circulation and use.

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Decontamination 3.0	Aug-23	Reasonable	Arrangements be put in place to ensure that there is a dedicated Microbiologist (Decontamination) in place for Princess of Wales site as soon as practically possible.	Medium	3a Escalation to the Deputy Medical Director and escalated to the last IP&C Committee meeting (11/07/23). 3b Multi-stakeholder meeting to discuss the current arrangements with active service level agreements, Public Health Wales and CTM to inform the programme of work required to reach an appropriate substantive outcome. 3c Outcome report and appropriate plan from stakeholder engagement to be presented to IPC Committee meeting.	Director of Nursing	3a Lead IPC Nurse Deputy Medical 3b Director and Deputy 3c Director of Nursing Deputy Medical Director	3a July 2023 3b September 2023 3c October 2023	3b October 2023 3c January 2024		In progress	December 2023 update 29/11/23 Concerns escalated to Deputy Medical Director. The issue was discussed further in IP&C committee on the 17/10/23. We have been informed that the Consultant cover in POW will form part of the IP&C strategic review. The Deputy Executive Director of Nursing is leading the review.	October update 04/10/2023 - There is no dedicated Consultant Microbiologist for Decontamination at the Princess of Wales Hospital. This is a requirement for SSD accreditation and will be raised at IPC committee on the 17/10/23. Rationale for revised implementation date - Multi stakeholder meeting to take place in October 2023, outcome report to follow
Decontamination 5.0	Aug-23	Reasonable	A schedule/programme of independent decontamination audits be implemented to evaluate and assess the decontamination facilities/arrangements across the Health Board. The outcome of these audits be summarised into a report for presentation to the Decontamination Committee so that appropriate actions can be taken.	Medium	5a Decontamination audit tools are currently being developed. Three audit tools will be taken to the next Decontamination Committee meeting for approval. Decontamination audit programme to commence. 5b Audit program to review decontamination facilities/arrangements across the Health Board to inform all appropriate future governance.	Director of Nursing	Deputy Lead IPCN/Decontamination Officer	5a Sept 2023 5b June 2024			In progress	December 2023 update 3 audit tools agreed in September 2023 as planned. Action 5a completed.	October Update 4/10/23 - 3 audit tools agreed in September 2023 as planned
National Incident Reporting Framework 1.1	Aug-23	Reasonable	Management should ensure all out of date guidance documents are removed from the intranet and only relevant policies and procedures are made available.	Medium	All policies and procedures relating to Incident & Concerns Management will be uploaded to SharePoint and previous versions removed.	Director of Nursing	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	01.10.23	Now January 2024		In progress	December 2023 Update Following approval of the Concerns Policies & Procedures, Incident Reporting Policy and Incident Management Framework a review of all SharePoint sections relating to Concerns, Datix, Quality & Safety will be reviewed and updated.	October 2023 update Following approval of the Concerns Policies & Procedures, Incident Reporting Policy and Incident Management Framework a review of all SharePoint sections relating to Concerns, Datix, Quality & Safety will be reviewed and updated. Rationale for revised implementation date: From Oct 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.
National Incident Framework 1.2	Aug-23	Reasonable	The Incident Management framework should be reviewed and updated where necessary to take account of the Health Boards new operating model, the recently published updated guidance and incorporate information on reporting processes.	Medium	The Health Board's Incident Management Framework to be reviewed in line with the recommendation, duty of Candour requirements and agreed proposal to remove reference to the Locally Reportable Incident Proforma.	Director of Nursing	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	01.10.23	Now January 2024		In progress	December 2023 Update A task and finish group has been established to review the Incident Management Framework. A number of meetings have been held and input received from key leads. The document will be circulated for consultation on the 04.12.23. The final document will be submitted to January's Quality & Safety Committee. Cross reference to the Incident Reporting policy, Concerns Policy & Procedures and NHS Executive Policy is included as part of the review. The Central patient safety team are members of the All Wales Investigation Management Process task and finish group, led by the NHS Executive and actively involved in the development of the policy. A project has been initiated centrally, to introduce patient safety link nurses to all appropriate Health Board areas, this project is in its infancy with support from the QI team.	October 2023 update A task and finish group has been established to review the Incident Management Framework. The first meeting took place on 14.08.23. A further meeting has been arranged for 18.09.23. Cross reference to the Incident Reporting policy, Concerns Policy & Procedures and NHS Executive Policy is included as part of the review. Rationale for revised implementation date: From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.
National Incident Framework 2.1	Aug-23	Reasonable	The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend incident management training and RCA training. As part of the process of identifying staff training needs, consideration should be given to if refresher training on Datix is required.	Medium	A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements. Following approval of the Strategy, a training need analysis will be undertaken and a training Programme established.	Director of Nursing	Clinical Lead for Serious Incidents Head of Concerns & Business Intelligence	01.11.23	Now January 2024		In progress	December 2023 Update A training strategy is being developed which reflects the scope of the Concerns Policy & Procedures, Incident Management Framework and Datix Cymru requirements. The strategy is being developed alongside the review of the Concerns Policy & Procedures and Incident Management Framework. An analysis has been completed of all records held centrally, of health board staff that have received RCA training since 2019. The staff records have been identified into their care groups and are being cascaded to the Heads of Quality and Safety and triumvirates. To support the training needs analysis to be undertaken. RCA training has recently been updated following extensive evaluation of user feedback. The training is delivered by the central patient safety team, via the articulate platform, plus a face to face session 6 weekly across all HB sites. Bespoke care group training sessions are being developed for all staff groups, with drop in sessions for Q&A.	October 2023 Update The Internal Audit for Complaints and Incident Management both include recommendations for the undertaking of a training needs analysis. A joint approach will be adopted to develop a training strategy for the investigation of concerns (complaints & incidents) that will identify the levels of training that are required i.e. awareness, management review, complex concern / RCA investigation training. Rationale for revised implementation date: From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.

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National Incident Framework 2.2	Aug-23	Reasonable	In the meantime, it should be ensured that at least one member of the investigation team on cases is RCA trained.	Medium	Ensure that a member of the Investigation Team has received the appropriate RCA Training. Remind Care Group Leads of the requirement to include one appropriately RCA trained member in the Investigation Team. Undertake checks during the Quality Assurance Process to confirm the requirement has been fulfilled. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	Director of Nursing	Clinical Lead for Serious Incidents	01.09.23	Now January 2024		In progress	December 2023 Update All incidents reported are subject to a quality assurance process via the Care Group structure and this forms part of the questions raised at the Quality Assurance panels. Oversight of this is undertaken by the Quality & Safety / Patient Safety Team. These arrangements will be outlined in the Incident Management Framework. The assurance process commences at the initial rapid review meeting. There is a dedicated proforma for the review and care group or central governance leads attend all rapid reviews providing assurance of a suitable investigator that is RCA trained. All documents are available as appendices uploaded to the Investigation Framework on SharePoint. QA documents are uploaded to the Datix system by the central admin team following the approval of NRI closure bundles by the Executive team.	October 2023 update All incidents reported are subject to a quality assurance process via the Care Group structure and this forms part of the questions raised at the Quality Assurance panels. Oversight of this is undertaken by the Quality & Safety / Patient Safety Team. These arrangements will be outlined in the Incident Management Framework. Rationale for revised implementation date: From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.
National Incident Framework 3.1	Aug-23	Reasonable	Management should ensure all documentation in relation to NRIs is appropriately completed with relevant documentation saved to Datix. This includes: • Evidence of rapid review meetings taking place or confirmation that one was not required. • NRI forms capturing the proposed investigation timeline which will allow future monitoring and reporting to take place. • The quality assurance checklist recording all relevant information such as who the RCA training investigators are, as opposed to just ticking that someone is RCA trained. • All relevant fields within Datix completed as required. • Copies of the RCA report saved to Datix. • A consistent approach to the saving of panel minutes to Datix, giving consideration to if a panel reviews more than one case, the data protection implications of saving the full set of minutes to individual Datix records.	Medium	Reminder to be sent to all Care Groups of the need to ensure that all documentation has been uploaded to Datix Cymru. Datix Cymru Incident Management Training to include the requirement to upload all documentation to Datix Cymru. The quality assurance process will include a check that ensures all required documentation has been uploaded. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible Care Group.	Director of Nursing	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	01.09.23	Now January 2024		In progress	December 2023 Update The quality assurance checklist is currently being reviewed and updated as part of the review of the Incident Management Framework. Staff are also reminded in the Face to face RCA training session and at all other opportunities, to upload all documents to Datix, complete progress notes and utilise the actions module to log and assure all actions are completed.	October 2023 Update An email was sent out to all Care Groups Leads by the Executive Director of Nursing, Midwifery and Peoples Service on 05.07.23. A follow up email was sent on the 05.08.23. The quality assurance checklist is currently being reviewed and updated as part of the review of the incident management framework. Rationale for revised implementation date: Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.
National Incident Framework 4.1	Aug-23	Reasonable	Further work should be carried out to explore the option of accessing the action plan module in Datix, thus allowing the NRI to be closed in Datix more timely following completion of the investigation, yet still allowing the monitoring of the implementation of actions. Whilst this option is explored, it should be ensured that the action plans saved to Datix are adequately completed with evidence of actions taken to date and if necessary, a process for following up on actions following submission of the paperwork to the NHS Wales Executive (formerly the DU.)	Medium	Ensure that all required staff have access to the actions module and appropriate training is provided. This will be linked to the implementation of the revised Incident Management Framework. The quality assurance process will include an assessment to confirm that an action plan has been developed and upload to Datix Cymru. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	Director of Nursing	Head of Concerns & Business Intelligence	01.10.23	Now December 2023		In progress	December 2023 Update A programme for robust implementation of the actions module is currently being developed. Requirements for recording actions within Datix Cymru will be included in the revised Incident Management Framework. The action module will be used for all upheld PSOW cases from the 04.12.23.	October 2023 Update A programme for robust implementation of the actions module is currently being developed. A meeting took place on the 19.09.23 to support the implementation of the actions module within Mental Health. This work will then be progressed across the care groups. Mechanisms and templates for Extrapolation of action plans for monitoring and reporting are being developed. Rationale for revised implementation date: From Oct to Dec 23 This action has commenced but requires further time to roll out and embed across the organisation.
Performance Reporting Integrated Performance Report 1.1	Aug-23	Reasonable	The draft performance management framework should be reviewed to ensure: • There is alignment to the most up to date Welsh Government Performance Framework, ensuring all metrics and measures outlined are accurate and there is link the IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made available to relevant staff.	Medium	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Director of Digital	Executive Director of Strategy & Transformation / Director of Digital	QTR 4 2023 / 2024	Now December 2023		In progress	December 2023 Update: Performance framework being produced / plan to complete by December 2023	October 2023 Update - Work Ongoing - no progress to date
Radiology Workforce Follow Up Review 4.1	Aug-23	Reasonable	Management at RGH should continue to liaise with the Learning and Development team to ensure the suggested amendments to learning profiles are implemented on ESR. It should be determined if similar exercises to refine learning requirements are required for staff at the PCH and POW sites.	Medium	Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development.	Chief Operating Officer	Superintendent Radiographer Quality and Governance	Sep-23	Now December 2023 Now February 2024		In progress	December 2023 Update - work ongoing with learning development team as described in October. There have been issues identified with spaces for training for Resus and Patient Handling. Work is ongoing and there will be an update at the next meeting.	October 2023 Update - Contact made with People's Services and L&D. The workforce team has been assigned to create new ESR positions for roles where there are differing requirements. Awaiting a further update from L&D. People's Services have also sent a chaser email.

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Radiology Workforce Follow Up Review 4.2	Aug-23	Reasonable	The CSG should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	Medium	Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	Chief Operating Officer	Radiology Clinical Service Group Manager	Ongoing	Now December 2023 (date not included in the last update)		In progress	December 2023 update - staff are encouraged to undertake core mandatory training. Training dates for departmental Resus and Patient Handling have been issued for December and January.	October 2023 Update - Current compliance September 2023 64.13%. Increased compliance since August 2023 - from 64.04%. Teams are driving compliance in all areas. BILS training booked for Consultants on 09/10/23. Monthly reports sent out to all superintendents. Plans being developed to run in house training for Resuscitation and Manual Handling.
IT Infrastructure 2.1	Oct-23	Reasonable	Older, out of support devices should be removed from use.	Medium	Continue to prioritise and review aged assets with a view to replacement, balanced with limited funding sources. Manage and maintain the related risk within the Departmental risk register.	Director of Digital	Assistant Director of Digital Delivery	Ongoing			In progress	December 2023 Update - Aged assets will continue to be reviewed and replacement prioritised balanced against limited funds. Funding decisions around AWIP are due mid-December, funding for the cyber bid has been approved.	
IT Infrastructure 3.1	Oct-23	Reasonable	Documentation should be produced that sets out the processes for: - Managing and configuring Solarwinds; and - Handling of alerts.	Medium	The individual has now left. Management of the SolarWinds platform is now shared across the infrastructure team, although there is no lead and documentation produced is of limited value. Develop the skills and documentation within the team to maximise the use and value of the system for monitoring purposes. Recruit Additional staff in line with the Infrastructure Review resource plan.	Director of Digital	Assistant Director of Digital Delivery	Jun-24			In progress	December 2023 Update - Recruitment has been successful into our cyber team that will pick up this action.	
IT Infrastructure 4.1	Oct-23	Reasonable	The approach to patching and the mechanisms for undertaking this should be set out within formal documentation.	Medium	Create a patching policy and procedure document to cover patching of managed devices.	Chief Operating Officer	Interim Head of Cyber Security	Dec-23			In progress	December 2023 - An update has not been provided against this recommendation on this occasion	
Health & Safety Management 06	Aug-20	Reasonable	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Director for People	Head of Health, Safety & Fire	01/01/2021 Now 31 May 2022	01/07/2021 Trial Audit on Social Distancing completed August 2021. New completion date for audit package to be suitable for H&S Audits 31/01/2022 Now May 2022 Now September 2022 Now February 2023 Now June 2023 Now December 2023 Now June 2024		Part Completed	November 2023 Update - The Health and Safety Team will be undertaking 1 main audit and 2 flash audits using iPassport over the next 6 months to enable an evaluation of iPassport.	October 2023 Update - The Health and Safety Team have fully explored the use of AMaT to undertake these type of audits. The AMaT package is unable to manage these audits so the Team are currently undertaking 2 further audits using a package called iPassport (used within Pathology services). Once the 2 audits have been completed an evaluation of the system capabilities will be undertaken.
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 Now November 2023 Now January 2024		In progress	December 2023 Update - Plan for performance monitoring will be agreed by Project Board. Contract will confirm agreed KPIs and will be used to monitor ongoing performance.	October 2023 Update - Date delayed to expected date of appointment of new contractor when this can be put in place. Reasons for delay have been covered above

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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 Now November 2023 Now January 2024		In progress	December 2023 Update - As above , once signed the new contractor will agree the form of contract variations and the HB will implement the arrangements for sign off of variations outlined in the updated PEP	October 2023 Update - Variations have been mentioned above and the process will be confirmed to all parties on updated the PEP and recommencement of the project post approvals, timescales have been adjusted slightly in line with this
CSG & ILG Quality Assurance 2.0	Aug-22	Reasonable	Quality governance training should be provided to all relevant staff in the ILGs and their constituent CSGs to ensure a sound understanding of quality assurance principles and practices	Low	The Health Board launched a new Patient Safety Incident Management Framework and Toolkit in June 2022. This describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. In July 2022, the Health Board also launched a rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience. The training also introduces the important concepts of psychological safety, human factor errors and safety thinking. Attendance is recorded on the Health Board's Electronic Record System, which ensures that those undertaking incident investigations are appropriately, and consistently trained to improve standards and performance. Bespoke Datix training has been rolled out by the Datix Management Team following the adoption of the Once for Wales incident module, and is ongoing. The corporate team have initiated good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. Training sessions are supported by the Health Board's Communication channels, Intranet SharePoint system where further information and assistance for colleagues is signposted by the Patient Care and Safety site. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework.	Director of Nursing	Assistant Director Quality & Safety	The nature of this action is ongoing; however, the new structure will provide an opportunity to target CSGs. Quality & Patient Safety Framework December 2022	Now January 2023 Now June 2023 Now October 2023 Now January 2024		In progress	December 2023 Update Link to Internal Audit Incident Management Recommendation 2.1 and Internal Audit Concerns Management Recommendation 3.1. As part of the review of the Incident Management Framework and Concerns Policy & Procedures a training strategy is being developed. This will set out the requirements for training at all levels of the Organisation. In conjunction with the Care Groups a training needs analysis will be undertaken and a rolling 12 month programme implemented that will include all aspects of incident / complaints management.	October 2023 Updated The Internal Audit for Complaints and Incident Management both include recommendations for undertaking a training needs analysis. A joint approach will be adopted to develop a training strategy for the investigation of concerns (complaints & incidents) that will identify the levels of training that are required i.e. awareness, management review, complex concern / RCA investigation training. Rationale for revised implementation date: Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.
Concerns Follow Up Review 1.1	Jun-23	Reasonable	1.1a The concerns SOP should be revisited ahead of approval to ensure all sections are populated and reference is made to other relevant SOPs / supplementary documents. Consideration should be given to re-naming the SOP and removing the reference to 'written' concerns only. 1.1b The revised Concerns Policy and Standard Operating Procedures should be formally approved and made available to staff. The concerns pages on the CTM internet site should also be updated with the revised policy and the previous version removed.	Low	1.1a The Concerns SOP will be reviewed in line with the recommendation above and will be renamed and written concerns will be explained. 1.1b The various SOPs/policy will be made available on SharePoint for all staff to access once approval has been received in Quality & Safety Committee in July 2023.	Director of Nursing	Head of Concerns & Business Intelligence	1.1a May 2023 1.1b August 2023	Now September 2023 Now December 2023 Now January 2024		In progress	December 2023 update Approval of the Concerns Policy & Procedure has been deferred to January 2024 due to the impending release of the updated PTR guidance and the review of the incident management Framework following revised National Incident Guidance from the NHS Executive. The Health Board's Concerns Share Point pages are being reviewed to ensure they are up to update and accurate information is available to support staff involved in the management of concerns. Rationale for revised implementation date: From Sept to Dec 23 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	October 2023 update Approval of the Concerns Policy & Procedure has been deferred to December due to the impending release of the updated PTR guidance and the review of the incident management Framework following revised National Incident Guidance from the NHS Executive. The Health Board's Concerns Share Point pages are being reviewed to ensure they are up to update and accurate information is available to support staff involved in the management of concerns. Rationale for revised implementation date: From Sept to Dec 23 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.
Concerns Follow Up Review 9.0	Jun-23	Reasonable	Once the Assistant Director of Quality & Safety has commenced in post, the terms of reference for the Shared Listening and Learning Forum should be reviewed and formally agreed for use.	Low	Listening and Learning Forum TOR to be reviewed.	Director of Nursing	Assistant Director of Quality & Safety	Jun-23	Now October 2023		Completed	December 2023 update -Terms of Reference reviewed and action closed A review of the governance arrangements by the Deputy Director of Nursing is ongoing following OCP. The Terms of Reference for the Shared Listening & Learning Forum will be reviewed and the mandatory requirements incorporated into the proposed new group terms of reference for organisational wide sharing and learning, this new group will include reports from the newly developed Nutrition & Hydration group, Falls group and Medication Incident review group	October 2023 Update Review of governance arrangements with regards to the Shared Listening & Learning Forum is ongoing by the Deputy Director of Nursing who is reviewing the ToR of this forum together with the Assistant Director of Quality & Safety. This work aligns to the outcome of OCP.
Decontamination 4.0	Aug-23	Reasonable	The Terms of Reference for the Local Decontamination Groups should be reviewed and revised (where applicable) and presented to the Decontamination Committee for overall approval.	Low	4a Update the terms of reference for the local decontamination meetings in CTM. 4b Updated and agreed terms of reference to be presented to the Decontamination Committee for discussion and ratification. 4c Present reviewed and agreed local decontamination terms of reference to IPC Committee for noting.	Director of Nursing	Deputy Lead IPCN/ Decontamination lead	4a August 2023 4b Sept 2023 4c October 2023	4b December 2023 4c January 2024		In progress	December 2023 update The ToR will be presented to the next Decontamination Committee meeting for approval on the 05/12/23.	October 2023 Update - Terms of reference have been developed and will be presented at the next Decontamination Committee meeting for approval Rationale for revised implementation date - The terms of reference were not updated in time to be presented at the last Decontamination committee which has delayed them being presented at IPCC
National Incident Reporting Framework 5.2	Aug-23	Reasonable	In order to allowing monitoring and ensure compliance with the 72-hour timeline placed in changing the new incident to 'make safe', the make safe date should be captured within Datix.	Low	An audit programme of new, open and closed incidents to be implemented to ensure that all required fields are completed in the required timescales. Feedback from the audits will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	Director of Nursing	Head of Concerns & Business Intelligence	01.10.23	Now December 2023		In progress	December 2023 update A data validation checklist is being developed to inform all users of the data requirements. Once this has been disseminated, weekly audits will commence. This will be implemented as part of the launch of the Incident Management Framework.	October 2023 update A data validation checklist is being developed to inform all users of the data requirements, which will be included in the Incident Management Framework. Once this has been disseminated, weekly audits will commence. Rationale for revised implementation date: From Oct to Dec 23 Completion of the Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.
Radiology Workforce Follow Up Review 5.0	Aug-23	Reasonable	Work should continue to resolve the issues raised with the five Consultant job plans within PoW.	Low	Current compliance POW: • 7 signed off • 1 awaiting 1st sign off • 1 expired but booked – date arranged for 20/09	Chief Operating Officer	Radiology Clinical Service Group Manager, Consultant Radiologist	End September 2023	Now December 2023 (date not included in the last update)		In progress	December 2023 update - job plan meetings have been set up for those who are either out of compliance or will be out of compliance scheduled throughout November and December.	October 2023 Update - POW 6 signed off, 1 in first sign off, 1 in second sign off. 1 Awaiting a second JP meeting due to a flexible working application.
IT Infrastructure 1.1a	Oct-23	Reasonable	Work to complete the register / CMDB should be progressed. Asset information for the Bridgend area should be included and kept up to date.	Low	The Asset manager has been extended to March 2024. They will continue to gather and maintain records of these assets. Service Management tooling and the related CMDB are not in place and a system for this requires investment. A case will be developed to support with the specification, costs and resources required for this.	Director of Digital	Assistant Director of Digital Delivery	Mar-24			In progress	December 2023 Update - Progress continues on the CMDB as well as active conversations on ITSM tooling.	
IT Infrastructure 6.1	Oct-23	Reasonable	The network topology and make up should be recorded outside of the monitoring tools.	Low	Plans in place to review and document individual sites. Staffing levels will determine the time it will take to complete the work. Priority will be given to the critical sites, as this also supports the review work required for NIS-D assessment.	Director of Digital	Head of Voice and Data Communications	Mar-24			In progress	December 2023 Update - We are actively trying to recruit additional resource to enable us to complete this action	

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				Changes will be made to the Concerns Policy and management process in line with the Concerns Improvement project. This will be undertaken via a collaborative process between Corporate and the ILGs and in light of any changes to the Operating Model following the current									

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Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Audit of Accounts Addendum 2020/2021 02	Aug-21	The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	CTM Focussed Review	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	Director for People		Immediate	Now August 2022 Now October 2022 Now December 2022 Now March 2023 Now August 2023 Now December 2023 Now January 2024		In Progress	December 2023 Update - The Health Board has reviewed its governance and procedures for the appointment of senior officers A new documented Action Plan process was piloted during the recruitment process for the Executive Director of Public Health Post in January 2023, with small amendments being made based on the lessons learnt. The process was successfully used during the recent appointment to the Executive Director of Public Health, following the post being readvertised. This process deals with all of the governance requirements and process matters, from post approval to appointment to sign off and approval by the RATs Committee. Formal and clear minutes are taken, recording the discussions and decision made by the RATs Committee in compliance with the governance arrangements. This process review is now completed. As the All Wales new Pension Policy work is not progressing at pace (it was to be issued to the Service by December 2023, this now looks uncertain) the Health Board's People Policy Review Group is currently reviewing and drafting a stand alone Retire and Return Procedure. The application form will ensure that appropriate questions are asked and answers provided which will provide transparency in respect of the consideration taken into account by the manager to either approve or reject the application business cases. The process will also confirm the process for providing retire and return information to the NWSSP Payroll and Pension Team.	October 2023 update - It has been confirmed a partnership group is being established under the Welsh Partnership Forum Business Committee to develop an All Wales Pensions Policy. The timescale for the policy to be developed is autumn 2023. The work on the CTM Pension Policy has been halted on the request of the NHS Confederation, however our draft policy has been shared with the WPF Business Committee to inform the All Wales policy. The implementation date has been amended to December 2023, but this date will be dictated by the WPF.
Audit Wales/HIW Quality Governance Follow Up Review R2.3	Aug-21	The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically; a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board c- The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework	CTM Focussed Review	The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows: • Strengthened focus on quality on strategic planning; • Individuals' voices are better heard; • Shared learning and continuous quality improvement; • Risk better articulated, shared and mitigated; • Strengthened two-way 'point of service delivery' to Board sight; and • Extensive review and improvement of the management of concerns and serious incidents. Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's . The revised framework will provide improved granular detail in respect of ILG governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSG/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded.	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022 Now May 2023 Now June 2023 Now October 2023		Completed	December 2023 Update - The Audit Wales report submitted to the October 2023 meeting highlighted that they felt that this recommendation had been fully implemented. Therefore this is proposed for closure	October 2023 update: OCP consultation completes 29/09/2023 at 17:00. Timeline agreed and aiming for structural implementation by December 2023. Alignment arrangements will be commenced from closure of OCP consultation and confirmation of agreed modelling by 13/10/2023.
Audit Wales/HIW Quality Governance Follow Up ReviewR3.5	Aug-21	Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: a- Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety b- Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates c- Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety	High	Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	Director of Nursing		Oct-21	Now June 2022 Now October 2022		In Progress	December 2023 update Quality & Safety Committee now receive a Clinical Executive Quality & Safety report at each bi-monthly meeting. There is a weekly Executive Director led Patient Safety meeting which is chaired by the Executive Director of Nursing/Deputy CEO with support from the Executive Director of Therapies & Health Science. This group receives weekly data on all urgent quality and safety related issues that require Executive Director oversight and direction, weekly data related to Patient Experience, Concerns which includes: serious incidents, Early Warning Notices, LFER position updates as well as any issues of concerns relating to: Inquests, Investigation delays, patient safety incidents and complaints related concerns. Where escalation is required these matters are also discussed at this weekly group. The group receives oversight and assurance of performance where any concerns are raised related to quality and patient safety and experience. At the weekly ELG meeting each Clinical Executive provides an update on quality and safety for wider executive sharing. Each Care Group has their own Quality, Safety, Risk & Experience meeting in place with defined roles in relation to quality leadership, responsibilities, accountability and governance for quality and patient safety. Total quality management system set out within both the Quality Strategy & Quality & Safety Governance Framework. There are Governance leads across all Care Groups and service lines.	September 2021 - No update received. November 2021 - No further update provided. January 2022 update Quality Dashboard and new metrics agreed at Quality & Safety Committee and presented at each meeting. Work continues in relation to developing population outcomes measures linking with the organisational outcome strategy work. Benchmarking opportunities across Wales remains limited. ILG performance meetings include a section on Quality & Safety metrics led by the Executive Nurse Director. Update April 22. Quality metrics and template reporting agreed by ILG Q&PSE and data team to ensure that Q&SC receive a robust, consistent measure across the HB. The NHS Delivery Unit are developing their quality & patient safety dashboards to permit a greater ability to benchmark across the organisations, as well as sharing and learning opportunities. July 2022 Update - ILG's present an agreed consistent set of Q&S metrics to committee and Boards. An overarching report is produced by the central team to illustrate themes and trends, hot spots and analysis. This will need refining within the new organisational model to maintain good line of sight on services. Further development of the data is planned to improve understanding, target and trajectory setting, bed days etc. The DU dashboards are included in the Q&SC quality dashboard report. OFW incident module functionality has been implemented since April 22. October 2022 Update - No further update provided on this occasion. December 2022 Update - The Quality Dashboard report to Q&SC continues to provide information and assurance on the breadth of health boards services and performance with spotlight focus on issues of concern to the Board. It is anticipated within the new operating model structure that in addition to the overarching report, each Care Group will be invited to present QSPSE reports in turn to Q&SC to provide enhanced granular assurance
Audit Wales/HIW Quality Governance Follow Up ReviewR4.1	Aug-21	The roles and function of the QSRC need to be reviewed to ensure that it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following; a- Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively b- Improvements to the content, analysis, clarity, and transparency of information presented to QSRC c- Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications, and training.	High	Meeting structure to sit under Management Board being developed to support the operational oversight and Health Board wide co-ordination and learning.	Chief of Staff		Dec-21			In Progress	December 2023 - The follow up review undertaken in August 2023 identified that Audit Wales felt that this recommendation had been partially implemented so this has been added back onto the tracker. An update against this recommendation has not been provided on this occasion.	September 2021 Update • I've mapped what I believe to be the sub structures in place. • ToR for each forum has been captured • Next step is for us to look at what structures are delivering and how they are reporting • Performance is the key here and we have nominated Director of Strategy & Transformation as the lead for Performance who is in the process of pulling together Performance reporting for Management Board. • In terms of flow from ward to board I believe there is a session with corporate governance team to discuss this to make sure papers aren't going to committees before they've had Executive Director input / sight. • I understand the Executive Business Manager now ties in closer with Corporate Governance team to ensure clarity of what's going where. • Operational oversight – ongoing ops oversight sits with COO and he has a structured set of weekly meetings in place with ILGs to ensure performance is tracked and scrutinised. November 2021 Update - • Management Board restructured to Strategic Leadership Group. Removal of consent agenda and repurposed to strategic whole HB items for discussion. Promotion of Performance agenda which is now under review and will continue to be iterated, led By DoS&T and informed by improved Performance Information. • Executive catch up reformatted to Executive Leadership Group with a tighter agenda incl. key focus area highlight reports as well as taking in all formal decision making at this forum incl. decisions having a financial consequence. • Additional scrutiny and advice inputted by CEO office when papers are submitted from a variety of sources. Emphasis on collaborative workup of papers involving key areas e.g. Finance, WF etc. This approach prevents papers landing 'cold' at formal Executive meetings.
Audit Wales/HIW Quality Governance Follow Up Review R6.1	Aug-21	There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	CTM Focussed Review	Health Board purchased CIVICA (captures population feedback using a patient insight software platform)	Director of Nursing		Jul-21	Now December 2021 Now July 2022 Now March 2023 Now December 2023 Now December 2024 when Civica contract ends		In Progress	December 2023 update Band 2 has been recruited and starting 16th Dec 23. Band 3 has been recruited and starting 2nd Jan 2024. Issues remain on inputting paper copies onto system due to resource issues- Therefore the data on the system for Have Your Say is not a true reflection of response rates and feedback. Emergency Department survey went live on SMS 1st Nov. Roadshow in Princess of Wales has been completed with 3rd party stakeholders. RGH roadshow has been agreed for Feb 2024. Civica to be presented in the Senior nurse and Lead nurse Professional forum in Dec. Palliative Care survey- inpatient only to go live 1st Dec. CIVICA patient experience feedback from 22/23 presented to Q&SC September meeting	October 2023 update- Due to recruitment freeze band2 and band 3 roles have been delayed despite funding being approved as part of 23/24 financial HB investment from the unavoidable cost pressure investment fund. Job roles are being taken to the exception review panel W/c 2/10/23. Delays being seen with inputting of patient feedback due to resource issues. National survey has gone live for Covid-19 investigation, ED to be automated approx. November 2023 but paper copies and survey live within CTM. Palliative care survey being phased in, due to resource issues in service area- Advanced supportive care in heart failure to go live w/c 2/10/23 and the remainder of CTM palliative care to follow approx. end of Oct23. Roadshow's scheduled across 3x acute sites and comms plan being developed. Strategy and scoping exercise currently being undertaken. The Q&SC were presented with the CIVICA 2021/22 Patient Feedback themes and trends for assurance

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Audit Wales/HIW Quality Governance Follow Up ReviewR8.6	Aug-21	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	CTM Focussed Review	Quality Governance Framework to reflect enhanced governance processes	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022 Now January 2023 Now May 2023 Now June 2023 Now October 2023		Completed	December 2023 Update - The Audit Wales report submitted to the October 2023 meeting highlighted that they felt that this recommendation had been fully implemented. Therefore this is proposed for closure	October 2023 update: OCP consultation completes 29/09/2023 at 17:00. Timeline agreed and aiming for structural implementation by December 2023. Alignment arrangements will be commenced from closure of OCP consultation and confirmation of agreed modelling by 13/10/2023.
Audit Wales/HIW Quality Governance Follow Up Review R7.7b		There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	CTM Focussed Review	Undertake audit of compliance against Royal College of Anaesthesia (RCOA) Standards (ACSA process) identify and develop standards to meet with RCOA recommended GPICS (set standards by RCOA for Anaesthetic services) baseline and inform continuous improvement programmes and improve compliance against the standards.	Medical Director		Jul-24			Completed	December 2023 Update - The Audit Wales report submitted to the October 2023 meeting highlighted that they felt that this recommendation had been fully implemented. Therefore this is proposed for closure	October 2023 Update - This work will be picked up further following the completion of 'Phase 2', once the new Clinical Director for Anaesthetics has been recruited. This individual will take up the ACSA lead role.
Equality Impact Assessments R4	Nov-22	Reviewing public bodies' current approach for conducting EIAs: While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	National Review	CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSED. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	Director for People	EDI Practitioner	Mar-23	Now May 2023 Now July 2023 Now October 2023 Now January 2024		In Progress	December 2023 Update - Work on the EIA review and update is on track. Meeting with Welsh Language Lead to look at embedding Welsh language impact assessment into EIA so that there are not two different documents. Work continues with the Health Boards across Wales to develop an All Wales approach to the EIA process – this however will not delay CTMUHB EIA review and update. Deadline for completion is still January 2024 with a support offer to enable those undertaking EIA to develop more confidence and awareness on the importance of EIAs and its purpose. Once review is complete and the support offer is live – this process will be continually evaluated to see what impact is being made and what additional interventions may need to be put in place to support the roll out and embedding of EIA process within CTMUHB. The numbers completed and evaluation will be discussed at the newly formed EDI working group which has been established to support the delivery of the Strategic Equality Plan of which EIA activity sits within.	October 2023 update - The EDI Lead has met with Strategy & Transformation to look at the implementation of EIA within the IMPT. The EDI lead has also met with Quality to discuss the alignment of EIA process with QIA process to reduce duplication; another meeting is due to take place with the lead on this. There is also close links to the current organisational review of the development of Policies which will be in two phases. There is a commitment to embed the EIA in future policy development; as well as current policies and procedures. The EIA process sits within our Strategic Equality Plan (SEP) which the ED&I Lead will take to People & Culture Committee for sign off on 8th November 2023. Within the SEP; we are also including an educational offer around the application of the EIAs as a diagnostic has identified that there is a gap in understanding the use of the EIA and this has led to numerous queries as an outcome to the OD&I (Organisational Development & Inclusion) Team. As well as CTM's internal review, the All Wales Equality Leadership Group (which our ED&I Lead is a member of) have decided to collectively review all EIA processes for all Health Boards across Wales so that there is an alignment with each other and best practice is utilised. This review will be carried prior to PHW review of an All Wales digital approach, as it is understood this may take some time. Deadline for completion of the all wales Review and an EIA process being agreed is End of Q3 (December); with an educational offering starting with CTM in Q4.
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.	CTM Focussed Review	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners	Director of Strategy & Transformation	Head of Regional Collaborative Unit	31 March 2023	Now 31 March 2024		In Progress	December 2023 Update - Director of Integration Post commenced to drive forward integration agenda. Implementation plan including reference to performance management arrangements and pooled budget arrangements.	October 2023 Update - A model focussing on two pathways Urgent and emergency care and population health management have been agreed that aligns the efforts of 6 Goals of UEC, ACD and RIF. Regional work streams have been aligned to new national specifications and identified 'transformation resource' (RIF) to support local leadership, facilitate change and disseminate learning. By aligning programmes and core resources will support longer terms sustainability.
Transformational Leadership Programme Board – Baseline Governance Review	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	CTM Focussed Review	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	December 2023 Update - Directors drafted letter to HB (community capacity, adults) to provide collective assurance that risks to posts however level of risk to appoint to longer term posts varies and appointing organisations need to manage these risks. Varying terms and conditions exist across the region and between organisations. Workforce a key enabler to delivering the ambitions of the integrated pathways.	October 2023 Update - There remains uncertainty over any additional resource to implement further faster (noting AHP funding being received) and recognition that there exists an ever-increasing financial challenge the need to accelerate the rebalancing of the health and care system, ensuring that existing resources are utilised most effectively and strive towards the Further Faster ambitions remains. Effective transformation of our existing model of care including engagement, understanding resistance to change, create a learning environment that studies each change and is flexible to respond to new knowledge and data is needed
Transformational Leadership Programme Board – Baseline Governance Review R5	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.	CTM Focussed Review	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Director of Strategy & Transformation	Head of RCU	31 December 2022	Now December 2023 Now January 2024		In Progress	December 2023 Update - Director for Integration post commenced November 2023 . Capital planning officer started within regional team at the beginning of October. NEST Co-ordinator / Children and young people lead shortlisting 8th December for appointment early January 2024. 3x Capital Project manager roles (Funded through Integrated Care Capital Resource for 2 year fixed term), slightly delays. Expected to be advertised early January 2024 note one post to focus on digital/assistive tech development. Integration Director exploring cross overs and support levered through various strategic programmes.	October 2023 Update - Director for Integration post appointed, expected to commence in role mid-November. Capital planning officer started within regional team at the beginning of October. NEST Co-ordinator / Children and young people lead to be appointed and 3x Capital development roles expected to be in post before end of December (Funded through Integrated Care Capital Resource for 2 year fixed term. Further opportunity to create capacity to support Integration Director being explored.
Transformational Leadership Programme Board – Baseline Governance Review	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	CTM Focussed Review	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	December 2023 Update - To be explored as part of integrated pathway developments.	October 2023 Update - No further update. Awaiting further guidance from WG following Consultation response.
Transformational Leadership Programme Board – Baseline Governance Review R7	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	CTM Focussed Review	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	December 2023 Update - Update to Market Stability report required in 2024. This will highlight any changing position in relation to regulated services staffing challenges. Exploring the use of assistive technology and digital solutions to better support individuals to maintain independence in the community.	October 2023 Update - Staffing challenges have been experienced in the delivery of community services however issues are now being compounded by recruitment freezes and blanket stops on recruitment by the health board affected integrated community teams. This is considerably impacting the functioning of community services and the overall 'flow' of patients in an already very pressurised health and social care system in advance of the winter period. Within Bridgend there are currently 11 RIF vacancies in service. Posts have been added to TRAC over the last 3 months but unfortunately have not been authorised, this is adversely impacting on service delivery. Directors across CTM partnership are committed to maintaining community capacity through RIF funding. A letter has been drafted to support this position.

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CTMSB SLA Review R3	Feb-23	Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.	CTM Focussed Review	Changes in patient flows and impact on patients is addressed in the cessation paperwork and is always discussed as part of the disaggregation discussions. Equality Impact Assessments have started to be completed for the cessation of the Clinical Capacity SLAs in NPTH as the changes will impact on patient flow and access to services. However, there is not enough corporate resource to complete a detailed impact assessment for each SLA cessation and in most cases the impact is not necessary as there is no change in patient flow. The Community Health Councils are kept up to date on all cessations and detailed engagement is undertaken where changes will affect patient flow.	Director of Strategy & Transformation	Assistant Director of Strategy (SB) & Assistant Director of Transformation (CTMUHB)	Nov-22			In Progress	December 2023 Update - The communication and engagement group continues to meet and there will be joint engagement with Llais on any service changes in the shared work programme. All service changes are subject to benefits appraisal, impact assessment and risk assessment prior to agreement of any changes to commissioned service arrangements. The Joint Executive Group approved an updated process flow chart which strengthens the agreed processes. (4.12.23)	October 2023 Update - A communication and engagement group has been set up to provide coordination for all activities relating to SBUHB SLAs. This will enhance existing processes, enabling proactive engagement with Llais regarding service changes.
Structured Assessment 2022 R1	Apr-23	Improving administrative governance arrangements We found opportunities for the Health Board to improve its administrative governance arrangements to enhance public transparency and support Board and committee effectiveness. The Health Board, therefore, should: a) publish the agendas of private Board and committee meetings; b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner; c) update report cover sheets to enable authors to better link their reports to the requirements of the Well-being of Future Generations (Wales) Act 2015; and d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.	CTM Focussed Review	a) In the exceptional circumstances where the Health Board is required to hold a Private Board meeting or Board Committee it will endeavour to highlight the agenda items covered on the Public Agenda for transparency. b) Due to capacity constraints within the Corporate Governance Function it is accepted that the timely publishing of papers maybe impacted. Discussions are underway with the Web Development Team to consider if they can provide interim support over the next 3-6 months. c) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act. d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues.	Director of Corporate Governance	Assistant Director of Governance & Risk	a) 30th April 2023 - Complete b) 31st August 2023 31.10.2023 - Part 2 of action. c) 30th June 2023 31.10.2023 d) 30th June 2023- Complete	Now 31 October 2023 for completion of Action B Now 31 March 2023 for completion of Action B		In Progress	December 2023 Update - The Health Board would like to benchmark with how other Health Boards are approaching Advisory Groups. The Director of Corporate Governance & Board Secretary appointed in September 2023 would also need sufficient time to attend and review these meetings in order explore any further support needed. It is anticipated that the pace of change for the Advisory Groups may take longer than originally assessed and a revised implementation date of 31.03.2024.	October 2023 Update A) Complete. B) Further work is required in terms of Advisory Groups and this will be explored and may require further support to leads in this area. It is anticipated that the pace of change for the Advisory Groups may take longer than originally assessed and a revised implementation date of 31.10.2023 is proposed. c) Complete. Cover reports updated and relaunched. d) Complete.
Structured Assessment 2022 R3	Apr-23	**Strengthening performance management arrangements** The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.	CTM Focussed Review	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable the Board to align measures to strategic priorities etc, the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.	Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)		30th September 2023 The workshop with Board Members is scheduled for Quarter 1 – 2023-2024.	Now December 2023		In Progress	December 2023 - An update has not been provided against this recommendation on this occasion.	October 2023 Update - First adaptation of the performance report was presented at Sept board
Structured Assessment 2022 R4	Apr-23	**Establishing measurable outcomes for strategic priorities** Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.	CTM Focussed Review	We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter". In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible.	Director of Strategy & Transformation		30th June 2023 Now September 2023	Now December 2023		Part Completed	December 2023 - An update has not been provided against this recommendation on this occasion.	October 2023 Update - This work is ongoing and we are also exploring measures of social value to be utilised in community and partnership arena
Structured Assessment 2022 R9	Apr-23	**Maximising the benefits of digital technologies and solutions** There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it indents to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	CTM Focussed Review	The themes identified in the existing Digital Strategy continue to be aligned to the NHS Wales Digital Strategy and are embedded and will continue to evolve with the CTM2030 strategy in relation to digital activity. The Health Board has performed an analysis and identified a minimum set of resources (staff and capital/revenue) required over the next 3 years. Aligned to this work, during 2022 the Health Board completed a functional map of services required from a Digital and Data perspective. The next stage in the process is to align staffing resources to the functions, which will be achieved by following organisational change process. For significant Digital and Data changes (i.e. projects/programmes) the Health Board has developed a process of creating business cases to support service transformation. These business cases indicate the resources (staffing & Infrastructure) required to implement service change and ensure ongoing provision of support services to sustain change. The Health Board is committed to adopting all National Digital developments, where appropriate, and has invested heavily in the deployment of these products across the Health Board. The current strategy is to continue to operate in this manner and ensure it maximises resources efficiently and effectively.	Director of Digital		31st December 2023 (Qtr 3) Qtr 1 – Business Case for Patient Centred Contact. Qtr 2 – Business Case for e-prescribing. Ongoing as National Digital Developments are released.			In Progress	October 2023 Update - We have completed the initial recruitment with colleagues starting during September and October. However given the current recruitment constraints we are unable to recruit further at this point in time	August 2023 Update - An update has not been provided against this recommendation on this occasion
Review of Orthopaedic Services R3	Jun-23	The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	National Review	The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place: • Ensure that prehab services are improved by setting up a Prehabilitation Service to ensure patients are medically optimised for surgery. Both digital and face to face options to be considered. • The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board • Increase the capture of PREMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures –timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement • Updated GIRFT action plan to be created with new CD and monitored through the reconfiguration programme. • Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved.	Chief Operating Officer	COO / Planned Care Director/ Clinical Restart Manager/DTS Director/USC Care Director/ Planned Care Medical Director	Various Dates from between May 2023 - April 2024			In Progress	October 2023 Update - Work continues in this area as part of the Planned Care Programme and other projects. In particular, the Prehabilitation Service has just been launched and monitoring of the GIRFT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.	August 2023 Update - An update has not been provided against this recommendation on this occasion
Review of Orthopaedic Services R4	Jun-23	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	National Review	The Health Board will undertake the following in order to ensure the recommendations are achieved: • The fragility of a small CMATS team was recognised within physiotherapy. Since the merger with Bridgend the UHB has invested training and development into the band 7 clinical specialist team in order to increase the number of staff working at the advanced practice level, to meet the demand across CTM. • In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialties, Nurse led, Consultant led and AHPs • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Chief Operating Officer		No target date for completion identified			In Progress	October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting.	August 2023 Update - An update has not been provided against this recommendation on this occasion

CTM Internal [date]

Red -
Orange -
Yellow -
Green -
Blue - Action

Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Review of Orthopaedic Services R5	Jun-23	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	National Review	The Health Board will undertake the following in order to ensure the recommendations are achieved: • Within POWH, PREMS and PROMs data is currently being captured electronically for all arthroplasty patients and utilising the MyMobility applications AI system, patients with anticipated poorer outcomes are having enhanced Therapies input digitally. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Within POWH, all Arthroplasty patients are enrolled on the MyMobility application to provide prehab for all patients awaiting surgery to try and minimise the harm caused by delays and ensure patients are medically optimised. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Single Clinical Director Leadership required to establish performance structure and review of current services. • Weekly performance reviews that monitor waiting list volumes and actions being taken to address and recover the position • Action plan development with singe CD for performance and governance structure across CTMUHB	Chief Operating Officer	COO / Planned Care Director/Medical Group Director/ Clinical Director	From April 2023 to April 2024			In progress	October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting.	August 2023 Update - An update has not been provided against this recommendation on this occasion
Audit Wales/HIW Quality Governance Follow Up Review R14.5	Aug-21	The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	CTM Focussed Review	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Director of Nursing		Sep-21	Now December 2021 No revised date for completion provided - currently in discussion Now March 2023 Now June 2023		In Progress	December 2023 - The follow up review undertaken in August 2023 identified that Audit Wales felt that this recommendation had been partially implemented so this has been added back onto the tracker. An update has not been provided against this recommendation on this occasion.	June 2023 Update- CIVICA-Governance and the performance paper submitted. Awaiting response from finance on CIVICA funding and to move funding to VBHC. August 2023 Update -The funding agreement process for CIVICA has been concluded. The workforce and implementation plan is now being actioned. The learning from the fundamentals of Care audit which has been completed in POW has been taken and included in the wider Nursing & Midwifery work through the use of AMaT - An analysis of the CIVICA Patient Experience feedback for 2022/23 has been completed and will be presented to Q&SC in September 23 Each Care Group presents a highlight report to the Q&SC on a bi-monthly basis which takes into consideration integrated learning.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
5.2.2

Audit & Risk Committee

CONSULTANT JOB PLANNING

Dyddiad y Cyfarfod / Date of Meeting	01/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mr Nicholas Price, Senior Medical Workforce Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
ABUHB	Aneurin Bevan University Health Board
ADH	Additional duty hours
AMD	Assistant Medical Director
BMA	British Medical Association

CAVUHB	Cardiff and the Vale University Heath Board
CTM	Cwm Taf Morgannwg
DCC	Direct Clinical Care
LNC	Local Negotiating Committee
NWSSP	NHS Wales Shared Services
SAS	Specialty & Associate Specialist
SPA	Supporting Professional Activities
UHB	University Health Board

1. Situation /Background

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

2.1 Job plan completion and sign-off

- Job planning is a contractual requirement for consultants and SAS Doctors.
- It was recently discovered that the 'signed-off' job planning figure shown on e Job Planning included job plans signed-off at any time in the past. Thus misleading data have been presented for a number of years. This has been highlighted to Executive Directors and reported to People and Culture Committee.
- The current and correct state of job planning is as follows. 26% of Consultant and 17% of SAS Job Plans have been signed off in the last 12 months.
- Of great concern, it must be noted that 170 medics do not have a signed off job plan from any date in the past.
- The 50% target set for April 2023 was not reached.
- The Care Group Medical Directors have a responsibility to 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 and Directorate Managers who will be instrumental in ensuring that job planning is completed.
- There is a new SPA document guide for Consultants and one being developed for SAS Doctors.
- The UHB job planning guidance has been updated and the Medical Director will share this with the BMA at the December meeting of the LNC.
- The Chief Operating Officer has been given a table of all consultants and SAS doctors, showing the status of each job plan. The Care Groups will be asked to complete this, giving a schedule of when job plans will be undertaken.

2.2 Weekly number of sessions, activities and outcomes

- Development of a SPA policy document was required to standardise the approach across the Health Board for SPA and DCC split, to ensure fairness and equity. This document has been distributed to Consultants within CTM and an SAS version is currently in discussion.

2.3 Clear personal outcomes within the job plan

- As part of the job planning training, it is stated that clear personal outcomes should be factored into the process and be recorded in new job plans. The job plans should 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 Job Planning Quality Assurance Group

- This was set up to ensure there is a consistency across the Health Board with regard to job planning.
  - Members of the team include the Executive Medical Director, Deputy Medical Director, Assistant Medical Director (Workforce), Senior Medical Workforce Manager and the Medical Director team manager. The relevant Directorate manager and Clinical Director are also invited.
  - Areas addressed so far include some of the more challenging areas including surgery, ENT, Ophthalmology and Paediatrics.
  - These meetings happen on a monthly basis.

2.5 Additional Duty Hours (ADH)

- Executive colleagues agreed a Non-Consultant Rate Card which went live across CTM on 19th October 2023.
- The Non-Consultant Rate Card mirrors that of ABUHB to ensure there is consistency across South East Wales.
- A consultant rate card requires further work and analysis. Of note CAVUHB have just released a Consultant Rate Card to their medical workforce.

3. Key Risks / Matters for Escalation

3.1 None.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality**	Culture and Valuing People
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: 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.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Recruitment and retention perspective, good job planning is key.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Good job planning leads to better use of resources	

5. Recommendation

5.1 The Committee are requested to **NOTE** the report and the update provided.

6. Next Steps

6.1 Deliver job planning training for newly appointed clinical directors and directorate managers.

6.2 Chief Operating Officer to send out job planning schedule for completion by care groups.

6.3 Discuss job planning guidance with LNC

6.4 Develop consultant rate card

Agenda Item
5.2.3

Audit & Risk Committee

MEDICAL ROSTERING PROGRESS REPORT

Dyddiad y Cyfarfod / Date of Meeting	19/12/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Andrew Stocken, Medical & Dental E-Systems Manager; Nicholas Price, Senior HR Manager - Medical Workforce, Medical Personnel and Nerys Conway, Assistant Medical Director.
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
AMD	Assistant Medical Director
BMA	British Medical Association
ED	Emergency Department
MD	Medical Director
MWSG	Medical Workforce Sustainability Group
LNC	Local Negotiating Committee

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

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 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 submitted to LNC and comments have been received; the policy is currently being updated and will be submitted back to the LNC for approval.

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 – Complete
The E-System Team have received copies of "How-to" Guides from the respective system providers. The departments are providing these to staff who join their services.

2.3 Recommendation 4.1
Responsible person: Executive Medical Director (MD)
"Management should ensure that the Professional and Study Leave policy is approved and circulated within the Health Board."

Update – In progress
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 on the gift of the Health Board to do unilaterally, it needs to be agreed in partnership.

The Medical Director has met with the BMA and following this a draft policy has been created and will be presented to the LNC to the first LNC meeting in 2024 for approval. In essence it offers those who joined form SBUHB into CTMUHB a choice to stay on current contract with the Study leave time and budget as in place then or to transition to the CTM wide policy. All staff employed after the merger are on CTM contracts on all sites.

3. Key Risks / Matters for Escalation

3.1 There is a risk the BMA will not agree to the proposed changes to the Professional and Study leave policy for former Swansea Bay employees, if it is detrimental to offer in comparison to the current policy.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality**	Not Applicable
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not a Policy
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Committee are requested to **NOTE** the report and the update provided.

6. Next Steps

6.1 Both policies mentioned previously to go to LNC Meeting

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee
Internal Audit Progress Report

December 2023

NWSSP Audit and Assurance Services

Contents

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

1 Introduction

1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at **11 December 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 October meeting of the Committee five reports have been finalised, two reports are in draft, and we have ongoing fieldwork in relation to seven 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
Deprivation of Liberty Safeguards (DoLS)	1	3	-	4	Reasonable
Arrangements for financial savings: • Central processes - Substantial • Enabling schemes - Reasonable • Care group processes - Limited	2	-	1	3	See column 1
PCH - Quality – Site supervisor role	-	2	1	3	Substantial
PCH - Validation of management actions	-	-	-	-	Substantial
WHSSC – Integrated commissioning plan	-	1	2	3	Substantial

3 Delivering the Plan

3.1 Our agreed performance indicators are set out in table 2 below:

Table 2 – Performance Indicators 2023/24

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	Green	82%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to	Red	56%	80%	v>20%	10%<v <20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
draft report [15 working days per Internal Audit Charter]						
Report turnaround: time from management response to issue of final report [10 working days]	Green	100%	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. We have issued eight feedback requests to date.

5 Other activity

Meetings

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

5.2 We also regularly observe the Board and committees of the Board to help ensure we have an understanding and gain valuable insight into the activity of the organisation.

Appendix A – 2023/24 Programme of work

Table 3: Core programme of work for Q1, Q2 and Q3

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
22	Follow up – Radiology – workforce	Reasonable	Q1	Final	Y	N	Reported at August AC.
19	IT Infrastructure	Reasonable	Q1	Final	Y	N	Reported October
-	Interventions Not Normally Undertaken (INNU)	Limited	-	Final	Y	N	Reported October
7	Deprivation of Liberty Safeguards (DoLS)	Reasonable	Q2	Final	N	Y	Reported December
-	Arrangements for financial savings	Substantial/ Reasonable/ Limited	-	Final	N	N	Reported December
4	Estates Assurance / condition	Limited	Q1	Draft	Y	-	Part of all Wales review - Draft report issued in August. Updated and reissued 18.10.23.
3	Performance management of 4-hour target	Limited	Q1	Draft	N	-	Draft report issued 30.10.23. Debrief rearranged for 18.12.23

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
2	Gastro-intestinal pathway	-	Q1	WIP	-	-	Fieldwork complete. Drafting report.
6	Management of controlled drugs	-	Q2	WIP	-	-	Fieldwork started later than planned. Data extraction has taken time.
9	Adult mental health – CSG review	-	Q2	WIP	-	-	Fieldwork started 06.10.23.
18	IT Service Management	-	Q2	WIP	-	-	Fieldwork started 14.09.23. Has been some delays due to auditor sickness.
-	Follow up – Patient pathway appointment management	-	-	WIP	-	-	Fieldwork ongoing. Review was brought into 23/24 as implementation date of management actions were revised.
13	Decarbonisation	-	Q3	WIP	-	-	Fieldwork started 13.11.23.
1	Leadership and management development	-	~~Q1~~ Q4	Planned	-	-	Management request to move to Q4 as internal development ongoing. Brief agreed 05.12.23

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
8	Finance - Budgetary controls	-	Q2	Planning	-	-	On going planning.
23	Follow up – medical variable pay	-	~~Q2~~ Q4	Planning	-	-	Have had to reschedule as audit tracker identifies implementation date of actions moved to end of October 2023. Brief issued 15.11.23
25	Follow up – reasonable offer	-	~~Q3~~ Q4	Planning	-	-	Have had to reschedule as audit tracker identifies implementation date of actions moved to end of October 2023.
24	Follow up – digital operating model	-	Q3	Planning	-	-	Fieldwork planned to start Q3.
12	Finance – Savings delivery	-	Q3	Planning	-	-	Scoping discussions on going.
11	Job planning medical pay	-	Q3	Planning	-	-	Liaising to have scoping meeting.
5	Charitable funds	-	~~Q2~~ Q3	Defer	-	-	Move to 2024/25.

Table 4: Status of PCH plan work 2023/24

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

Assignment	Status	Assurance	Notes
Financial management and change control	WIP	-	Fieldwork is concluding.
Quality – Site supervisor role	Final	Substantial	Reported December
Validation of management actions	Final	Substantial	Reported December
Technical	Planning	-	-
Governance	Planning	-	-
Delivery of key project objectives	Planning	-	-

Table 5: Hosted bodies programme of work

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	WHSSC – Integrated commissioning plan (ICP)	Substantial	Q1	Final	Y	Y	Reported December
2	WHSSC – Welsh Kidney Network	Substantial	Q2	Final	Y	Y	Reported October

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
4	EASC	-	-	Planning	-	-	Planning meeting held with EASC on 28.11.23

Arrangements for financial savings Internal Audit Report

December 2023

Cwm Taf Morgannwg University Health Board

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

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

Contents

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Final report issued:	27 November 2023
Auditors:	Ken Hughes, Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Sally May, Director of Finance
Distribution:	Mark Thomas, Deputy Director of Finance Andrew Jones, Assistant Director of Finance - Financial Planning
Committee:	Audit & Risk Committee

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

Acknowledgement

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

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Executive Summary

Purpose

To seek assurance that there are effective arrangements in place to support the achievement of the 2023/24 savings targets, including work carried out as part of the value and effectiveness enabling schemes.

Overview

This review focussed on three areas of the financial savings arrangements: the centralised processes; processes within care groups; and arrangements for enabling schemes. As such, we have issued three separate opinions relating to the relevant areas.

The matters requiring management attention include:

- Gaps remain in the identification of savings schemes needed to achieve Care Group targets.
- There was no evidence to demonstrate that impact assessments, risks or resource needs have been considered for the identified savings schemes.
- At the start of the year the nursing productivity programme did not have a number of key documents in place to inform its work.

Assurance summary

Due to large number of objectives covered in our review of the arrangements for financial savings we have provided separate assurance opinions for each of the areas that we reviewed.

Opinion for assurance area[1]

	Area	Assurance
1	Centralised processes for determining savings targets, disseminating and monitoring.	Substantial
2	Care Group processes for allocating targets, identifying, planning and monitoring schemes.	Limited
3	Enabling schemes governance structures, workplans and monitoring arrangements.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Savings Scheme assessments	5 & 6	Design	High
3	Value & Effectiveness programmes governance arrangements	8, 9 &10	Operation	High

1. Introduction

1.1 Our review of the arrangements to help achieve financial savings was undertaken in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board').

1.2 The Health Board submitted its 2023/24 Annual Plan, incorporating its financial plan, to Welsh Government (WG) at the end of March 2023, which included significant savings targets. This is the first year of planning under the Health Board's new Care Group operating model.

1.3 The Health Board has developed a Unified Change and Transformation Portfolio, merging all of its key change projects and portfolios. The Value and Effectiveness sub-portfolio brings together programmes to focus on the development and delivery of initiatives that will improve quality and effectiveness, and provide an important conduit to improve financial sustainability and meet WG targets. The Health Board has identified six programmes of work (enabling schemes) as part of the Value and Effectiveness portfolio. These are Medical Workforce Productivity, Nursing Productivity, Meds Management, Clinical Administrative Processes, Estates Rationalisation & Utilisation and Commercial Contracting & Commissioning Effectiveness.

1.4 Delivering savings is a key risk to the Health Board's financial plan for 2023/24 as it is a key component in achieving an in-year break even position. Our review sought to provide assurance that there were effective arrangements and processes in place prior to the start of the financial year, at a central and care group level to support the achievement of the 2023/24 savings targets, including the work carried out as part of the Value and Effectiveness enabling schemes. At the time of writing this report, there remained a significant gap between the Health Board's savings target for 2023/24 and the value of the schemes that had been identified.

2. Detailed Audit Findings

Objective 1: There is a centralised process in place for determining savings targets for each care group and corporate function. There are arrangements to monitor and report progress against targets. There is adequate guidance to ensure consistency in approach.

2.1 The overall savings target for 2023/24 is 3.2% (£27.3m). The savings target forms part of the finance plan developed for the three-year Integrated Medium-Term Plan (IMTP) for 2023-26.

2.2 The IMTP for 2023-26 was submitted to the CTMUHB Board in March 2023. The plan was endorsed by the Board and submitted to WG, noting that it was an annual plan set in a three-year context as the Health Board had not produced a balanced three-year plan.

2.3 The savings target for Care Groups and corporate directorates has been calculated as a percentage of their recurrent budget allocation for the year. Early planning was initially based on a 2% savings target, subsequently amended to 2.6% with some areas also having a 'stretch' target. The savings target was determined by

the Executive Leadership Group and approved by the Board. Savings plans were developed with Care Groups and corporate directorates with an aim to achieve the overall savings target.

2.4 To ensure a standardised approach to planning across the Health Board, the finance team produced an IMTP financial planning template to be completed by all Care Groups. The template includes a number of 'tabs' to record the detail of the Care Group's financial plans including savings schemes. The profiled savings are to be used for monitoring monthly progress against agreed financial savings targets.

2.5 The template includes a 'notes' page which explains how to use the 'tabs'. However, this does not detail how to populate the data on each tab, and there are no separate guidance notes to aid Care Group directors. Instead, Care Group staff work closely with their Finance Business Partners to populate the template spreadsheet. **(Matter Arising 1)**

2.6 As the Care Groups worked to develop their 2023/24 savings plans, the finance team issued a timetable setting out key actions and dates for the finance team, Care Groups, enabling scheme leads, and the executive teams.

2.7 In 2022/23 there were monthly finance meetings with Care Groups and corporate directorates to monitor the progress of savings schemes against their targets. We understand that this arrangement will continue for 2023/24 monitoring. Monitoring will include reporting progress to the Executive Leadership Group, the Planning, Performance and Finance Committee and the Board. The reports to be used show the annual savings target and the forecast savings total against the target, with explanations for variances.

2.8 In addition, as part of the financial reporting process, each month a standard monitoring return is sent to Welsh Government, which includes progress against savings targets.

Conclusion:

2.9 There is an established process for determining savings targets for Care Groups and the corporate directorates that sit outside of the care group structure. The IMTP template provides a structure for capturing savings plans. There are guidance notes for staff on the financial plan templates, and a timetable setting out the key tasks to be completed.

2.10 Monthly progress against the savings targets is monitored and reported both at various levels within the organisation, including the Executive Leadership Group, and Welsh Government. We have provided substantial assurance for this objective.

Objective 2: There are arrangements to identify and plan savings schemes within care groups, which includes a process to allocate saving targets within the care groups. Savings schemes are scrutinised and monitored, and also supported by business partners and the Project Management Office (PMO).

2.11 Care Group savings targets are based on a percentage of their revenue budgets and are set centrally by finance. The savings targets are then devolved to Clinical Service Groups (CSG) within each Care Group.

2.12 Once the targets have been set, each Care Group works with their finance business partners and CSG managers to identify potential savings schemes to achieve their allocated savings targets.

2.13 We reviewed the Unscheduled Care and Mental Health Care Groups who have three and four CSGs respectively. We saw evidence of analytical discussion between finance staff, Care Group Directors and CSG managers to identify savings schemes within the CSGs in order to achieve the savings target across the Care Group. The initial planning discussions in each of the Care Groups was based on a 2% target, but we then saw later planning documentation where the increased target had been set.

2.14 The identification of savings schemes is undertaken by the Care Groups in conjunction with Clinical Service Group managers and their finance business partners.

2.15 We saw that initially managers developed savings plans by reviewing expenditure variances against budgets towards the end of the financial year. A variance analysis was undertaken to understand if underspends could be maintained, overspends reduced, and to explore other areas where savings could be made.

2.16 A template provided by the finance team was used to record all potential savings schemes. For 2023/24, an initial submission of the finance template was prepared in December 2022 and submitted to the central finance team.

2.17 In January 2023, a presentation was made to the Care Group leads at a savings plan meeting, where the initial savings targets for each Care Group, and the actions required to further develop and refine the first drafts of their finance plans and savings plans, were discussed.

2.18 Care Groups were required to develop their finance plans and produce a 'second cut' of their savings plans by late February for submission to the central finance team. Throughout this process we saw evidence of support for Care Groups from their finance business partners, which facilitated the plans to be submitted on time. It is our understanding that the Project Management Office (PMO) were not involved at that time in providing support to any of the Care Groups to aid the development of their savings plans.

2.19 Our review of the February 2023 plans identified that the Mental Health Care Group had identified schemes equating to 97% of their original target. The Unscheduled Care Group had an additional 1% 'stretch target' on top of their original target. Their February submissions shows they identified schemes equating to 99% of the original target, but only 66% of the value when including the stretch target. It was

only after the submission of the February finance plans that the increased savings target was announced, as such, further work was required to identify additional schemes in order to achieve the revised targets. **(Matter Arising 2)**

2.20 The finance template details each savings scheme identified by a Care Group. This information is used to monitor monthly progress. Management assesses each scheme before it starts, and it is assigned a developmental 'stage' number from 1 to 4 based on the probability of the scheme delivering savings. Schemes generally will not deliver savings until they reach stage 4 of development.

2.21 We reviewed the financial plans from February 2023 for the Unscheduled Care and Mental Health Care Groups. These show that both Care Groups had identified a range of savings schemes for 2023/24, although at the time of our fieldwork, neither had identified schemes to the value of their revised target, so work was ongoing to identify further schemes. The Mental Health Care Group had an initial target of £2,120k and had identified 29 savings schemes with a value £2,060k, of which £1,931k were at stage 4. This target then increased to £2,808k. Unscheduled Care had an initial stretch target of £4,320k of savings. Thirty-nine savings schemes, with a value of £2,781k, had been identified, but only £668k were at stage 4. Their target was then increased to £5,100k.

2.22 For each identified savings scheme, the template records the CSG to which it applies, the total anticipated saving, and the scheme start and anticipated end date. The planned savings are profiled over the coming financial year to facilitate monitoring.

2.23 The template captured information such as key dependencies, scheme leads, non-financial benefits, and if Project Initiation Documents (PIDs) were in place, which should be used to describe a scheme. However, this information was not always captured. The template for Mental Health contained no information for these areas. The Unscheduled Care template had information for some of the identified schemes, but not all. Furthermore, despite the spreadsheet showing that there were no PIDs in place, RAG ratings against 'PID milestones' had been attributed to each scheme. We understand that the ratings were based on management judgement as opposed to a calculated assessment of progress against agreed targets.

2.24 We understand that PMO support was not used when developing the savings schemes, and no guidance was offered in relation to when it would be appropriate to complete a PID or project plan, or the type of information to be considered and captured. For new schemes we would expect resources, risks and impact assessments to be documented, and where relevant, included in a PID or plan. While there was no evidence in relation to this, our discussion with a CSG Manager identified that they were aware when to capture this information, based on the size of a scheme. **(Matter Arising 2)**

2.25 The finance template contains a 'risk' tab. However, this is for broader risks in relation to the Care Group's financial position and not specific to savings. This was evident for the two Care Groups that we reviewed, as while some of the risks linked to identified savings schemes, the documented risks were generally broader with

potential to impact on the financial position of the Care Group as a whole. **(Matter Arising 2)**

2.26 Within the Mental Health Care Group, savings are reviewed and discussed as part of the monthly CSG Integrated Performance Meetings (IPM). We confirmed that for 2022/23 there was ongoing scrutiny and monitoring of the savings schemes, with explanations provided for slippages and action plans for recovery at the IPM meetings. We understand that this arrangement will continue for 2023/24.

2.27 For Unscheduled Care, savings schemes are scrutinised at the fortnightly 'Finance Tracker' meetings attended by CSG managers and Care Group managers. We saw evidence of review of the whole finance position and of the savings and recovery actions. The meeting notes included the status of each savings scheme, a RAG summary and an action plan for recovery where schemes have slipped. We understand that this monitoring approach will continue for 2023/24.

2.28 While both Care Groups have mechanisms in place for monitoring their financial positions including savings, the financial performance for 2022/23 resulted in a Health Board deficit of £24.5m, a major contributor of this was the shortfall in the achievement of recurrent savings. We note that in 2023/24 the month five savings target position shows a shortfall of £3.2m against the £11.4m year-to-date target.

Conclusion:

2.29 Savings targets are allocated to CSGs within Care Groups. We saw evidence of engagement with CSG leads and Finance Business Partners to refine savings targets and to start the development of savings schemes. However, there was no PMO involvement at this time. There were arrangements in place between Care Groups and CSGs to regularly scrutinise and monitor the progress of savings schemes.

2.30 However, at the time of our fieldwork, the savings schemes identified for the Care Groups that we looked at did not meet the full value of the increased savings targets for the year. The schemes identified the expected financial savings within the financial year and the probability and timing of delivery. However, we saw no evidence that quality and risk impact assessments had been undertaken before the savings schemes started, or that an assessment of the resources required had been undertaken. We acknowledge that this type of information may be captured in a PID or project plan, but the spreadsheets indicated that none were in place for the schemes listed. We have provided Limited assurance for this objective.

Objective 3: The value and effectiveness portfolio has an appropriate governance structure. Its enabling schemes have work plans and progress is monitored and reported.

2.31 The Value and Effectiveness portfolio is made up of six enabling schemes (programmes) and is overseen by the Change Hub (Project Management Office). As part of our fieldwork, we reviewed two of these schemes: Medical Workforce Productivity; and Nursing Productivity. At the time of our review the Medical Workforce scheme had a number of established workstreams, and the Nursing Productivity scheme had one workstream. The enabling schemes and their

workstreams do not have savings targets but have been set up to work across each of the Care Groups to help them achieve their respective savings targets.

2.32 Both of the enabling schemes that we reviewed had a Board that reported into the Value and Effectiveness Board, which in turn reported into the CTM Transformation Portfolio Board.

2.33 The Medical Workforce Productivity enabling scheme is overseen by the Medical Productivity Programme Board (MPPB). The MPPB has an appropriate terms of reference that was re-approved at the April 2023 meeting.

2.34 A 2023/24 Project Initiation Document (PID) for the scheme was approved by the MPPB in April 2023. The PID sets out the rationale for the scheme, the programme workstreams, objectives, deliverables, KPIs and governance arrangements, including the name and position of accountable staff within the programme. For example, the programme manager, the Senior Responsible Officer and the operational lead for the programme. Each workstream had also been assigned a lead / responsible officer.

2.35 At the start of the financial year, the Nursing Productivity enabling scheme was not as advanced as the Medical Workforce Productivity scheme, due to changes in key staff. A Nursing Productivity Programme Board (NPPB) has been established and while an appropriate terms of reference for the group was in place, it required updating to reflect the new Care Group structure; the Value and Effectiveness Programme Board and the Unified Change and Transformation Portfolio Board. We have since been informed that an updated terms of reference has been developed, but we have not sighted a copy. **(Matter Arising 3)**

2.36 We understand that, at the time of our fieldwork, a PID for the Nursing productivity enabling scheme was in place, although we have not seen a copy. At that time, a new PID was in the process of being developed, that would set out a greater number of workstreams to aid achieving the strategic objectives and operational plans for the programme. Subsequent meetings have confirmed that a revised Nursing Productivity PID was agreed, though this was a number of months after the start of the financial year. We understand that the new PID contains three main workstreams and still has reference to the previous workstream. **(Matter Arising 3)**

2.37 The detailed plans, desired achievements and leads for the workstreams within each of the enabling schemes should be recorded within the individual programme PIDs along with timelines for delivery.

2.38 For the Medical Workforce Productivity scheme, a PID and timeframe was in place. The timeframe identifies indicative start and end dates for each workstream and the tasks to be completed against a timeline for each of the workstreams.

2.39 For the Nursing Productivity scheme, the revised PID was still under development at the time of our review. We confirmed that work was taking place against the workstream identified for this scheme. At the time the revised PID with the additional workstreams was approved, a Gantt chart was also produced. As highlighted above, due to staffing changes, these documents were not in place for

a number of months into the financial year and therefore may have an impact on achieving delivery within the year. **(Matter Arising 3)**

2.40 We have confirmed that a Programme Board has been established for both of the enabling schemes that we have reviewed. Both programmes have held Board meetings in line with the frequency set out in their terms of reference, and both have risk logs that are reviewed at each meeting.

2.41 Neither Board takes minutes of their meetings, instead recorded transcripts of the meetings are kept and an action log of decisions made, and actions arising from the meetings is retained. We note that the MPPB log sets out if an entry is an action or a decision, which helps provide clarity. However, the approach to recording absence or attendance is not consistent. Without this information it is not possible to determine if meetings were quorate and in line with their terms of reference. **(Matter Arising 3)**

2.42 The action logs for the two enabling schemes we tested showed that actions were recorded, and regular progress updates were being received by the respective Programme Boards. We saw that highlight reports are produced for the Value and Effectiveness Programme Board by the Programme Managers. These provide RAG rated progress updates for each workstream and an overall RAG rating is then attributed. The key risks / issues and the identified benefits, plus any matters that need escalating are also included on the highlight reports.

2.43 For the Medical Workforce Productivity scheme, quarter 1 tasks and an indicative timeline for each workstream were detailed in the PID and Gantt chart. We saw a clear link between the workstreams listed in the PID, the Gantt chart, the MPB agendas and the highlight reports, and therefore evidence of appropriate monitoring.

2.44 At the time of our fieldwork the revised PID for the Nursing Productivity enabling scheme was in draft and was not finalised until quarter 2. While the highlight report demonstrated monitoring, early reports reflected the position that the scheme was in at that time, with reference made to the development of the revised PID.

2.45 The March and April 2023 highlight reports for both programmes were rated amber. The Medical Workforce scheme was still in the very early stages, with Q1 of 2023/24 used to assess and agree the value of savings opportunities, and to further develop the highlight reports. We note that the MPPB action log references 'Care Group directors more involved in the programme and its workstreams', which we would encourage to ensure there is a joined-up approach between the work of the programmes and the savings targets the Care Groups are working to achieve. Further work was needed in relation to monitoring the Nursing Productivity scheme, once a revised PID had been agreed.

Conclusion:

2.46 We saw governance arrangements in place for the value and effectiveness portfolio and its enabling schemes. While decisions taken and agreed actions were recorded in action logs, there is scope to enhance the way information is captured on the action logs.

2.47 We saw detailed plans, desired achievements, leads and timeframes for the workstreams within the Medical Workforce Productivity enabling scheme however we did not see this in place for the Nursing Productivity scheme.

2.48 Progress was monitored by enabling scheme Programme Boards although at the time of our fieldwork this was happening to a greater extent for the Medical Workforce enabling scheme as it was more progressed. We have provided reasonable assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Guidance notes (Design)			**Potential Impact**
Finance templates which include multiple tabs have been produced for completion by Care Groups to record details of their financial plans including savings schemes. The templates include a 'notes' tab which provides comments on what each tab is for. However, there are no detailed guidance notes in the form of desk notes, or procedures in place. Whilst Care Group staff work closely with their Finance Business Partners, they may benefit from supplementary guidance.			Lack of documented guidance for staff may lead to errors and inconsistencies in the way financial savings plans are compiled and monitored.
Recommendations			**Priority**
1	Management should consider developing desk notes or Procedures to aid Care Group staff involved in the preparation and monitoring of the financial Plan, which includes guidance on the development of the savings schemes.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1	The finance templates are completed by the Finance Business Partners. The templates have been used for many years and regular meetings are held with the finance business partners each year to discuss any changes and to answer any questions. We do not believe that detailed procedure notes are required to support the completion of the finance templates.	N/A	N/A

Matter Arising 2: Savings scheme assessments (Design)	**Potential Impact**
There was evidence that identified savings schemes had been planned to show the expected financial savings deliverable within the 23/24 financial year, the probability of them delivering, and the timing of delivery. However, we note that neither of the Care Groups that we reviewed had identified schemes to the value of their savings target, with a significant gap to be identified in the Unscheduled Care Group, at the time of our fieldwork. In January 2023, management informed Care Groups that impact assessments were needed for all major spending decisions and efficiency programmes. However, we have not seen any guidance around this. Similarly, we are unaware of any guidance in relation to developing project plans for identified schemes. As such, we saw no evidence that risk assessments or quality impact assessments had been undertaken prior to savings schemes starting, or that any assessment of the resources required had been undertaken.	Savings schemes are not properly assessed go ahead and fail to deliver the expected savings.

Recommendations		**Priority**
2.1	Work by Care Groups and their finance support officers should continue in an attempt to close the gap between the savings targets and identified schemes.	**High**
2.2a 2.2b	Guidance should be in place in relation project plans for identified savings schemes, including when consideration should be given to developing a detailed PID for a scheme. Guidance should also include details in relation to producing quality impact assessment and risk assessment for identified schemes. Before a savings scheme starts and depending on size, a project plan should be put in place and a quality impact assessment and risk assessment should be undertaken, together with an assessment of the resources that may be required to deliver the anticipated savings.	

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	**Mental Health** This happens on an ongoing basis.	Ongoing to year end	Elaine Lorton - Service Director MH & LD

	Unscheduled Care As referenced in the report, there is active engagement between the Care Group and CSGs with the Finance team to progress saving schemes. We do not propose changing this approach. The hope is that with the conclusion of the organisational change process and staff appointed to permanent roles and fewer management gaps, there will be capacity to focus on service transformation and release of savings. To M06 savings of £3.8m savings are forecast against the 2.6% improvement target and 1% stretch (£5.1m). Unfortunately, wider service pressures have driven increased spend elsewhere which has prevented the same level of progress towards the control total.	Ongoing to year end	Sarah Follows - Director of Operations
2.2a and 2.2b	Agreed. The guidance is already in place will be updated and will set out the documentation requirements and resource assessments etc for savings schemes, which will vary depending on the size of the schemes. This will be in place ready for 24/25 planning.	Mid-January 2024	Mike Dickie - Head of Change Hub

Matter Arising 3: Value & Effectiveness programmes governance arrangements (Operation)	**Potential Impact**
Our review of the governance arrangements for the sample of two enabling schemes identified that for the Nursing Productivity programme, at the start of the financial year: • The terms of reference for the Nursing Productivity Programme Board were dated May 2022 and need to be updated to reflect the Care Group structure and the correct reporting structure of the Value and Effectiveness Programme Board and Unified Change and Transformation Portfolio Board. • A revised PID had yet to be completed and therefore had not been formally agreed. As such timeframes for the various workstreams in the programme were not in place from the start of year. We understand that since our initial fieldwork was completed, the terms of refence for the Nursing Productivity Board have been updated and a revised PID and associated work programme for 2032/24 was agreed in July 2023. We have not been sighted on any of these documents. From our review of the programme Board meetings we noted: • The action log maintained for NPPB meetings does not differentiate between what is an action and what was a decision, in the same way the MPPB does. • Neither of the programme boards consistently capture in their action logs who was in attendance or absent from each meeting. As such there is no way to determine if the meetings where decisions were made were quorate.	The Programme Board may not be operating in accordance with their Terms of Reference.

Recommendations		**Priority**
3.1	It should be ensured that future Project Initiation Documents and associated work programmes for the Value and Effectiveness schemes are developed in a timely manner to allow activity to start and be monitored from the start of the financial year.	**High**
3.2	For both the Medical Workforce and Nursing Productivity programmes, the approach to capturing attendance at Board meetings should be reviewed, allowing quoracy to be confirmed at meetings where decisions are made.	**Medium**

	For the Nursing Productivity Board, consideration should be given to amending the format of the action log to incorporate a column to identify if and entry is an action or a decision.		
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	To ensure that future PID's and associated work programmes are completed in a timely fashion to enable monitoring to begin at the start of the relevant financial year. This has now been completed for both of the sampled programmes e.g. Nursing productivity and Medical Productivity.	Completed	Greg Dix – Deputy CEO/Executive Director of Nursing, Midwifery and Patient Care (Nursing Productivity Programme) Dom Hurford – Executive Medical Director (Medical Workforce Productivity)
3.2	To amend the format of the action log to record attendance, quoracy and key decisions. This has now been implemented.	Completed	Greg Dix – Deputy CEO/Executive Director of Nursing, Midwifery and Patient Care (Nursing Productivity Programme) Dom Hurford – Executive Medical Director (Medical Workforce Productivity)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

Appendix C: Detailed scope and objectives

Scope	Objectives of the areas under review: 1. Centralised process: ▪ There is a process in place for determining the 2023/24 savings targets for each Care Group and any corporate functions. ▪ Guidance documentation and templates have been created and are available for use by Care Groups to ensure consistency in approach. ▪ There are arrangements to clearly and appropriately monitor and report progress against targets. 2. Care Group process: ▪ There is a process in place for determining how the Care Group savings target will be allocated within the Care Groups, that incorporates engagement with service leads. ▪ There are timely and effective arrangements to identify savings schemes, including the provision of support from key business partners and the Project Management Office, where relevant. ▪ Identified schemes have been effectively planned to show the expected financial saving, the probability and timing of the saving, risks to achievement and resources that may be required. Quality and risk impact assessments are undertaken prior to a scheme commencing. ▪ Arrangements have been established to allow for the scrutiny and monitoring of progress of schemes within the Care Group to ensure schemes remain on target. The requirement to providing explanations of slippages, action plans for recovery is in place. 3. Enabling schemes: ▪ An appropriate governance structure has been set established to oversee the Value and Effectiveness portfolio, with accountable people in key positions. ▪ Agreed work plans for the enabling schemes are in place, setting out the desired achievements, leads and timeframes. ▪ The enabling schemes are operating in line with the governance structures. ▪ Ongoing monitoring and reporting of progress against the enabling scheme timelines takes place to ensure progress.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

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

Deprivation of Liberty Safeguards (DoLS)

Final Internal Audit Report

November 2023

Cwm Taf Morgannwg University Health Board

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

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

Contents

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Auditors:	Paul Dalton - Head of Internal Audit Emma Samways - Deputy Head of Internal Audit John Cundy - Lead Auditor
Executive sign-off:	Greg Dix – Executive Director of Nursing, Midwifery and Patient Care
Distribution:	Claire O'Keefe – Head of Safeguarding Nadine Long – Deputy Head of Safeguarding Anthony Zdzieblo – DoLS and Mental Capacity Act Team Leader
Committee:	Audit & Risk Committee

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

Acknowledgement

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

Executive Summary

Purpose

This audit looked to ensure the current processes for DoLS applications are compliant with the DoLS Code of Practice, Welsh Government guidance and Health Board procedures. We also considered what is being done to improve and underpin staff awareness of the Mental Capacity Act (2019).

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- Localised procedures in relation to the DoLS process are not in place.
- All staff need to be trained to the required level in a timely manner.
- The system used to capture DoLS applications should be enhanced to capture additional information and have controls to check applications are not deleted in error.
- Once additional information is captured this should be used to strengthen management information reported in relation to applications, the backlogs and ongoing issues.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Policies, procedures and guidance	Reasonable
2	Staff training	Substantial
3	System for logging and managing applications in a timely manner	Limited
4	Management information	Limited
5	Liberty Protection Safeguards preparation	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Standard Operating Procedures	1	Design	Medium
2	Training	2	Operation	Medium
3	Capturing information in the application management system	3	Design	High
4	Management Information and future caseload prediction	4	Operation	Medium

1. Introduction

1.1 Our review of the Deprivation of Liberty Safeguards (DoLS) process was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board').

1.2 DoLS are an amendment to the Mental Capacity Act 2005 (the 'Act'), and provide protection for vulnerable people, in care homes or hospitals who lack capacity to consent to the care or treatment they need. If it is in the best interests of a person for a hospital or care home ('the Managing Authority') to deprive a person of their liberty to keep them safe from harm and provide appropriate treatment, then the Managing Authority must apply for permission (a DoLS authorisation). Following an assessment by a Best Interests Assessor (the Health Board has four full time and four part time), and an independent Section 12 Doctor, if needed, the Supervisory Body (the Local Authority or Health Board) gives permission to deprive that person of their liberty by granting a DoLS authorisation.

1.3 In 2014, following a Supreme Court ruling, the law in relation to DoLS changed, meaning the Act applied to more people than it had previously. The Health Board has seen an increase in the number of applications for DoLS assessments. In 2021/22 the Health Board's Safeguarding Annual Report identified that there had been 1,216 applications, which was a 20% increase in the number compared to the previous year. In 2022/23, applications rose by a further 17% to 1,428. Waiting times in 2021/22 were approximately 12–14 weeks.

1.4 In 2019 the law was changed with an amended Mental Capacity Act (2019) (the MCA). The MCA (amendment) 2019 was to put in place new legislation, the publication of a new code, and regulations under Liberty Protection Safeguards (LPS). However, in April 2023 the Department of Health and Social Care announced that the implementation of the LPS, and the Mental Capacity (Amendment) Act 2019, would be delayed. As such, existing DoLS policies, rules and regulations are still extant. However, in preparation for LPS implementation the Health Board had started to focus on embedding the MCA into its operational activities.

1.5 Our review looked at the current processes for DoLS applications to ensure they are managed in accordance with the DoLS Code of Practice, Welsh Government guidance, and Health Board procedures. We also considered the LPS preparatory work undertaken by the Health Board, and how it is used to improve current DoLS processes.

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

- Policies, procedures and responsibilities relating to DoLS are not clear resulting in non-compliance with regulations.
- DoLS applications are not logged and actioned promptly causing delays in assessments, patient's clinical needs not being met, and possible patient harm.

- Information used for monitoring DoLS applications is not up to date, accurate or complete and action is not taken to address backlogs, causing reputational damage to the Health Board and the risk of financial penalties.

2. Detailed Audit Findings

Objective 1: The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.

2.1 Safeguarding information and policies and procedures in relation to DoLS and the MCA are available on the CTM intranet pages. The information includes the UK Government DoLS Code of Practice and Welsh Government (WG) guidance. In addition, contact details for the DoLS support team are on the intranet.

2.2 Application of the legislation is covered by the WG 'Revised Standard Forms Guidance 2015', which gives clear, easy to follow guidance on what information is required on each form used in the DoLS process. Stand-alone copies of several of the most relevant forms were also available on the intranet, including 'Form 1' which is the first document to be completed when seeking a DoLS authorisation. We saw appropriate use of a number of these forms during our fieldwork.

2.3 The Code of Practice requires Supervisory Bodies (the Health Board) to have a procedure for when applications are received, that identifies the actions to take and the timescale. The Cwm Taf Safeguarding Board DoLS policy and procedures document links to the WG Standard Forms Guidance and UK DoLS Code of Practice but had not been tailored to the Health Board or been updated to reflect the 2019 boundary change. We understand that a new policy reflecting the boundary change has been drafted and is awaiting approval, however there are no other standard operating procedures (SOPs) in place which would set out the day-to-day operating processes for the team. **(Matter Arising 1)**

Conclusion:

2.4 The policies, procedures and guidance documents available on the intranet are consistent with the current Welsh Government requirements. However, there are no localised SOPs. We have provided reasonable assurance against this objective.

Objective 2: Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.

2.5 In September 2023 a new DoLS and MCA training programme was introduced as part of the Health Board's preparations for LPS. This replaced the previous training requirements. This new training is mandatory for all staff and is split over three levels dependant on role. Training requirements will be captured as part of a staff member's ESR profile. Level one training focuses on raising awareness amongst staffing groups who may have contact with patients, whereas level three is aimed at staff who are providing care to patients and are more likely to make DoLS referrals. Level three training will be required to be retaken every two years. **(Matter Arising 2)**

2.6 The first stage of the DoLS process is the completion of a Form 1 document, often by ward staff where a patient is being treated. The Form 1 should be completed by a registered practitioner who has undertaken level three MCA and DoLS training. We understand that this qualification is assumed by the DoLS team, as they do not have the capacity to check the training records of the staff submitting the forms. If a Form 1 is completed by an untrained staff member key information may be missed. However, to mitigate this, prior to accepting new applications, the DoLS team perform a quality check of the Form 1 and return it to the submitting department if information is incomplete or unclear.

2.7 Assessments are carried out by Best Interests Assessors (BIAs). There is accredited post graduate training available for the BIA role. This training is mandatory in England, but not in Wales. However, we note that six of CTM's BIAs have completed this training with two awaiting this advanced training.

2.8 At the time of our fieldwork external assessors were not used by the DoLS team, although this may change. We are aware that funding has been received and work is starting to buy in additional BIA support to help address the current backlog of applications.

Conclusion:

2.9 We note that although not mandatory, CTM have ensured all permanent BIAs have completed the accredited training course. As a minimum, DoLS and MCA awareness training is now mandatory for staff. We have provided substantial assurance against this objective.

Objective 3: An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed in a timely manner with completed documentation authorised by responsible and accountable people where necessary.

2.10 Form 1 applications received by the DoLS team are reviewed for accuracy and completion by a BIA. If the form is not correct it is returned to the ward, with a request for additional information. This is the first quality check, which ensures the DoLS team have enough information to make an initial assessment of the application. Returned forms may delay the start of the application process. Currently, no data is gathered to identify error rates in Form 1 completions that could be used to identify training requirements. **(Matter Arising 3)**

2.11 The DoLS team use a spreadsheet as their application management system. This, and all other DoLS documentation, is kept on a secure shared drive with access restricted to authorised persons only. The spreadsheet contains a number of worksheets. One is guidance which specifies what and how data is to be recorded onto the 'data' worksheet, which forms the annual report on DoLS applications as required by WG.

2.12 The remaining worksheets have been developed by the DoLS team and are used to log applications as they are received, capture details about ongoing applications and record completed applications. The approach used is simple, as

new applications are added to the bottom of the list on the 'outstanding' worksheet, with the BIAs going to the top of the list to select their next assessment for working. The 'outstanding' worksheet is the backlog, as it lists the applications received that have not yet been decided (or withdrawn/authorised/not authorised). However, there is a risk that data may be deleted from the spreadsheet. While reference numbers are attributed to each application, this is the patient number and not a sequential number. **(Matter Arising 3)**

2.13 The code of practice sets out six assessments for each application. Five of these are completed by a BIA and the sixth by an independent Section 12 doctor. All assessments should be carried out within 21 days of receipt of Form 1. However, the Health Board captures limited information in relation to stages in the application process. For example, it is not clear which BIA is working on an application, when work started or delays experienced, for example if the patient was not well enough to participate, or when the doctor assessment took place. Furthermore, there is no mechanism in the spreadsheet to identify impending due dates or expiring assessment deadlines. **(Matter Arising 3)**

2.14 Following completion of an assessment, a recommendation is sent to either the Executive Director of Nursing, or the Deputy Director of Nursing for their review and decision. This is the final quality assessment of the application. The spreadsheet does not capture the date the recommendation is sent to the Executive. When assessments are completed the decision, and its expiry date is added to the relevant spreadsheets and removed from the 'outstanding' worksheet. **(Matter Arising 3)**

Conclusion:

2.15 The process appears simple and operationally effective, and is easy for those involved to understand and operate. However, using a single excel workbook to manage an increasing caseload means there is a risk that application information could be lost or omitted. Furthermore, the spreadsheets are not capturing all of the information that could be used to enhance monitoring and decision making. We have provided limited assurance for his objective.

Objective 4: The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS applications.

2.16 WG require annual reporting on the DoLS applications received and have specified how the data should be presented. We reviewed the 2022/23 return and found it to be complete in relation to the information required by WG. The 2023/24 spreadsheet is a 'live' document and is updated as applications are received.

2.17 The Health Board's Safeguarding Adult Group oversee DoLS arrangements. A quarterly report is presented to the group which includes information on the number of assessments, the backlog, and for instances where applications are not progressing, the associated risk. However, there is no information relating to the code of practice requirement for DoLS assessments to be completed within 21 days from application receipt, or for those requiring urgent assessment within

7 days. We note that this data is not captured in the spreadsheet used for managing applications. **(Matter Arising 4)**

2.18 We analysed data for the year up to August 2023 for the 21-day timeline assessment. Our analysis showed that 363 of the 422 applications year to date were received more than 21-days prior to the date of testing. Of the 363:

- 203 were 'withdrawn' prior to decision. Meaning that the patient had been either discharged, was deceased or the patient had regained capacity. Of these, 70 were withdrawn after the 21-day target.
- For 103 a decision had been made, although for 65 the decision was made after 21-day target.
- At the time of the report, 55 were not complete, and were therefore after the 21-day target.
- For 2 applications data was missing, so analysis could not be undertaken.

As such, out of 306 applications completed, 135 (44%) were outside of the 21-day time limit.

There were 114 'live' applications, 55 (48%) were already outside of the 21-day time limit.

2.19 Each month, a caseload report for each BIA is prepared for use by the DoLS team manager. As the spreadsheet used for capturing applications holds limited information there is no record of the total time per application, particularly how long is spent on each stage of the application and what delays are being experienced. As such, there is no detail to explain why applications take longer than 21-days. **(Matter Arising 3)**

2.20 We note that while assessment interviews, documentation and preparation of reports can be time-consuming, these are processes, that cannot be shortened without risking the integrity of the decision making process.

2.21 However, there are some delays in the process which could be analysed. For example, Section 12 Doctor assessments are undertaken by doctors from other health boards. However, there is no data to support when applications are passed for S12 assessment or when the assessment is undertaken. **(Matter Arising 3)**

2.22 In three of the last four years, the DoLS team have seen an increase of approximately 20% more applications per year. There appears to be a link between MCA and DoLS training sessions and the number of applications received by the team. With greater awareness of DoLS across the Health Board resulting in more applications, means the risk of unlawfully depriving individuals of their liberties is reduced.

2.23 DoLS quarterly reporting to the Safeguarding Adult Group identifies the ability to forward plan and deal with an increasing number of applications and the backlog as a concern. There is no modelling of the predicted future DoLS demand, either for the current process, or consideration of the potential impact of LPS changes on the process.

2.24 We analysed applications received up to July 2023. We undertook some simple forward modelling which suggests that without the external BIA support identified above, present staffing levels may not be able to reduce the back log and meet future demands within the expected timelines. We are also aware that two of the current BIAs are secondees and may be required to return to their substantive posts. We acknowledge that this risk is captured in the quarterly reports. **(Matter Arising 4)**

Conclusion:

2.25 While there is management information to inform senior management of the current position of DoLS caseload and the problems the process is encountering, improvement in capturing information are required such as information on compliance with the code of practice expected target dates, and scope for the prediction of future caseloads. We have provided limited assurance for this objective.

Objective 5: Progress has been made embedding the MCA into the Health Board operations so that if/when the LPS regulations come into force the Health Board is prepared for the planned changes.

2.26 It is not clear when the UK and Welsh Government will bring in legislation to implement the LPS. However, the Health Board continues to prepare for future changes in regulations and to strengthen the current DoLS system. The Health Board has developed an MCA practitioner role who will embed MCA requirements into ward operations so that the front-line staff can recognise the need for any MCA consideration.

2.27 The new MCA training package has been mandated for all staff. There are different levels of training dependant on staff roles.

2.28 The Th MCA/DoLS Team Leader and Mental Capacity Practice Facilitator is part of the regional and national task and finish groups working to prepare for LPS and MCA changes, although due to the lack of clarity around the changes progress has been limited.

Conclusion:

2.29 The Corporate safeguarding team that incorporates the MCA and DoLS team have made progress in preparing to embed the MCA requirements into operational areas. Participation in national and regional task and finish groups has helped ensure they are aware of ongoing developments. Given the national situation regarding LPS, and the work done to promote MCA requirements, we consider substantial assurance appropriate for this objective at this time.

Appendix A: Management Action Plan

Matter Arising 1: Standard Operating Procedures (Design)			**Potential Impact**
National guidance documents are in place including UK Government DoLS Code of Practice and WG guidance notes. These documents provide the guidance and information the DoLS team need to follow to ensure compliance with the Mental Health Act. The UK Government DoLS Code of Practice requires managing authorities (the Health Board) to have procedures in place for when applications are received. The procedures should identify the action to be taken, who should take it, and within what timescales. However, there are no localised operating procedures in place setting out the CTM processes to be followed for the various stages such as receiving applications, reviewing and categorising, logging on department spreadsheet, allocating to the BIAs, quality checking and approval.			Inconsistent approach to applications resulting in non-compliance with regulations.
Recommendations			**Priority**
1	A standard operating procedure (SOP) should be developed for reference by current and future DoLS staff to ensure a consistent approach is in place for all applications. The SOP could include the process for reviewing applications ahead of logging on the spreadsheet, completion of the spreadsheet, processes for chasing outstanding information, quality checks and the authorisation process.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1	The DoLS team will develop a Standard Operating Procedure (SOP) for the following processes: • Identification of a Deprivation of Liberty and how to make a referral (ward Based) • Receiving, prioritising and recording applications. • Completion of Welsh Government datasheet and referral maintenance.	April 2024	DoLS Team Leader – Anthony Zdzieblo

	• The Role of the Best Interest Assessor, s12 Doctor, DoLS Administrator, DoLS Team Leader, Signatories, Relevant Persons Representative. • The ward responsibilities following authorisation. This SOP will complement the Health Board and Safeguarding Board DoLS policy.		

Matter Arising 2: Training (Operation)			**Potential Impact**
A revised DoLS and MCA mandatory training package has been developed, with training requirements linked to roles and captured against ESR profiles. We acknowledge that the roll out of the revised training has recently started and as such, at the time of our fieldwork training completion rates were low. Completion of training both raises awareness of the need for DoLS applications and ensures that those applications that are made are of a suitable quality.			Inconsistent approach to applications resulting in non-compliance with regulations.
Recommendations			**Priority**
2	Management should monitor DoLS / MCA training completion rates at the various levels and take action to escalate concerns where training is not being completed.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	CTMUHB compliance in MCA reset following work to allocate competencies to reflect new MCA/DoLS training. Since the audit the following changes have been implemented: • A scorecard has been developed to evidence numbers of staff who have received MCA and DoLS Training. This will continue to be monitored quarterly through the Safeguarding Operational and Executive Group (SEG). • The DoLS/MCA team now attend the CTMUHB monthly Core Learning Compliance Group to discuss compliance and highlight any areas of concern.	Action Completed	Mental Capacity Act Practice Facilitator & DoLS Team Leader – Anthony Zdzieblo

Matter Arising 3: DoLS application management system (Design)	**Potential Impact**
The DoLS application management system is an excel spreadsheet comprising of a number of worksheets that are used to log new applications, list outstanding ones, record authorisations and prepare information for the WG annual data report. We note that: • The target assessment date of 21-days for standard applications, or 7-days for urgent applications, is not calculated on the spreadsheets. As such, there are no flags to warn of impending or breached deadlines. • There is limited data captured in relation to the stage of an application, or issues that may impact on the achievement of the target deadline. For example, knowing which BIAs are allocated to applications, when they first started working on them, any delays because of patients not being well enough to participate in assessments, when passed to a Section 12 Doctor for final assessment, when that took place, when passed for Executive approval and when that took place. Such information could be analysed to identify trends and inform future planning. • Application data could be deleted in error from the spreadsheet. The unique reference number given to applications is the patient number and not a sequential number, therefore checks for missing numbers are not possible. • The team do not record applications that are received and then returned to wards for additional information. Such information would allow the team to identify departments or wards that may require DoLS application process training.	• Loss of patient information. • Patients unlawfully deprived of their liberty. • Inability to analyse information for management decision making purposes.

Recommendations		**Priority**
3.1	A review of the current application management system should be undertaken to determine what additional data should be captured that facilitates monitoring of applications, completion timeframes and the issues encountered that prevents timely completion.	**High**
3.2	Each application should be allocated a sequential reference number that allows monitoring to ensure logged applications are not deleted from the spreadsheet in error.	**High**

3.3	Consideration should be given to maintaining a log of returned applications, and the data used to identify if there are any training needs in certain wards or departments.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1 & 3.2	• Benchmarking with neighbouring Health Boards has been completed to establish what systems they use to monitor timeframes and issues experienced. Both SBUHB and ABUHB use a similar system to the one currently in place. • Options of management systems will be explored in partnership with the performance and information team and digital colleagues within CTMUHB, to ensure a robust management system within the DoLS team. One that will allow a sequential reference number.	Completed Nov '23 April 2024	DoLS Team Leader – Anthony Zdzieblo Head of Safeguarding – Claire O'Keefe
3.3	• Following the discussions prior to this report, a new returned applications log has been developed and trialled. This is completed on a daily basis and any returned applications are followed up the next day by the next BIA monitoring the inbox. • Quarterly quality assurance meetings will be held by the Head or Deputy Head of Safeguarding to review a selection of returned applications and assessments for the purposes of identifying themes and barriers. These meetings will also facilitate oversight of audits and action plans.	Initiated and trialling Nov '23 Quarterly DoLS quality assurance meetings will commence in January 24.	DoLS Team Leader – Anthony Zdzieblo & DoLS Team Deputy Head of Safeguarding - Nadine Long & DoLS Team Leader – Anthony Zdzieblo

Matter Arising 4: Management information and future caseload predictions (Operation)	**Potential Impact**
DoLS activity reports do not reference the achievement of the recommended 21-day target for assessment completion. Furthermore, no data is captured or reported in relation to the stages in the assessment process, or analysis in relation to causes of delays. There is no time recording of casework stages and actions, for example administration, interviewing, reporting, this means that opportunities for streamlining or improving the overall process are harder to identify. Finally, there is no forward look to consider future DoLS caseloads levels or related resource requirements.	• Continued failure to achieve desired timeframes. • Future resource requirements are not identified and addressed in time.

	Recommendations	**Priority**
4.1	Management information reports should include data and commentary on application numbers where the desired timeframe was not achieved and where possible analysis of reasons behind this.	**Medium**
4.2	Consideration should be given to capturing time in relation to casework stages to assist in identifying, quantifying and confirming areas where delays commonly occur	**Low**
4.3	Data modelling of future (short, medium and longer term) demands on the DoLS service in comparison to available resources should be carried out and used to help determine if short term fixes (procurement) are an appropriate solution in the medium and longer terms.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4.1	• The monthly performance management report submitted to the Deputy Head of Safeguarding by the DoLS Team Leader will be strengthened to include data analysis, identifying barriers in meeting the 7 day and 21 day statutory timescales.	December 2023	DoLS Team Leader – Anthony Zdzieblo & DoLS Team

	• Breaches in legislative time frames will be monitored and reported quarterly through the Safeguarding Executive Group.	January 2024	
4.2	• Current performance management spreadsheets will be reviewed and amended to reflect the complete DoLS process from referral to authorisation. • The development of a quality assurance and monitoring group headed by the Deputy Head of Safeguarding will identify and deliver a process for escalating operational deficits which impact on time.	Completed January 2024	Deputy Head of Safeguarding - Nadine Long
4.3	• The Health Board will undertake a retrospective review for the number of DoLS applications for the previous 4 years, when the MCA Amendment Act (2019) was passed. This data set will then be examined with a view to identifying possible trends in order to condition a respective trend for the forthcoming year. This will in turn decide on the ability to predict future flow and numbers for DoLS activity in CTMUHB.	February 2024	Head of Safeguarding – Claire O'Keefe & DoLS Team Leader – Anthony Zdzieblo

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

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

PCH Redevelopment Programme: Supervisor Role

Final Internal Audit Report

December 2023

Cwm Taf Morgannwg University Health Board

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Distribution:	Tim Burns, Assistant Director of Strategic & Operational Planning Jeremy Holifield, Responsible Officer, Prince Charles Hospital Construction Programme Gareth Watts, Director of Corporate Governance
Committee:	Audit & Risk Committee

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

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

Executive Summary

Purpose

The objective of this audit was to review the appointment of the Supervisor for the Prince Charles Hospital (PCH) Redevelopment Programme, including fulfilment of the role and associated responsibilities.

Overview

Good practice was evidenced in the appointment and contracting of the Supervisor, with the tendering process in line with the UHB's Standing Financial Instructions. Application of the NEC Professional Services Contract provides a clear Schedule of Duties, with the Contract appropriately executed by the UHB. The clear definition and delivery of the agreed role and responsibilities, and comprehensive management of site data was evident.

The matters requiring management attention include:

- Concerns noted in relation to the observations raised on Snag-R and the time taken by the Contractor to address these should receive focus in progress meetings; and
- Improved clarity of key information in monthly Supervisor reporting.

Based on the findings of the audit, substantial assurance has been determined in respect of this discrete area.

Report Classification

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary [1]

Assurance objectives		Assurance
1	Appointment	Substantial
2	Role & Responsibilities	Substantial
3	Records Management	Reasonable
4	Reporting & Monitoring	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	Concerns noted in relation to the time taken by the Contractor to address observations should be highlighted at progress meetings to gain increased traction.	3	Operation	Medium
2.2	Improved clarity in the presentation of key information at the monthly Supervisor's Reports.	4	Design	Medium

1. Introduction

1.1 This audit originated from the 2023/24 integrated audit plan for the PCH Redevelopment Programme, agreed with management and approved by the Audit and Risk Committee.

1.2 The Prince Charles Hospital (PCH) Phase 2 Ground and First Floor works has been developed with six sections of works with a total approval of £220m (which includes an allowance of £23m for inflation) and completion anticipated in June 2026.

1.3 The audit focused on the appointment of the Supervisor role for the Programme and the fulfilment of defined responsibilities.

1.4 The potential risks considered in this review included:

- The quality of works on the project may not be subject to the required level of scrutiny and challenge.
- There may be insufficient or inadequate information to adequately inform management.
- There may be no management action to control matters, or proposed action may be inadequate.

2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Supervisor Appointment: *To obtain assurance that the appointment process followed was robust and in keeping with national and local procurement policies. That formal contracts were in place and had been signed in line with UHB Standing Orders.*

2.2 The Supervisor was appointed following a tender exercise undertaken in 2018 (noting the Supervisor role was not included within the applicable NHS Building for Wales Framework).

2.3 The tender and evaluation processes were managed and reported to the UHB by the external Project Manager. The exercise resulted in four expressions of interest and three tender returns, with the highest scoring bid selected for appointment.

2.4 The report demonstrated that the tender exercise was undertaken in accordance with the requirements of the UHB's Standing Financial Instructions.

2.5 Whilst the appointment covered the whole programme, individual contracts were being issued for each phase. The current (Phase 2) contract, in the sum of £435,961, was reviewed at this audit.

2.6 The New Engineering Contract (NEC) 3 Professional Services Contract was applied, with a Schedule of Services included to clearly specify the duties required from the appointment.

2.7 The contract had been appropriately signed by the UHB in line with Standing Orders, only shortly (one week) after the date of commencement of duties.

2.8 Recognising the above, **substantial assurance** has been determined in this area.

Supervisor Role & Responsibilities: *To gain assurance that the appointed individuals had the required professional qualifications to fulfil the role and that the duties undertaken reflect those agreed within appointment documents.*

2.9 The quality assessment undertaken during the tender evaluation process included the consideration of technical / professional ability, NEC experience and the team delivering the Supervisor role during the construction period, with the appointed Supervisor team awarded the highest score of the three bidders in this area.

2.10 The members of the Supervisor team as named within the Phase 2 contract held extensive relevant experience and were observed to be fully engaged in providing the Supervisor services to the UHB: with wider team members utilised as needed for specialist input.

2.11 Resources assigned to the project were based on Activity Schedules reviewed and revised at the commencement of each phase (rather than relying on the out-of-date submission made at the time of the tender submission) and were incorporated into the formal Contract.

2.12 The required duties were specified within the Schedule of Services (included at Appendix A of the Contract), and involvement in the same was evidenced during the audit.

2.13 Management advised that performance was assessed via monitoring the quality of outputs against the Schedule of Services (rather than e.g., monitoring inputs in line with the Activity Schedule), with no concerns noted to date. However, no formal performance metrics were maintained for this process (see the ***Reporting & Monitoring*** section below).

2.14 Noting performance monitoring has been separately assessed below, **substantial assurance** has been determined in respect of Role and Responsibilities.

Records Management: *To obtain assurance that the Supervisor maintained adequate information in accordance with the requirements of the role.*

2.15 Records management arrangements were demonstrated to the Auditor during a site visit to PCH.

2.16 The Supervisor team had access to site records (drawings, programme etc.) via A-Site (a construction document management system).

2.17 The Supervisor team utilised the Snag-R system (a web-based defect and inspection management system) to record all aspects of site observations. This included:

- Weather;
- Site activity (no. tradesmen etc.);
- Site progress (including photo logs); and
- Observations / defects.

2.18 The system facilitated the monitoring and closing out of observations / defects, including interaction with the Contractor to demonstrate actions taken.

2.19 The system also enabled the auto-generation of weekly progress reports, which were issued to key parties including the UHB and Contractor, and the population of monthly progress reports, which incorporated dashboards generated from the system (see ***Reporting & Monitoring***). The UHB project management team also had direct read-only access to the system to view any areas of interest / concern.

2.20 It was noted from discussion with the Supervisor and review of reports there was a concern regarding the time taken by the Contractor to close out the observations raised within the Snag-R system. Timely closure of observations / defects is key to ensuring a smooth commissioning and handover process on completion of each section of the Phase, and it was evident that the Supervisor was actively working with the Contractor to improve this situation. Whilst recognising the focus currently being given to this issue at an operational level, it has been recommended that this be highlighted at progress meetings to gain traction until improvements are achieved, given the impact highlighted during the lessons learnt exercise following the previous sectional completions (**MA1**). See also the ***Reporting and Monitoring*** section regarding suggested improvements to reporting, including in respect of the observations / defects position.

2.21 To test the completion of site activity data of the system, a sample of dates was examined to verify data entry for the period. No concerns were noted.

2.22 Recognising the above, **reasonable assurance** is determined in this area, noting the implementation of the recommendation may help avoid future disruption during sectional commissioning and handover stages.

Reporting & Monitoring: *To ensure that the UHB received periodic reports and updates from the Supervisor in keeping with what the role requires, around the control of quality of works on the project. Also to gain assurance that the performance of the Supervisor role was monitored by the UHB and reported on as part of the six monthly KPI returns.*

2.23 As noted above, the Supervisor had a comprehensive and up-to-date data set of site activity, maintained within the Snag-R system, from which to produce project reports.

2.24 The Supervisor also discussed the lessons learned process undertaken following completion of earlier sections of the Phase, to ensure improved preparation for the next round of section completions, including readiness for the commissioning processes.

2.25 The Supervisor provided two types of routine reports to the UHB: weekly Progress & Activity Reports (auto-generated from the data held within Snag-R) and the monthly Supervisor's Report (appended to the Project Manager's Project Progress Report).

2.26 Both types of reports were found to be comprehensive in nature and shared with the UHB in a timely manner. Management has commented on the usefulness of the reports to aid wider aspects of routine project management, and to investigate areas of concern.

2.27 Recognising the largely narrative-based style of the monthly report, suggestions have been made to improve the clarity to the reader in identifying and tracking key issues, and to bring them in line with other reports received by the Project Board (**MA2**).

2.28 Noting the Supervisor appointment was not made from the NHS Building for Wales Framework, the associated 6-monthly Key Performance Indicators were not mandated. Whilst management advised they had no concerns over Supervisor performance to date, with delivery of duties and quality of output monitored against the Schedule of Services contained within the Contract, the addition of formal performance metrics would improve this process (**MA3**).

2.29 Recognising some suggestions for improved processes, **reasonable assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Records Management - Defects / Observations (Operation)	**Impact**
The Supervisor's Snag-R electronic system was used to raise, monitor and close observations and defects (observations being issues in the quality of work, but not yet escalated to formal defect) during the works. The Supervisor has highlighted a concern that the observations raised within the system were not being addressed in a sufficiently timely manner by the Contractor. Lessons learnt from the review of previously completed areas has shown that the timely addressing of quality concerns ahead of handover should improve the handover process and the quality of the finished area. Recognising the importance therefore of improving the current position, the Supervisor was actively working with the Contractor to increase the use of Snag-R in closing out observations promptly. The matter had been reported in the monthly Supervisor reports and discussed at the monthly progress meetings. Snag-R dashboards, presenting the position in terms of open/closed observations and defects, were also included in the monthly Supervisor reports (see **MA2**). Whilst noting the issue has been raised in the monthly progress meetings, increased focus should ensure this receives due attention, to gain traction on the timeliness of addressing observations ahead of the forthcoming commissioning and handover periods.	Potential risk of: • The quality of works may not be of a sufficient standard at the point of handover to the UHB.

Recommendations		**Priority**
1.1	The management of observations / defects (and specifically the rate of closure) should be highlighted at progress meetings to gain increased traction.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Agreed. Will highlight within Supervisors presentation at monthly Site Progress meetings.	December 2023	Responsible Officer, PCH Construction Programme

Matter Arising 2: Monitoring & Reporting - Reports (Design)	**Impact**

The Supervisor team produced two routine reports for the UHB:
• Weekly Progress & Activity Reports: automatically generated from the Snag-R system, providing a weekly snapshot of activity against the programme, trades on site and associated photographic evidence; and
• Monthly Supervisor's Report: included within the Project Manager's Project Progress Report (at Appendix G), and providing more detailed narrative in key areas including:
  • Site observations;
  • Areas handed over;
  • Snag-R dashboards (showing the defects/observations position);
  • Progress against programme;
  • Quality of works; and
  • Other items.
The reports were found to be timely and comprehensive, with management commenting on the usefulness of the information provided to inform wider areas of project management.
Noting the largely narrative-based nature of the monthly reports, the reader may find it difficult to interpret the key messages, and track movement / progress from one month to the next. The reports would benefit from more visual indicators and comparative data. Assurance dials (such as those used in the Project Manager's report), and an indication of movement from the prior month, for each key area, would focus the information being provided.
Where the reports included dashboards from the Snag-R system, to indicate number of defects/observations raised and closed (with comparator dashboards included from the prior month), it may be beneficial to expand this information to include the priority nature of the defects/observations which have not been addressed, to give a picture of the risk that these outstanding issues are posing.
	Potential risk of:
	• Insufficient clarity to the reader reduces the ability to scrutinise information and act accordingly.

Recommendations			Priority
2.1	The monthly Supervisor Reports could be improved in terms of the clarity of key information provided. The following is suggested: • Assurance dials could be used for each key area (progress against programme, quality of works, progress in closing defects/observations etc.), with an indication of movement from the prior month.		**Low**
2.2	• The data provided in respect of defects/observations closed/outstanding, could be enhanced to provide information regarding the priority nature of the defects which have not been actioned (e.g. high priority/low priority).		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed, though some of these areas are subjective.	January 2024	Responsible Officer, PCH Construction Programme With support from the Supervisor team
2.2	Agreed.	January 2024	Responsible Officer, PCH Construction Programme With support from the Supervisor team

Matter Arising 3: Monitoring & Reporting – Performance (Design)	**Impact**
The Project Execution Plan (PEP) stated that performance of the Supervisor, along with the other appointed support consultants, would be monitored at key milestones / every six months, as part of the NHS Building for Wales Framework requirements; with Key Performance Indicators (KPIs) to be maintained in areas such as performance and fee predictability. It is noted however that the Supervisor was not appointed via the NHS Building for Wales Framework, and formal KPIs have not been maintained for this role. Management advised that instead, performance is monitored by quality of output against the Schedule of Services included within the Contract. However, a formal record of this assessment was not maintained or reported. Whilst acknowledging that no concerns have been noted regarding the Supervisor's performance to date, formal performance monitoring (similar to the NHS Building for Wales process for other advisers, but recognising this will have to be managed separately) would be good practice, recognising the financial value and importance of this appointment.	Potential risk of: • Inadequate performance may not be appropriately recorded, reported and addressed.

Recommendations		**Priority**
3.1	Formal KPI monitoring for the Supervisor appointment should be considered.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed, will consider introduction of relevant KPIs.	January 2023	Responsible Officer, PCH Construction Programme

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

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

PCH Redevelopment: Validation of Management Action Final Internal Audit Report

December 2023

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance

Contents

Review reference:	CTM_SSU-2324_01
Report status:	Final Report
Fieldwork commencement:	October 2023
Fieldwork completion:	November 2023
Draft report issued:	30 November 2023
Management response received:	1 December 2023
Final report issued:	7 December 2023
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Sally May, Director of Finance
Distribution:	Tim Burns, Assistant Director of Strategic & Operational Planning Jeremy Holifield, Responsible Officer, Prince Charles Hospital Construction Programme Bill Rogers, Programme Director Gareth Watts, Director of Corporate Governance
Committee:	Audit & Risk Committee

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

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

Executive Summary

Purpose

The audit sought to determine the status of agreed audit recommendations contained within previous PCH Redevelopment Audit Reports.

Overview

All 9 of the agreed actions from the prior reviews have been fully implemented.

Further audits will be progressed in these areas as a part of the 2023/24 agreed Integrated Audit Plan. This will enable us to further consider and appraise the ongoing effectiveness of the actions taken by management.

Report Classification

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance Summary

	High	Medium	Low	**Total**
Closed	-	8	1	**9**
Partially Implemented	-	-	-	**-**
Outstanding	-	-	-	**-**
Total	**0**	**8**	**1**	**9**

Key Matters Remaining

	Control Design or Operation	Recommendation Priority
No issues to note.		

1. Introduction

1.1 This audit originated from the 2023/24 integrated audit plan for the Prince Charles Hospital (PCH) Redevelopment, agreed with management and approved by the Audit Committee.

The audit sought to determine the current status of agreed audit recommendations contained within previous PCH Redevelopment Audit Reports, namely:

- Validation of Management Action – October 2022.
- Phase 1b Final Account – October 2022
- Combined Report – July 2023:
  - Governance Review
  - Community Benefits
  - Change, Risk & Contingency Management

1.2 The potential risks considered in the review were:

- Management control frameworks continue to exhibit weaknesses;
- Management may not have processes in place to review and action agreed audit recommendations; and
- Management may not have adequate recording systems to inform whether requisite actions have been undertaken and are therefore unable to evidence actions.

Appendix A: Status of Previously Agreed Action

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status/ Timescale/ Responsibility
Validation of Management Action – October 2022				
1	Appropriate arrangements will be made to ensure that vacancies identified within the resource schedule are filled as a matter of priority.	Responsible Officer, PCH Construction Programme November 2021	**Medium**	Closed. The band 7 appointment commenced in post on the 1st of June 2023.
2	The stakeholder engagement strategy will be defined.	Programme Director/ Responsible Officer, PCH Construction Programme August 2022	**Medium**	Closed. A stakeholder engagement strategy was developed within the existing Project Execution Plan.
Phase 1b Final Account – October 2022				
1	The remaining subcontractor statements of final account will be obtained, and assurances provide to the UHB that these reconcile with the amounts claimed by the Supply Chain Partner.	Responsible Officer, PCH Construction Programme November 2022	**Low**	Closed. All remaining subcontractor statements have been obtained to allow agreement of the final account.

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status/ Timescale/ Responsibility
2	The cost of changes to the Target Cost should be agreed promptly and prior to work commencing.	Responsible Officer, PCH Construction Programme November 2022	**Medium**	Closed. This issue was raised with the external advisers and was being monitored at the Project Board.
Governance Review – July 2023				
1	The Planning, Performance and Finance committee will receive a regular update/ assurance on the PCH Refurbishment Programme.	Director of Finance/ Head of Capital August 2023	**Medium**	Closed. This was reported to the Planning, Performance and Finance committee and is now part of the cycle of business each 3 months.
Community Benefits – July 2023				
1	A timeline will be agreed for the reintroduction of monitoring of those community benefits suspended during the covid pandemic.	Responsible Officer PCH Programme August 2023	**Medium**	Closed. The remaining benefits were re-introduced within reporting to the November 2023 Project Board.
2	A joint exercise should be undertaken with the Supply Chain Partner to agree the focus of community benefit efforts for the remainder of the programme.	Responsible Officer PCH Programme August 2023	**Medium**	Closed. Target opportunities with community partner organisations have been identified and reported.

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status/ Timescale/ Responsibility
Change, Risk and Contingency Management – July 2023				
1	Appropriate resource should be committed to resolving the 'open' changes as a matter of priority.	Responsible Officer PCH Programme August 2023	**Medium**	Closed. This was escalated with the external advisers and monitored via Project Board.
2	The remaining financial values and risk scores at the risk register should be reviewed for adequacy/ accuracy.	Responsible Officer PCH Programme August 2023	**Medium**	Closed. The Risk Register was reviewed, and the number and rating of outstanding risks re-assessed and reduced to reflect the progress of the works. This was reported to Project Board.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

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

Archwilio Cymru
Audit Wales

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

Date issued: December 2023

Document reference: 3313A2023

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

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

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

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

Contents

About this document

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

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Certification
The Health Board's Charity's 2022-23 Annual Report and Account	Executive Director of Finance	The statutory audit of the Report and Account.	We are currently doing the audit. Trustees are due to meet in January to consider the audited Report and Account; and our audit report.	By 31 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
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.	Completed	October 2023
Structured Assessment 2023 – Core	Executive Director of Corporate Governance	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 Structured Assessment work will review: • Board and committee cohesion and effectiveness;	Completed	December 2023

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		• Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.		
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by 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.	Report drafting	February 2024

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.	Report Drafting	February 2024
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.	Report Drafting	February 2024
Structured Assessment 2023 – Deep Dive	Executive Director of Finance	We had previously indicated an intention to undertake deeper dive work to examine digital arrangements. However, given the significantly challenging financial position across NHS Wales, we are now looking at	Planning	April 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		replacing the work on digital with focused work examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.		
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from our 2022 review. The specific focus of this work is to be confirmed.	Scoping	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
Corporate Joint Committees – commentary on their progress	**November 2023**
NHS Workforce Data Briefing	September 2023
NHS Wales Finances Data Tool - Up to March 2023	September 2023
Approaches to achieving net zero across the UK	September 2023

Additional information

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

8 There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Equality Report	November 2023
Audit Wales Interim Report	October 2023
Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2025 Supporting information for the Estimate for Audit Wales 2024-25	October 2023

Audit Wales

1 Capital Quarter

Tyndall Street

Cardiff CF10 4BZ Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Structured Assessment 2023 – Cwm Taf Morgannwg University Health Board

Audit year: 2023

Date issued: October 2023

Document reference: 3920A2023

This document has been prepared as part of work performed in accordance with statutory functions.

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

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.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2023 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 under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.

2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, 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 Board transparency, cohesion, and effectiveness; corporate systems of assurance, corporate approach to planning, and corporate approach to financial management. We have not reviewed the Health Board's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers;
- Model Standing Financial Instructions;
- Relevant Welsh Government health circulars and guidance;
- The Good Governance Guide for NHS Wales Boards (Second Edition); and
- Other relevant good practice guides.

We undertook our work between July 2023 and October 2023. The methods we used to deliver our work are summarised in **Appendix 1**.

5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6 Overall, we found that **the Health Board has generally effective arrangements to ensure good governance; however, opportunities exist to improve some of these arrangements further. Addressing the financial challenges currently facing the Health Board and preparing a long-term Clinical Services Plan and an approvable Integrated-Medium Term Plan remain key priorities for the Board.**

Board transparency, effectiveness, and cohesion

7 We found that **the Board and its committees operate effectively, cohesively, and transparently, but opportunities to further enhance some arrangements remain.**

8 The Board continues to conduct its business in an open and transparent manner. Agendas and papers for Board and committee meetings continue to be published on the Health Board's website in a timely manner. However, the confirmed minutes of Board and committee meetings are not made available on the Health Board's website in a timely manner. Board meetings are held in person and are livestreamed to allow the public to observe virtually, with recordings made available on the Health Board's website. The Health Board makes good use of social media to promote Board meetings, but it should provide more guidance on how members of the public can request to attend meetings in person should they wish to do so. The Board and committees review, update, and publish key control frameworks on a regular basis, but some policies are out of date.

9 The Board and committees are operating well,and receive good support from the Corporate Governance Team despite the significant capacity challenges the team has been dealing with during 2023. Meetings are well chaired, with members and attendees observing the necessary etiquette.. Whilst the Health Board continues to have a stable and well embedded committee structure in place, it plans to review this structure next year. In doing so, the Health Board has an opportunity to align it to its long-term vision and strategic goals. Board and committee work programmes and agendas cover all aspects of their respective terms of reference and are shaped by the Board Assurance Framework. Oversight of the Health Board's estate is improving. Board meetings are generally well chaired, with members and attendees observing the necessary etiquette. Papers for Board and committee meetings are generally well written and clear.

10 The Health Board continues to demonstrate a strong commitment to hearing from staff and patients. The Board acts cohesively, with Independent Members providing a good balance of scrutiny, support, and challenge. There have been some changes to the Independent Member cadre during this year which have been managed well to with no disruption to Board business. The Health Board has continued to make effective use of self-assessments, appraisals, and board

development sessions to support learning, development, and continuous improvement.

Corporate systems of assurance

11 We found that **the Health Board's risk, performance, and quality governance arrangements continue to strengthen, but further work is required to ensure they are fully embedded across the organisation and achieving the desired impact.**

12 The Health Board's Board Assurance Framework is well embedded and starting to drive Board and committee business. The Health Board has an appropriate Board-approved risk management framework in place, with the risk management strategy, statement, and risk domains up-to-date and reflecting the organisation's new operating model.

13 The Health Board has appropriate arrangements in place to manage performance. However, it lacks a documented framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at all levels of the organisation. The Health Board's Integrated Performance Dashboard continues to provide a detailed overview of its performance, and now appropriately focusses on the key challenges facing the organisation.

14 The Health Board's arrangements for quality governance have improved significantly. The Health Board has a stronger strategic focus on quality and patient safety. Its new three-year Quality Strategy and three-year Quality and Patient Safety Framework provide a good foundation to support the delivery of the Duty of Quality and Duty of Candour which came into effect in April 2023. There is greater clarity on roles, responsibilities, accountability, and governance in relation to quality and patient safety. Organisational scrutiny of quality safety has also improved considerably, with greater openness and transparency evident. This is a positive development, and the Health Board is aware that some further action is required to fully embed its revised quality governance arrangements across the organisation.

15 The Health Board's arrangements for monitoring internal and external audit recommendations have improved. Whilst positive steps are being taken to track recommendations from other inspectorates and regulators, more could be done to identify and analyse key themes.

Corporate approach to planning

16 We found that **the Health Board's corporate planning arrangements have matured, and work is underway to develop the Clinical Services Plan. However, as with other Health Boards, it has been unable to produce an approvable IMTP. Furthermore, its arrangements for monitoring the delivery of corporate plans and strategies require further improvement.**

17 The Health Board's corporate planning arrangements continue to mature. It has a clear Board-approved vision and strategic goals, which are being used to shape its

Clinical Services Plan. There is a clear timeline in place for developing the Clinical Services Plan, progressing this work at pace remains a priority for the Health Board.

18 The Health Board has effective arrangements in place for preparing its Integrated Medium-Term Plan (IMTP). However, in common with other Health Boards in Wales, it has been unable to produce a Welsh Government approved IMTP for 2023-26 and is instead working to an Annual Plan. Further work is still required to develop clear milestones, targets, and outcomes for corporate plans and strategies to enable the Board and its committees to ensure effective monitoring, assurance, and scrutiny of progress.

Corporate approach to managing financial resources

19 We found that **despite a clear process for financial planning, and good arrangements for managing and monitoring the financial position, the Health Board's financial position is extremely challenging for 2023-24.**

20 The Health Board has a clear process for financial planning, with good involvement from the Board. However, the Health Board did not meet its statutory duties in 2022-23 in respect of achieving financial balance and having an approvable medium-term plan. The financial position for 2023-24 is extremely challenging with the Health Board working to a planned financial deficit of £79.6m million. The Health Board reported a £36.0 million year-to-date deficit against is core revenue plan in Month 5 2023-24, which was £2.8 million worse than plan. In October 2023 additional allocations were made available to Health Boards, alongside a requirement for a 10% stretch saving delivery. As a result, the Health Board now has a break-even planning position for 2023-24. position.

21 Arrangements to oversee and scrutinise financial management are effective, and the Health Board has updated several of its financial control procedures. However, the delivery of its savings plan is a challenge. The Health Board requires savings of £22.9 million but was reporting a gap of £4.4 million in its savings plans at Month 5 2023-24.

Recommendations

22 **Exhibit 1** details the recommendations arising from our work. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**. [Appendix 3 will be finalised once the report and organisational response have been considered by the relevant committee]

Exhibit 1: 2023 recommendations

Recommendations
Public observation of Board Meetings R1 Whilst the Health Board meets in public, it is not clear how members of the public can request to attend these meetings in person. The Health Board, therefore, should provide clear guidance on how members of the public can request to observe public Board meetings in person. **(Medium Priority)**
Accessibility of videos R2 The Health Board makes good use of videos in committee meetings to present patient and staff stories. However, they are not subsequently made available on the Health Board's website. The Health Board, therefore, should ensure that any videos shown during committee meetings are made available on its website for completeness with agreement of the contributors. **(Medium Priority)**
Enhancing transparency of committee business R3 Draft committee meeting minutes are produced quickly and reviewed by the relevant chair; however, they are not made publicly available until the papers of the subsequent meeting are published. Furthermore, committee meetings are not livestreamed or recorded for public use. The Health Board, therefore, should consider putting appropriate arrangements in place to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. **(Medium Priority)**
Confirmed minutes R4 Whilst the Board and committees review and confirm the minutes of previous meetings, they are not always uploaded to the Health Board's website in a timely manner. The Health Board, therefore, should ensure that all confirmed minutes are uploaded to the relevant section of its website in a timely manner to ensure the public have full access to the approved records of meetings. **(Medium Priority)**
Health Board policies and procedures R5 Whilst the Health Board has a dedicated area on its website for policies and procedures, some of them are out of date. The Health Board, therefore,

Recommendations	
	should ensure that all policies and procedures on its website are up-to-date and, if not, put a clear plan in place to revise and approve them. **(Medium Priority)**
Performance Management Framework	
R6	The Health Board has appropriate arrangements in place to manage operational performance; however, it lacks a documented performance management framework. In order to enhance its arrangements further, the Health Board should prepare a written framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at service, management, committee, and Board levels **(High Priority)**

Board transparency, effectiveness, and cohesion

23 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.

24 We found that **the Board and its committees operate effectively, cohesively, and transparently, but opportunities to further enhance some arrangements remain.**

Public transparency of Board business

25 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:

- meetings that are accessible to the public;
- papers being made publicly available in advance of meetings;
- business and decision making being conducted transparently; and
- meeting minutes being made publicly available in a timely manner.

26 We found that **transparency of Board business has continued to improve this year. However, opportunities remain to enhance some of the Board's arrangements further.**

27 The Board continues to conduct its business in an open and transparent manner. Board meetings are held in person and are livestreamed to allow the public to observe virtually, with recordings made available on the Health Board's website. The recordings are easy to access and are of good quality. We found that upcoming Board meetings are signposted effectively on social media. However, more guidance should be provided on how members of the public can request to attend these meetings in person if they wish to do so, particularly as the Board plans to hold some of its future meetings in different parts of the Health Board estate **(Recommendation 1)**.

28 The Health Board continues to publish agendas and papers for Board and committee meetings on its website in advance of meetings. Compliance with the timescales for publishing Board and committee papers has improved this year, but further work is needed to improve compliance with the timescales for publishing papers for meetings of the Board's advisory groups[1] (see **Appendix 2 - Structured Assessment 2022 R1b**). However, we recognise that this has been impacted by the capacity challenges within the Corporate Governance Team. In addition, the Health Board needs to find a way of including the videos of staff and patient stories

[1] The Health Board has three advisory Boards - the Clinical Advisory Group, the Local Partnership Forum, and the Stakeholder Reference Group.

presented during committee meetings in the papers it uploads to its website **(Recommendation 2)**.

29 The Board continues to make appropriate use of private sessions, reserving them for confidential and sensitive matters only. The Health Board publishes the agendas of private Board meetings to enhance transparency in line with our recommendation last year (see **Appendix 2 - Structured Assessment 2022 R1a**). This practice has also been extended to the majority of Board committees, with the exception of the Planning, Performance, and Finance Committee. The Health Board will need to address this to ensure consistency.

30 Draft committee meeting minutes are produced quickly and reviewed by the relevant chair; however, they are not made publicly available until the papers of the subsequent meeting are published. Furthermore, committee meetings are not livestreamed or recorded for public use. The Health Board, therefore, should consider putting appropriate arrangements in place to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business **(Recommendation 3)**. Furthermore, whilst draft minutes are confirmed at subsequent Board and committee meetings, they are not uploaded to the Health Board's website in a timely manner. Whilst we recognise that this has been impacted by the capacity challenges within the Corporate Governance Team, the Health Board should take appropriate action to address this for the future **(Recommendation 4)**.

Arrangements to support the conduct of Board business

31 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of formal, up-to-date, and publicly available:

- Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- policies and procedures in place to promote and ensure probity and propriety.

32 We found that **whilst the Board and committees regularly review, update, and publish key control frameworks and documents, some policies are out of date.**

33 The Board has formal, up-to-date, and publicly available SOs and SFIs in place with evidence of compliance. In September 2023, the Board approved updated versions of the SOs and SFIs to reflect the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2022 and the creation of the new citizen voice panel, "Llais", which has replaced the former Community Health Councils.

34 The Health Board has taken positive steps to increase public access to governance and assurance documents this year by creating a dedicated section on its website for key policies and procedures. However, some of the policies and procedures, including the Handling Concerns Policy and Incident Management Framework, are currently out of date. Whilst we recognise that this has been impacted by the capacity challenges within the Corporate Governance Team, the Health Board should take appropriate action to address this for the future **(Recommendation 5)**.

35 The Health Board has publicly available policies and procedures in place to promote and ensure probity and propriety. We have observed declarations of interest routinely being taken at the start of Board and committee meetings as a standing item on all agendas. The Audit and Risk committee routinely receives the Declaration of Interest, Gifts, Hospitality, and Sponsorship Register, which it last reviewed in August 2023.

Effectiveness of Board and committee meetings

36 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge;
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board; and
- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

37 We found that **Board and committee meetings are well chaired, conducted properly, have balanced agendas, and are generally supported by good papers. The committees are operating well, and oversight of estate matters has improved this year. The Health Board plans to review its committee structure in the next 12 months.**

38 The Board has an appropriate, integrated, and well-functioning committee structure in place which meets statutory requirements. Each committee has up to date and clear terms of reference which appropriately reflect the breadth of Health Board business. In our structured assessment report last year, we identified a gap in oversight of the Health Board's estate. The Health Board has since updated the

Planning, Performance, and Finance Committee's terms of reference to include estates (see **Appendix 2 - Structured Assessment 2022 R10b**). The Health Board intends to review the committee structure in the next 12 months to ensure it remains fit for purpose.

39 Board and committee work programmes and agendas cover all aspects of their respective terms of reference, and are shaped by the Board Assurance Framework (see **paragraph 56**). As noted earlier, the Planning, Performance, and Finance Committee is now responsible for maintaining oversight of the Health Board's estate. At the time of our work, it had received an assurance report on the Health Board's exposure to reinforced autoclaved aerated concrete (RAAC) in June 2023 and a mid-year update on the Capital and Estates Programme in October 2023. However, it had not received an overarching assurance report on the condition of the estate due to the delay in receiving the necessary data from the Estates and Facilities Performance Management System. An interim report will be presented in the meantime (see **Appendix 2 - Structured Assessment 2022 R10a and R10c**).

40 Our observations found that Board and committee meetings are generally well chaired, with members and attendees observing the necessary etiquette. Meeting agendas are appropriately planned, with the Health Board making appropriate use of consent agendas to allow sufficient time for discussion on other matters. We observed Independent Members providing a good balance of scrutiny, support, and challenge.

41 The Health Board continues to have an effective approach in place for referring matters between committees as well as to escalate matters to the Board via the highlight reports prepared by committee chairs. Chairs are effective at highlighting the key matters and risks identified by their respective committees at every Board meeting.

42 Papers for Board and committee meetings are generally well written and clear. Cover sheets clearly identify where papers have previously been scrutinised by a committee, and meeting chairs helpfully remind attendees of this to help avoid unnecessary repeat discussions. However, we found that some reports are lengthy, and opportunities remain to use cover sheets more effectively to draw attention to the key risks and issues requiring consideration.

43 Cover sheets have been updated to ensure more explicit links to the Well-being of Future Generations (Wales) Act 2015 (see **Appendix 2 - Structured Assessment 2022 R1c**). Whilst cover sheets are now used to accompany presentations, they are in a different format to report cover sheets. As a result, they do not sufficiently capture the key risks and issues associated with the presentations (see **Appendix 2 - Structured Assessment 2022 R1d**).

44 The Board and its committees are well supported by the Corporate Governance Team, despite significant capacity challenges as noted earlier. These capacity challenges arose during 2023 with the vacancy of the Director of Corporate Governance/Board Secretary role and the retirement of the Head of Corporate

Governance & Board Business. These vacancies have now been filled and the position should improve from October 2023 onwards.

Board commitment to hearing from patients / service users and staff

45 We considered whether the Board promotes and demonstrates a commitment to hearing from patients / service users and staff. We were specifically looking for evidence of:

- the Board using a range of suitable approaches to hear from patients / service-users and staff.

46 We found that **the Board demonstrates a good commitment to hearing from staff and patients.**

47 The Health Board engages effectively with staff and patients through various methods. The Board and Quality and Safety Committee receives a Shared Listening and Learning Story[2] at each meeting, which highlight both positive and negative experiences from staff and patients. The Health Board also has a formal framework in place for Board walkarounds which allow Executive Directors and Independent Members to engage directly with staff across primary, community, and acute services. There is good reporting to the Quality and Safety Committee on what was observed during walkarounds, and actions taken in response. The Health Board also has robust plans in place to involve stakeholders in the development of its Clinical Services Plan. At the time of our work, the Health Board was in the process of implementing the Speaking Up Safely Framework[3] and Guardian Service[4] across the organisation.

Board cohesiveness and commitment to continuous improvement

48 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;

[2] Patient and staff stories describing their experiences.

[3] The Speaking Up Framework aims to support organisations to create a culture where individuals feel safe and able to speak up about anything that gets in the way of delivering safe, high-quality care or which negatively affects their experience.

[4] The Guardian Service is an external independent service which operates 24/7 365 days a year offering staff a safe, confidential, and non-judgmental supportive way to raise any concern or risk in the workplace.

- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

49 We found that **the Board is cohesive and demonstrates a good commitment to self-reflection and continuous improvement. The Health Board has a strong executive team, and changes to the Independent Member cadre are being managed well.**

50 The Board acts cohesively and demonstrates appropriate support and challenge from Independent Members and appropriate responses from senior management. The Health Board's executive leadership is experienced and focussed on making a difference. The new Director of Corporate Governance joined the Health Board in September 2023, and an interim Director of Public Health is in place until a substantive appointment is made.

51 The Health Board is managing changes to its Independent Member cadre well. The new Chair took up their role in April 2023 following the retirement of the interim Chair. Since then, two Independent Members - the Vice Chair and Independent Member (Legal) - have reached the end of their terms of service in August and September 2023, respectively. Recruitment for both positions has been completed and appointments have been made. The Independent Member (Community) and Independent Member (Trade Union) will be leaving in March and September 2024, respectively. In light of these changes, the Health Board has recently refreshed the membership of its committees to maintain continuity and minimise disruption to Board business.

52 The Board and its committee routinely review their effectiveness and make good use self-assessments to inform and support continuous improvement. The Health Board has continued to make effective use of development sessions to support Board learning and development. These sessions have also been used during 2022-23 to support the development of the long-term vision and priorities for the organisation. The Chair has undertaken Personal Development Reviews with all Independent Members.

Corporate systems of assurance

53 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

54 We found that **the Health Board's risk, performance, and quality governance arrangements continue to strengthen, but further work is required to ensure they are fully embedded across the organisation and are achieving the desired impact.**

Corporate approach to overseeing risks

55 We considered whether the Health Board has a sound approach to identifying, overseeing, and scrutinising strategic and corporate risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives;
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.
- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and
- the Board providing effective oversight and scrutiny of corporate risks.

56 We found that **the Board Assurance Framework is well embedded and starting to drive the business of the Board and committees. Organisational risk management arrangements are appropriate and routinely reviewed.**

57 The Health Board's BAF continues to appropriately reflect the key risks to achieving the organisation's strategic goals. It provides good information on gaps in controls and assurance, as well as mitigating actions. The Board actively reviews and scrutinises the BAF at each public board meeting, and new strategic risks are added as required. For example, in September 2023, the Board approved the addition of a strategic risk relation to population health – prevention and early intervention. As recommended in last year's structured assessment report, the Health Board is now actively using the BAF to shape and inform committee business (see **Appendix 2 - Structured Assessment 2022 R2**). The BAF and committee assigned risks are discussed at all agenda planning meetings and considered when shaping committee cycles of business. The principal and strategic risks assigned to committees are now captured within the organisational risk register submitted to committee meetings.

58 The Health Board has an appropriate risk management framework in place which is effectively overseen and scrutinised by the Board. The risk management framework is reviewed annually. In May 2023, the Health Board updated the risk management strategy, risk management statement, and the risk domains to reflect the organisation's new operating model. Whilst the Board does not formally review the organisational risk register at each meeting, it is available to members of the Board to support the discussion on the BAF. There is appropriate review of the organisational risk register in its totality at Audit and Risk Committee meetings, with individual committees maintaining good oversight of the risks assigned to them.

Corporate approach to overseeing organisational performance

59 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

60 We found that **whilst performance management arrangements are in place, the Health Board lacks a documented framework. Performance reporting is now more appropriately targeted to areas of concern, and the Health Board is taking positive steps to improve the presentation of information.**

61 The Health Board has appropriate arrangements in place to manage operational performance which include a performance dashboard covering quality, performance, and monthly performance and finance meetings between the Care Groups and senior executives. In order to enhance its arrangements further, the Health Board should update the current draft performance management framework, to reflect the new Health Board structure and ensure it clearly sets out roles, responsibilities, and frequency for reviewing performance at service and management levels. **(Recommendation 6)**.

62 The Integrated Performance Dashboard (IPD) continues to provide a detailed overview of the Health Board's performance against national delivery measures, ministerial priorities, and local quality and safety measures. The report is presented at each public Board and Planning, Performance, and Finance Committee meeting by the relevant Executive Directors. As recommended in our structured assessment report last year, performance reporting is now more appropriately focussed on the key challenges the Health Board faces in both planned care, and urgent and emergency care (see **Appendix 2 - Structured Assessment 2022 R3**). Furthermore, in order to improve the presentation of information, the IPD was amended in September 2023 to include a key metrics section to help draw the attention of Board members to key performance areas. Whilst this aspect of the IPD gives Board members a more holistic overview of organisational performance, it is still in its early stages of development and continues to be refined.

Corporate approach to overseeing the quality and safety of services

63 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical / quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

64 We found that **the Health Board's arrangements for quality governance have improved significantly, but further work is needed ensure they are fully embedded and improve quality outcomes as intended.**

65 The Health Board has made significant progress in addressing the substantial concerns and recommendations set out in our 2019 Joint Review of Quality Governance Arrangements with Healthcare Inspectorate Wales. In August 2023, we published our Joint Review Follow-up report. We found that:

- The Health Board has a stronger strategic focus on quality and patient safety. Its new three-year Quality Strategy clearly articulates the organisation's quality vision, mission, pledge, ambitions, and goals. It also clearly sets out the Health Board's approach to quality, as well as what success will look like.
- The strategy, together with the new three-year Quality and Patient Safety Framework, provides a good foundation to support the delivery of the new Duty of Quality and Duty of Candour, which came into effect in April 2023.
- There is greater clarity on roles, responsibilities, accountability, and governance in relation to quality and patient safety at all levels of the organisation.
- Organisational scrutiny of quality and patient safety has improved considerably, with greater openness and transparency evident. The Health Board's Quality and Safety Committee is operating effectively. The quality of the papers prepared for the committee has improved, and we observed Independent Members providing a good balance of support, scrutiny, and challenge.

66 This is a positive development, and the Health Board is aware that some further action is required to address our outstanding recommendations and fully embed its revised quality governance arrangements across the organisation to ensure they consistently support the delivery of safe and high-quality healthcare and positive patient outcomes.

Corporate approach to tracking recommendations

67 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

68 We found that **arrangements for monitoring internal and external audit recommendations have improved, and steps are now being taken to track recommendations from other inspectorates and regulators.**

69 The Health Board has continued to strengthen its arrangements for tracking internal and external recommendations. The audit tracker for internal and external audit has continued to be refined and is working well. The summary report, which provides an update to the Audit and Risk Committee, on the closure of recommendations and subsequent removal from the tracker has also improved since last year, with more detail provided for assurance. As of October 2023, 73 of the 137 outstanding internal audit recommendations and 7 of the 21 outstanding Audit Wales recommendations had passed their target implementation date. Plans are in place to move the tracking of recommendations onto the AmAT[5] audit system which should support the Corporate Governance Team to obtain and provide timelier updates on progress. This move should also help the Health Board to identify, analyse, and respond to common themes and trends emerging from recommendations.

70 The Health Board has developed its arrangements for tracking recommendations made by external inspection and regulatory bodies, noting this was first flagged as a recommendation in our 2018 structured assessment report (see **Appendix 2 - Structured Assessment 2018 R6**). In July 2023, the Quality and Safety Committee received a prototype tracking report on the recommendations from Healthcare Inspectorate Wales. Whilst this is a positive development, the report was high level and did not provide detail on the areas where recommendations were outstanding, or any thematic analysis of the information. However, we understand that this data will be included in the new AmAT system, which should enable the Health Board to identify and analyse key themes. Furthermore, recommendations from other inspectorates and regulators including the Delivery Unit were not yet included.

[5] AMaT is an audit management and tracking tool, which utilises dashboards to give intelligence, and enables staff to update progress in real time reducing the burden on governance teams as it automates many of the processes, such as asking for progress updates.

Corporate approach to planning

71 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

72 We found that **the Health Board's corporate planning arrangements have matured, and work is underway to develop the Clinical Services Plan. However, as with other Health Boards, it has been unable to produce an approvable IMTP. Furthermore, its arrangements for monitoring the delivery of corporate plans and strategies require further improvements.**

Corporate approach to producing strategies and plans

73 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place, which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

74 We found that **the Health Board's corporate planning arrangements are generally good. However, as with other Health Boards, it has been unable to produce an approvable IMTP. The Health Board has clear plans in place to develop a Clinical Services Plan, and progressing this work remains a priority for the Board.**

75 The Health Board's approach to corporate planning continues to mature. As noted in last year's structured assessment, the Health Board has a clear Board-approved vision which is underpinned by four strategic goals – Creating Health, Improving Care, Sustaining our Future, and Inspiring People. We noted that whilst the Health Board had made positive progress in developing its new strategy, CTM 2030 – Our Health, Our Future, the document lacked clear and measurable outcomes. The Health Board is making good progress in addressing this through the work of the Strategy Groups, which have been established to develop clear actions and outcome measures for each strategic goal (see **Appendix 2 - Structured Assessment 2022 R4**). The Board and the Planning, Performance, and Finance Committee continue to maintain effective oversight of these arrangements, with Independent Members providing appropriate input, scrutiny, and challenge as required.

76 The Health Board has recently established a clear timeline for developing its Clinical Services Plan in the context of CTM 2030, which was approved by the Board in July 2023. The Health Board is aiming to develop its Clinical Services Plan in a phased approach to allow it to make key changes in the short-term whilst scoping and developing its plans for the medium- to longer-term. The Health Board also intends to develop an Estates Plan and People Plan alongside the Clinical Services Plan. Progressing this work at pace and ensuring all key corporate plans and strategies are aligned remains a priority for the Board.

77 The Health Board has effective arrangements for preparing its Integrated Medium-Term Plan 2023-26 / Annual Plan 2023-24. The Health Board adopted a bottom-up approach this year, building its plan from the service plans prepared by each Care Group and Corporate Directorate. Clear guidance and templates were issued to each Care Group and Corporate Directorate, and support was provided by the Corporate Planning Team and Business Partners to ensure plans reflected CTM 2030 and Welsh Government requirements. The Board and Planning, Performance, and Finance Committee were fully involved in the process of developing and approving the plan. Both the Board and committee provided good scrutiny, challenge, and input particularly in relation to the financial options and investment priorities for 2023-24. However, despite these arrangements, the Health Board was unable to produce a Welsh Government approved Integrated Medium-Term Plan for 2023-26 due to its planned financial deficit in 2023-24. This was also the case for other Health Boards in Wales. Instead, the Health Board is working to an Annual Plan set in the context of CTM 2030 and the unapproved three-year plan.

Corporate approach to overseeing the delivery of strategies and plans

78 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- Corporate plans, including the IMTP, containing clear strategic priorities / objectives and SMART[6] milestones, targets, and outcomes that aid monitoring and reporting; and
- The Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

79 We found that **further work is required to develop clear milestones, targets, and outcomes for corporate plans and strategies to enable effective monitoring, assurance, and scrutiny.**

80 As noted in **paragraph 75**, work is underway to develop clear milestones, targets, and outcomes for CTM 2030. Until this work is completed, the Board will be unable

[6] specific, measurable, achievable, relevant, and time-bound

to monitor the Health Board's progress in achieving its strategic goals and objectives. Whilst the IMTP and Annual Plan include a range of different priorities, actions, deliverables, or measures for 2023-24, they are still not summarised and presented in a way that would allow progress to be monitored and reported on a regular basis (see **Appendix 2 - Structured Assessment 2022 R5a**). Furthermore, there is still no clarity on which Executive Directors are responsible for ensuring the delivery of key actions/deliverables, thus limiting opportunities for appropriate accountability (see **Appendix 2 - Structured Assessment 2022 R5b**).

81 Whilst progress on delivering the Annual Plan is reported to the Board and Planning, Performance, and Finance Committee on a regular basis, the reports are very narrative in nature. Furthermore, they are still not sufficiently aligned to the Integrated Performance Report. As a result, the Board is still 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 (see **Appendix 2 - Structured Assessment 2022 R5c**).

Corporate approach to managing financial resources

82 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

83 We found that **despite a clear process for financial planning, and good arrangements for managing and monitoring the financial position, the Health Board's financial position is extremely challenging for 2023-24.**

Financial objectives

84 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:

- the organisation meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
- the organisation is on course to meeting its objectives and duties in 2023-24;

85 We found that **the Health Board did not achieve its financial duties for 2022-23, and the financial position is extremely challenging for 2023-24.**

86 The Health Board failed to meet its statutory financial duties for 2022-23. Firstly, the Health Board did not break-even against its Resource Revenue Limit over the three-year rolling period 2020-21 to 2022-23, thus breaching its cumulative revenue resource limit of £3.853 million by £24.221 million. Secondly, the Health Board was unable to produce a Welsh Government approved Integrated Medium-term Plan (IMTP) for 2022-25.

87 The Health Board has again been unable to submit a balanced financial plan for 2023-26. Instead, it is working to an Annual Plan which sets out a predicted deficit

of £79.6 million for 2023-24. At Month 5 2023-24, the Health Board reported a £36 million year-to-date deficit against is core revenue plan, which was £2.8 million worse than plan. The main driver for this adverse variance is a shortfall in savings delivery. At the time of our work the Health Board was forecasting that the deficit would remain at £79.6million as per the core plan submitted to Welsh Government, the situation remains very challenging. In October 2023, additional allocations were made available to Health Boards, alongside a requirement for a 10% stretch saving delivery. As a result, the Health Board now has a break even planning position for 2023-24."

Corporate approach to financial planning

88 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place, which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

89 We found that **the Health Board has a clear process for financial planning; however, the development and delivery of its savings plans is a challenge.**

90 The Health Board has a clear framework for developing its financial plan. The plan for 2023-24 was developed using a bottom-up approach from the Care Groups and Corporate Directorates, with support provided by Finance Business Partners. This year, the Health Board has centralised the Finance Business Partners as they had previously been part of the Integrated Locality Group structure which was recently disbanded. Centralising the Finance Business Partners as well as other Business Partners has improved consistency and strengthened resilience across the organisation. The Health Board has also strengthened resilience further by investing in more Finance Business Partners. Independent Members were regularly briefed throughout the process of developing and finalising the financial plan. The Board and the Planning, Performance, and Finance Committee were also fully engaged in the scrutiny of the plan prior to its original submission and subsequent resubmission to Welsh Government.

91 The Health Board requires a significant level of savings; however, there remain gaps in the savings plan and delivery of identified savings is off track. The Health Board set a savings requirement of £27.3 million at the start of the financial year. At Month 5 2023-24, the Health Board was forecasting delivery of £22.9 million in savings, which was £4.4 million below target. However, actual savings in Month 5 2023-24 year-to-date was £8.2 million, which was £3.2 million below the Month 5

year-to-date savings target of £11.4 million. The Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

92 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place, which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

93 We found that **arrangements in place to oversee and scrutinise financial management are effective.**

94 The Health Board has adequate arrangement to ensure compliance with its Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD). The SFIs and SORD have been reviewed and approved by the Board. The Health Board has reviewed the upper financial limit for the Chief Executive as recommended in last year's structured assessment report (see **Appendix 2 - Structured Assessment 2022 R7a**), and the new level set is consistent with the model Standing Orders and SFIs from Welsh Government. Good arrangements are in place for counter fraud, with an agreed annual workplan and reports which show delivery against the plan received at each Audit and Risk Committee meeting. There is also now a clear process for the Board to review and approve capital programmes and projects (see **Appendix 2 - Structured Assessment 2022 R7b**). Quarterly capital reports are presented to the Planning, Performance, and Finance Committee, with bespoke reports on special projects (such as the Llantrisant Health Park) being received by Board for scrutiny. Last year, some of the financial control procedures on the Health Board's website were out of date. Of the eight that needed to be reviewed, five have been updated and the remaining three are on track for approval in December 2023 (see **Appendix 2 - Structured Assessment 2022 R7c**).

95 The Health Board is aware of its cost drivers and controls are in place to manage the financial position. The Health Board has taken positive steps to enhance its financial management arrangements b by issuing strengthened accountability

letters from the Chief Executive Officer to Corporate Directorates and Care Groups (see **Appendix 2 - Structured Assessment 2022 R6**).

96 The Health Board has good arrangements in place to monitor financial performance. Monthly finance review meetings are held with all Care Groups, and with other functions on a bi-monthly basis. These meetings cover savings delivery, expenditure variances, and action plans to improve the overall control environment. However, as mentioned in **paragraph 60** there is currently no documented performance management framework in place to escalate areas of concern.

97 The Health Board submitted good quality draft financial statements as per the required timeline. Our audit identified no material misstatements but did identify some areas where corrections should be made. Our audit also made recommendations to improve working papers to support primary care expenditure, and several recommendations around improvements needed to digital controls. We issued an unqualified opinion in respect of the true and fairness of the accounts, but a qualified regulatory opinion due to the Health Board breaching its duty to deliver a break-even position over the rolling three-year period 2020-23.

Board oversight of financial performance

98 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- The Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- The Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

99 We found that **the Health Board has good arrangements for monitoring financial performance, with improved scrutiny of care groups and other directorates.**

100 The Health Board has effective arrangements for reporting financial performance to the Board and the Planning, Performance, and Finance Committee. Reports are timely and make good use of text and exhibits to convey key messages. They receive good scrutiny from Independent Members.

101 In last year's structured assessment report, we noted that the Health Board needed to report the financial performance of the Care Groups. This has been addressed, and the Health Board now reports the performance of Care Groups and Corporate Directorates against the delegated budgets at each Planning, Performance, and Finance Committee meeting (see **Appendix 2 - Structured Assessment 2022 R8b**). However, whilst reports continue to highlight key financial risks, opportunities, and assumptions, they could provide more detail on what actions are being taken, for example where care groups have not identified the required proportion of forecast savings. (see **Appendix 2 - Structured Assessment 2022 R8a**).

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

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; • In Committee Extraordinary Board Session; • 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 Board; • Chief Executive; • Chair of Audit and Risk Committee; • Executive Director of Finance; • Executive Director of Strategy and Transformation; • Chief Operating Officer; and • Director of Corporate Governance.

Appendix 2

Progress made on previous year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports.

Recommendation	Description of progress
Audit Recommendations Structured Assessment 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.	**In Progress –** see paragraph 70
Direct and Indirect Harm from COVID-19 Structured Assessment 2021 (Phase 2) R5: The Health Board has undertaken specific work in relation to COVID-19.	**Completed** – The Health Board has a framework in place and reports on its work in this area are presented to the Quality and Safety Committee.

Recommendation	Description of progress
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 accompanying report outlining key issues are monitored by appropriate operational, strategic groups and reported to the Board or on of its committees.	
Improving administrative governance arrangements Structured Assessment 2022 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	a) **In Progress**– See paragraph 28 b) **In Progress** – see paragraph 29 c) **Completed** – see paragraph 43 d) **No Progress** – see paragraph 43

Recommendation	Description of progress
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 Structured Assessment 2022 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.	**Completed** – see paragraph 57
Strengthening performance management arrangements Structured Assessment 2022 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	**In Progress** – see paragraph 61

Recommendation	Description of progress
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 Structured Assessment 2022 R4: 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.	**In Progress** – see paragraph 75
Enhancing arrangements for monitoring delivery of corporate plans and strategies and reporting progress to the Board	

Recommendation	Description of progress
Structured Assessment 2022 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.	a) **No Progress** – see paragraph 80 b) **No Progress** – see paragraph 80 c) **No Progress** – see paragraph 81
Strengthening financial management arrangements Structured Assessment 2022 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	**Completed** – See paragraph 95

Recommendation	Description of progress
sufficient grip and challenge at all levels of organisation on expenditure and savings delivery.	
Strengthening financial controls Structured Assessment 2022 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.	a) **Completed** – See paragraph 94 b) **Completed** – See paragraph 94 c) **In Progress** - See paragraph 94
Enhancing financial reports to the Board	a) **In Progress** – See paragraph 101

Recommendation	Description of progress
Structured Assessment 2022 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.	b) **Completed** – See paragraph 101
Maximising the benefits of digital technologies and solutions Structured Assessment 2022 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 indents to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	**In Progress** – Despite the limited resources the Health Board has made some progress developing digital plans. Within the 2023-24 plan there was an additional £3m allocated to digital. Projects included, digitising patient notes, investment in digital system and the digital team.

Recommendation	Description of progress
Strengthening Board-level oversight of estates issues and risks Structured Assessment 2022 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 estate issues which may have a significant health and safety impact with the Quality and Safety Committee.	a) **In Progress** – see paragraph 39 b) **Completed** – See paragraph 38 c) **No Progress** – see paragraph 39

Appendix 3

Organisational response to audit recommendations

Exhibit 4: Cwm Taf Morgannwg University Health Board response to our audit recommendations.

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	**Public observation of Board Meetings** Whilst the Health Board meets in public, it is not clear how members of the public can request to attend these meetings in person. The Health Board, therefore, should provide clear guidance on how members of the public can request to observe public	With effect from January 2024 the Health Board will include guidance on how members of the public can join Board meetings in person. This information will be captured on the Health Board's website and when sharing details of upcoming Board meetings via the Health Board's social media channels.	31 January 2024	Director of Corporate Governance / Board Secretary

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)
	Board meetings in person. **(Medium Priority)**			
R2	**Accessibility of videos** The Health Board makes good use of videos in committee meetings to present patient and staff stories. However, they are not subsequently made available on the Health Board's website. The Health Board, therefore, should ensure that any videos shown during committee meetings are made available on its website for completeness with agreement of the contributors. (Medium Priority)	Shared Listening and Learning Story videos will be published with the relevant Board Committee papers following the meeting. The Corporate Governance Team will also link in with the Patient Experience Leads and Communications and Engagement colleagues to consider how awareness of these stories can be enhanced internally and externally using the various communication channels available.	31 March 2024	Director of Corporate Governance / Board Secretary
R3	**Enhancing transparency of committee business**	The Corporate Governance Team will be reviewing how it can further enhance transparency around its Board Committee Business e.g.	31 March 2024	Director of Corporate Governance /

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)
	R3 Draft committee meeting minutes are produced quickly and reviewed by the relevant chair; however, they are not made publicly available until the papers of the subsequent meeting are published. Furthermore, committee meetings are not livestreamed or recorded for public use. The Health Board, therefore, should consider putting appropriate arrangements in place to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. (Medium Priority)	sharing a summary of planned business on the website ahead of publication of papers, publishing shared listening and learning videos (linked to R2) etc.		Board Secretary
R4	**Confirmed minutes** Whilst the Board and committees review and confirm the minutes of previous meetings, they are not always uploaded to the Health Board's website in a timely manner. The	With effect from January 2024 the Health Board will introduce a dedicated page on the website for "Latest Confirmed and Unconfirmed Minutes" for each Board meeting and Board Committee.	31 January 2024	Director of Corporate Governance / Board Secretary

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)
	Health Board, therefore, should ensure that all confirmed minutes are uploaded to the relevant section of its website in a timely manner to ensure the public have full access to the approved records of meetings. **(Medium Priority)**			
R5	**Health Board policies and procedures** Whilst the Health Board has a dedicated area on its website for policies and procedures, some of them are out of date. The Health Board, therefore, should ensure that all policies and procedures on its website are up-to-date and, if not, put a clear plan in place to revise and approve them. **(Medium Priority)**	The following policies and procedures are available on the Health Boards public facing website: • Risk Management Strategy • Risk Management Policy • Standards of Behaviour Framework Policy • Incident Management Framework • Handling Concerns Policy • Raising Concerns Policy (Whistleblowing) • Freedom of Information Policy • Environmental Policy	31 January 2024	Executive Director of Nursing / Deputy Chief Executive Officer

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)
		The Concerns Policy & Procedures which are linked to the review of the Incident Management Framework which is planned to be presented to the January 2024 Quality & Safety Committee for approval. With regards to the Incident Management Framework review and updating of this is in progress and expected to be completed by the end of the year. The other policies and procedures published on this page are in date in terms of their scheduled review.		
R6	**Performance Management Framework**	The Health Board has developed a working version of the Performance Framework, however it does require updating to reflect the new	28 February 2024	Executive Director of

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)
	The Health Board has appropriate arrangements in place to manage operational performance; however, it lacks a documented performance management framework. In order to enhance its arrangements further, the Health Board should prepare a written framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at service, management, committee, and Board levels **(High Priority)**	organisational structure and the latest Welsh Government performance framework. This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27 February 2024), for approval.		Strategy & Transformation Director of Digital

Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

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