CTMUHB Audit & Risk Committee

Wed 21 June 2023, 11:15 - 12:30

Virtually via Microsoft Teams

Agenda

11:15 - 11:15
0 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Patsy Roseblade, Committee Chair*

1.2. Apologies for Absence

Information *Patsy Roseblade, Committee Chair*

1.3. Declarations of Interest

Information *Patsy Roseblade, Committee Chair*

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2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the meeting held on 19 April 2023

Decision *Patsy Roseblade, Committee Chair*

2.1.1 Unconfirmed Minutes CTMUHB ARC 19 April 2023 ARC 21 June 2023.pdf (17 pages)

2.1.2. Unconfirmed In Committee Minutes of the meeting held on 19 April 2023

Decision *Patsy Roseblade, Committee Chair*

2.1.2 Unconfirmed Minutes In Committee CTMUHB ARC 19 April 2023 ARC 21 June 2023.pdf (2 pages)

2.2. FOR NOTING

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

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

2.2.1a Audit & Risk Committee Cycle of Business - Cover Paper.pdf (2 pages)
2.2.1b Audit Risk Committee Cycle of Business ARC 21 June 2023.pdf (4 pages)

2.2.2. Audit & Risk Committee Forward Work Programme

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

2.2.2 Audit & Risk Committee Forward Work Plan ARC 21 June 2023.pdf (2 pages)

2.2.3. CTMUHB ISO14001 Certification Progress Report

Information *Gethin Hughes, Chief Operating Officer*

2.2.3 ISO14001 Certification position statement ARC 21 June 2023.pdf (7 pages)

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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 21 June 2023.pdf (8 pages)

3.2. Matters Arising not Contained within the Action Log

Discussion *Patsy Roseblade, Committee Chair*

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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 21 June 2023.pdf (2 pages)
- 4.1b Local Counter Fraud Update Report Jun 23 ARC 21 June 2023.pdf (4 pages)
- 4.1c Appendix 1 Counter Fraud Benchmark Report ARC 21 June 2023.pdf (6 pages)
- 4.1d Appendix 2 Proactive Exercise - Overpayment of Salary ARC 21 June 2023.pdf (12 pages)
- 4.1e Appendix 3 Counter Fraud Investigations Update ARC 21 June 2023.pdf (12 pages)

4.1.1. National Fraud Initiative progress and outcomes.

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

- 4.1.1 National Fraud Initiative Progress and Outcomes ARC 21 June 2023.pdf (3 pages)

4.2. Procurement and Scheme of Delegation Report

Discussion *Sally May, Executive Director of Finance*

- 4.2a Scheme of Delegation Report ARC 21 June 2023.pdf (6 pages)
- 4.2b Appendix 1 FCP Capital Monitoring review 2023 ARC 21 June 2023.pdf (31 pages)

4.3. Losses & Special Payments Report

Discussion *Sally May, Executive Director of Finance*

- 4.3a Losses Special Payments Report -March 2023 ARC 21 June 2023.pdf (12 pages)
- 4.3b Losses and Special Payments Report Appendices Mar 23 ARC 21 June 2023.pdf (10 pages)

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5. IMPROVING CARE

5.1. Organisational Risk Register

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

- 5.1a Organisational Risk Register Post ELG May - ARC June 2023.pdf (5 pages)
- 5.1b Appendix 1 - Master Organisational Risk Register May 23 - ARC June 23.pdf (14 pages)

5.2. Audit Recommendations Tracker

Discussion *Emma Walters, Corporate Governance Manager*

- 5.2a Audit Recommendations Tracker Update Report ARC 21 June 2023 - CH.pdf (7 pages)
- 5.2b Appendix 1 Internal Audit Recommendations Tracker June 2023 ARC 21 June 2023.pdf (20 pages)
- 5.2c Appendix 2 External Audit Tracker June 2023 Updates ARC 21 June 2023.pdf (5 pages)

5.3. AUDIT WALES

5.3.1. Audit Wales Audit & Risk Committee Update

Discussion *Sara Utley, Audit Wales*

5.3.1 AW Audit Update ARC 21 June 2023.pdf (14 pages)

5.3.2. Audit Wales Forward Work Programme 2023-2026

Discussion *Sara Utley, Audit Wales*

5.3.2 Audit Wales Forward Work Programme 2023 - 2026 ARC 21 June 2023.pdf (14 pages)

5.3.3. Audit Wales National and Local Report Orthopaedic Services - to include the Local Management Response

Discussion *Sara Utley, Audit Wales*

5.3.3a Orthopaedic_Services_in_Wales_Tackling_the_Waiting_List_Backlog (1) ARC 21 June 2023.pdf (43 pages)
5.3.3b AW ctm_orthopaedics ARC 21 June 2023.pdf (28 pages)
5.3.3c CTMUHB Organisational Management Response - Orthoepadic Review 21 June 2023.pdf (6 pages)

5.3.4. Audit Wales CTMUHB Detailed Audit Plan 2023

Discussion *Sara Utley, Audit Wales*

5.3.4 CTM Detailed Audit Plan 2023 (NHS) (1) ARC 21 June 2023.pdf (24 pages)

5.4. INTERNAL AUDIT

5.4.1. Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

5.4.1 CTM -Progress report - June 2023 ARC 21 June 2023.pdf (9 pages)

5.4.2. Internal Audit Reviews

Discussion *Paul Dalton, Head of Internal Audit*

- Welsh Risk Pool
- Concerns Follow Up Review
- SLA Arrangements (Limited Assurance)

5.4.2a CTMUHB 22.23 WRP Final Internal Audit Report ARC 21 June 2023.pdf (14 pages)
5.4.2b CTM Concerns Follow Up Final Internal Audit report ARC 21 June 2023.pdf (19 pages)
5.4.2c CTMUHB 22.23 SLA Arrangements Internal Audit Report final ARC 21 June 2023.pdf (17 pages)

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6. ANY OTHER BUSINESS

Discussion *Patsy Roseblade, Committee Chair*

6.1. HOW DID WE DO IN THIS MEETING

Discussion *Patsy Roseblade, Committee Chair*

6.2. Items Discussed at In Committee

Discussion *Patsy Roseblade, Committee Chair*

- Draft Annual Report 2022-2023
- Draft Annual Accounts 2022-2023
- Organisational Risk Register - Cyber Security Risks

6.3. Committee Highlight Report to Board

Discussion *Patsy Roseblade, Committee Chair*

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7. DATE AND TIME OF NEXT MEETING - WEDNESDAY 16 AUGUST 2023 AT 10:00AM

Agenda Item Number: 2.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee held on the 19 April 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Sara Utley	Audit Wales
Mark Jones	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Martyn Lewis	NWSSP – Internal Audit & Assurance (In Part)
Sally May	Executive Director of Finance
Owen James	Head of Corporate Finance (In part)
Jonathan Morgan	Health Board Chair (In part)
Cally Hamblyn	Assistant Director of Governance & Risk
Matthew Evans	Head of Local Counter Fraud
Anthony Gibson	Deputy Medical Director (In part)
Amanda Legge	Post Payment Verification Manager (In part)
Sara Jeremiah	Post Payment Verification Location Manager (In part)
Emma Walters	Corporate Governance Manager (Secretariat)
Philippa Peake-Jones	Interim Head of Governance & Assurance (Observing)

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

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

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

1.2 Apologies for Absence

Apologies for absence have been received from:

- Owen James, Head of Corporate Finance

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on 13 February 2023

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

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

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

2.1.2 Audit & Risk Committee Terms of Reference

In response to a query raised by the Committee Chair as to whether reference needed to be made to the National Collaborative Commissioning Unit (NCCU) within the constitution and purpose section, C Hamblyn advised that this had been captured within the Emergency Ambulance Services Committee (EASC) section as NCCU is established under the organisational arrangements of EASC.

Resolution: The Audit & Risk Committee Terms of Reference were **APPROVED.**

2.2 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

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

2.2.3 Annual Report Timetable 2022-2023

Resolution: The report was **NOTED**.

2.2.4 CTMUHB ISO14001 Certification Progress Report

Members noted that this report had now been deferred to the June 2023 meeting of the Committee.

2.2.5 Declarations of Interest and Gifts and Hospitality Report

Resolution: The report was **NOTED.**

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

Resolution: The report was **NOTED.**

2.2.7 Audit Wales Annual Audit Report

Resolution: The report was **NOTED.**

2.2.8 PCH Redevelopment Programme Integrated Audit Plan 2023/24

Resolution: The report was **NOTED.**

3.0.0 MAIN AGENDA

GOVERNANCE

3.1 Audit & Risk Committee Action Log

C Hamblyn presented Members with the action log. The following updates were noted:

- 18/099 Endoscopy JAG Accreditation Closure report – C Hamblyn advised that she had met with the Chief Operating Officer who advised that he should be in a position to provide an update in July on this matter;
- 5.4.5; 4.6; 5.3.4 – C Hamblyn advised that she had met with the Medical Director who had advised that he had been unable to meet with the Director for People to discuss these actions. A revised review date had been set for July 2023;
- 5.2 – Members noted that a meeting had now been held between Audit Wales and the Director of Digital and that this action was now completed.

C Donoghue expressed concern that the Medical Director and Executive Director for People had not been able to meet to discuss action 5.4.5 given that this was raised as an action nearly one year ago. C Hamblyn advised that assurance had been provided that the actions would be taken forward.

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

3.2 Matters Arising not contained within the Action Log

There were no further items identified. The Committee Chair advised that she had agreed that C Hamblyn could raise an item for discussion under Any Other Business in relation to a variation to Standing Orders.

4.0.0 SUSTAINING OUR FUTURE

4.1 Local Counter Fraud Report

M Evans presented the report and highlighted the key matters for Members attention. In addition to the Local Counter Fraud Report, M Evans also presented Members with the Counter Fraud Work Plan for 2023/2024, the Counter Fraud Annual Report for 2022/2023 and the Counter Fraud Annual Self Review.

In response to a question raised by I Wells in relation to the low percentage of staff that were attending awareness training and whether it was a requirement for staff to attend these sessions, M Evans advised that Counter Fraud Awareness training was not mandatory and added that there were groups of staff within the organisation that were at higher risk of experiencing fraud and advised that these staff would be targeted for awareness training. Members noted that the team would also continue to run general awareness sessions in addition to targeted sessions. I Wells suggested that instead of highlighting the percentage of staff that had attended sessions, it may be more helpful to show the percentage of targeted staff that had attended training.

I Wells commented on the increase in cases being presented and advised that whilst it was positive that more cases were being detected, it is concerning if this is an indication that there were more incidences of crime. M Evans advised that the levels of fraud within the Health Board were aligned to levels within other Health Board's and advised that there had previously been a deficit in the number of cases being reported within the Health Board, compared to other Health Board organisations.

J Sadgrove commented on the resource utilisation referenced within the annual report and welcomed the positive news that the plan had been delivered and extended her complements to the team for achieving this. J Sadgrove also welcomed the cross organisational comparison of data sets that had been introduced which was starting to yield results and would be a useful data set to use in regards to holding to account and preventing fraud.

C Hamblyn advised that in relation to awareness training sessions, over the last 18 months work had been undertaken to align the Counter Fraud Team and Corporate Governance Teams so that they could complement each other, for example, Counter Fraud awareness sessions include an update on the Declarations of Interest process.

S May advised that an increase in the number of referrals and cases should be seen as a positive step forward as it reflects the wider awareness raising that was being undertaken.

In response to a query raised by the Committee Chair as to whether the incoming Director of Corporate Governance had agreed to take on the role of Counter Fraud Champion, C Hamblyn advised that whilst this had been included in the role profile this would be discussed further between the Chief Executive Officer and the new post holder.

In response to a query raised by the Committee Chair as to whether discussions had been held with the Communications Team in relation to raising awareness regarding salary overpayments and timesheet fraud, M Evans confirmed that awareness raising regarding these issues was undertaken during Fraud Awareness week and advised that good support was being received from the Communications Team. Members noted that stories in relation to fraud were also shared during the Cyber Security Awareness sessions that had been held previously.

Resolution: The report was **NOTED.**

Action: Future reports to highlight percentage of targeted staff that had attended training sessions.

4.2 Procurements and Scheme of Delegation Report

S May presented Members with the report drawing attention to the Single Tender Action in relation to the Rental Hire of Emergency Stand-by Generator at Royal Glamorgan Hospital and advised that urgent approval had been required as it was deemed essential for patient safety. J Sadgrove advised that whilst she accepted that urgent approval needed to be given for this, she queried whether it was feasible to have an arrangement in place that could be called down on in future or whether this was too specialised an area. S May advised that there were only four generators in the country that would have been suitable and added that consideration would need to be given to what arrangements could be put into place if an incident like this occurred again. S May commended the Estates Team who spent the evening on site when the incident occurred to ensure that everything was rectified. The Committee Chair extended her thanks to the Estates Team on the Committee's behalf.

The Committee Chair made reference to the Single Tender Action regarding Pulse Oximeters & Sedline Modules and advised that it reads as if the Anaesthetists preferred the technology which is why they chose that option and did not make reference to there being a compatibility issue. S May agreed to review the narrative to improve clarity.

Resolution: The report was **NOTED** and the Financial Control Procedure for Patient's Property, Income & Allowances was **APPROVED.**

Action: Review to be undertaken of the narrative provided in relation to the Single Tender Action regarding Pulse Oximeters & Sedline Modules to ensure it was made clearer as to the rationale behind this request.

4.3 Post Payment Verification Annual Report

A Legge presented Members with the report and highlighted the key matters for Members attention.

J Sadgrove advised that she was pleased to hear that activity would be increased in this area over the coming year. In relation to General Medical Services revisits, J Sadgrove made reference to practices 9 and 10 and advised that the practices always seemed to be red during each visit which did not demonstrate that there was learning in these areas. A Legge advised that a revisit was only undertaken to the services that generated a trigger and advised that if there were issues with the same services then the practices would have been contacted to determine whether any further training could be offered. A Legge advised that there were practices who did require further training and this would be addressed moving forwards.

The Committee Chair advised that it would be helpful if the Committee could be provided with more information in relation to practices 9 and 10 so that the Committee could understand what the issues were. A Legge agreed to provide information to Committee members outside the meeting.

The Committee Chair advised that whilst there were only three initial visits in relation to General Medical Services, the error rate appeared to be significantly higher compared to the whole of Wales and questioned whether this would trigger a revisit. A Legge advised that two of the visits were revisits to practices 9 and 10 and advised that the percentage rate for revisits would always be higher.

Resolution: The report was **NOTED.**

Action: Additional information in relation to practices 9 and 10 to be provided to Committee Members so that the Committee could understand what the issues were in these areas.

5.0.0 IMPROVING CARE

5.1 Annual Review: Risk Management Framework

C Hamblyn presented Members with the report and advised that the Framework had been discussed with Board Members over recent weeks. Members noted that the documents had also been shared with Board Members as supporting documents to aid the discussions being held at Board Development in relation to Risk Tolerance.

I Wells advised that he supported the Framework and welcomed the risk appetite scores that had been set for Technology, Operational Performance and Estates.

In response to a comment made by the Committee Chair in relation to the need for the Health Board to understand its risks which had not been captured within

the framework, C Hamblyn advised that whilst this was captured within the Risk Management Policy, she would be happy to include a section within the Strategy regarding risk treatment options and objectives prior to submitting to the Board.

The Committee Chair advised that she felt the strategy needed to be more explicit regarding its applicability to all staff who hold a contract with the Health Board, including honorary and agency. C Hamblyn agreed to amend the report in this respect.

The Committee Chair advised that no reference was made within the framework in relation to calibration and standardisation of risk scoring. C Hamblyn advised that this was referenced within the Risk Management Policy and added that she would ensure cross reference was made in this respect.

Resolution: The Risk Management Strategy was **ENDORSED FOR BOARD APPROVAL** subject to the amendments discussed.
The changes to the Risk Appetite Statement were **ENDORSED FOR BOARD APPROVAL**
The Risk Domain & Scoring Matrix were **ENDORSED FOR BOARD APPROVAL**
The Board Assurance Framework remaining fit for purpose was **ENDORSED FOR BOARD APPROVAL**

Actions: Section to be included within the framework regarding risk treatment options and objectives prior to submitting to the Board.

Framework to be made more explicit regarding the strategy applying to all staff who hold a contract with the Health Board.

Cross reference to be made within the report to the Risk Management Policy which made reference to calibration and standardisation of risk scoring

5.2 Organisational Risk Register

C Hamblyn presented the report and provided an update against the key matters for Members attention. Members noted that a number of queries were raised by C Donoghue ahead of the meeting which are being addressed.

C Hamblyn provided members with feedback from the Operational Management Board held earlier that day and advised that the Terms of Reference for the Operational Management Board had been amended so that clarity was provided regarding their role in relation to risk escalation. Members noted that a focussed discussion was held in relation to risks scoring 20 to ensure that they were consistent in there scoring. Members noted that focus was also placed on the stagnant risks. C Hamblyn advised that a number of actions were assigned during the session which were being taken forward by Care Group leads.

The Committee Chair commented on Risk 3131 and advised that she was pleased to see that the Quality & Safety Committee had deferred this risk back

to the risk owner and would not be removed from the register until Members were provided with sufficient assurance.

In response to a comment made by the Committee Chair regarding the risk decreasing in relation Risk 5254, C Hamblyn advised that this risk was discussed at the Operational Management Board this morning where it was agreed that the risk needed to be reviewed and refined by the Assistant Director of Quality & Safety.

Resolution: The report was **REVIEWED**.

5.3 Audit Recommendations Tracker

E Walters presented the report and highlighted the key matters for the attention of the Committee. The Committee Chair recognised the significant amount of work in further improving the report and in addressing the comments raised at the last meeting, and extended her thanks regarding this.

C Donoghue advised that whilst she found the cover report to be well explained, she had found it difficult to read through the amount of information contained within the trackers particularly in its current presentation. C Hamblyn advised that this had been recognised as an area for improvement which will be addressed as part of resource allocated through the Quality Governance Operating Model exploring the use of an automated system such as AMaT.

In response to a query raised by I Wells as to whether discussions were being held with other Health Board's as to how they were capturing this information, C Hamblyn advised that the majority of Health Boards were using an excel based system with some Health Boards using an automated system. P Dalton agreed with the comments made by C Hamblyn as to the systems being used within other organisations and welcomed the evolvement of the audit trackers. P Dalton advised that he was pleased to see that comments had been included against each individual recommendation which was helpful.

E Walters advised that there were number of recommendations contained within the trackers and advised that a discussion was held at a previous meeting as to whether Members still wanted to see the level of detail contained within the previous updates column. The Committee Chair advised that it had been proposed previously that maybe the final column could be hidden or truncated when it was being presented to Members and advised that it would be helpful if this could be considered further. The Committee Chair also advised that when the document was being viewed on a laptop, the text was quite small and difficult to read and asked for this to be taken into consideration also.

C Hamblyn advised that one of the potential benefits for using AMaT was that it produces a PDF report in booklet format which could be easier to read. In the meantime, C Hamblyn suggested that the full version of the document could be uploaded into the documents folder on Admincontrol for members to make reference to, with a truncated version being included within the papers.

S Utley advised that she agreed with all comments that had been made and advised that it would be helpful if the cover report could also include a summary of recommendations that were being proposed for closure. S Utley also advised that Audit Wales were keen for the recommendations to be themed to enable better oversight to be undertaken of themes identified within other reviews.

The Committee Chair advised that, similar to what she had proposed for the risk register, it would be helpful if hyperlinks to the audit reports could be included against each recommendation to make it simpler to cross reference. C Hamblyn advised that she welcomed the discussions held and would consider the comments made in terms of future developments

The Committee Chair advised that the report had significantly improved, was much easier to read and clearly focussed on the higher risk areas and limited recommendations.

Resolution: The report was **NOTED**.

Actions: Final column of the trackers to be hidden or truncated. Full version of the document to be uploaded into the documents folder on Admincontrol with a truncated version being included within the papers.

Cover report to include a summary of recommendations that were being proposed for closure.

Hyperlinks to the audit reports to be included against each recommendation to make it simpler for Members to cross reference.

5.3.1 Consultant Job Planning Progress Report

A Gibson presented Members with the report advising that significant discussion had been held in relation to the British Medical Association (BMA) Rate Card which had been published without consultation being undertaken with Health Board's. Members noted that a National rate card was now being developed which also had its challenges in relation to being adopted nationally and the Health Board was currently exploring as to how elements of the rate card could be implemented in order to develop a more consistent approach in relation to rates of pay.

In response to a query raised by C Donoghue in relation to what the exact issues were in relation Additional Duty Hours (ADH), A Gibson confirmed that the BMA had published a Consultant and Non Consultant grade rate of pay card that they considered appropriate for what clinical staff should be remunerated for working additional hours. Members noted that this was not undertaken in consultation with any NHS organisations within Wales or England and was considered to be vastly unaffordable, with rates being quadruple to what the Health Board was currently paying. Members noted that the Assistant Medical Director for Medical Workforce and her Team had met with all Junior Doctors to explain the position

and to date Junior Doctors had not been requesting the higher rates of pay. C Donoghue welcomed the update and the way in which it had been handled and added that she was pleased to see that progress was being made in job planning which was a complex area of work.

J Sadgrove extended her thanks to A Gibson for the update and welcomed the engagement that had been undertaken with the workforce by the Medical Workforce Team in relation to the benefits of job plans which appeared to be having an impact. A Gibson confirmed that this was having a productive impact, particularly with SAS colleagues who were moving across to the new contract. A Gibson added that the engagement undertaken had helped colleagues to understand the purpose of a job plan and that job planning discussions could be used to discuss how the care being provided to patients within each individual service area could be improved. Members noted that there may be a risk that the 90% target for job plans would not be achieved during phase 2 as a result of clinical staff moving into new roles and noted that a central team was being developed to support these areas during the process.

J Sadgrove made reference to the Counter Fraud report received earlier in the meeting which stated that an allegation had been received via the NHS Fraud and Corruption line where a staff member was reported to be taking more SPA time than other staff. J Sadgrove added that the narrative from the investigation advised that whilst the subject had high SPA usage, this was relative based on their part time status, and advised that there was no guidance in place in regards to SPA allocation for full and part time staff. In response to a question raised by J Sadgrove, A Gibson confirmed that this was addressed in the new policy and added that there was also clear guidance within the All Wales Consultant Contract regarding the proportionality of SPA. This was also clearly outlined within individual job plans as to how much SPA time can be taken if part time.

In response to a query raised by the Committee Chair as to whether the new system that was being introduced was the reason behind the delays in getting job plans signed, A Gibson confirmed that the electronic system being used had been in place for a number of years and the delays were being experienced as a result of Consultant's not clicking yes on the system to accept their job plan. This was down to individuals not accessing the system to accept as opposed to them not signing their job plan as they were unhappy with its content.

In response to a query made by the Committee Chair as to whether Consultants would choose to work across the border as a result of the new rate card, A Gibson advised that the new rate card had not been accepted by any NHS organisations in England or Wales and added that the main issue for the Health Board at present was the variation of rates between neighbouring Health Board's.

S May advised that since the implementation of Patchwork, which had made the rates of pay transparent to everyone, this had exposed that in some specialties some sites were paying more for ADH than others, which suggested that having a standard rate card in place would be helpful. S May advised that if the rate

increased, then this would create a pressure as it would not be funded in any way as it would not be part of an actual pay award. Members noted that the BMA rate card had been disruptive in England and Wales in respect of moving things forward.

Resolution: The report was **NOTED.**

5.3.2 Medical Rostering – Progress Report

A Gibson presented the report which provided an update against the three Internal Audit recommendations. Members noted that Recommendation 4.1, which related to the Study Leave Policy, had now been closed.

I Wells made reference to the update provided for recommendation 4.1 and advised that the way in which the update had been worded seemed to imply that former Swansea Bay employed staff had a better policy compared to the policy within this Health Board and questioned whether this was the case, and sought clarity as to whether staff were requesting to remain on the Swansea Bay policy or move to the Cwm Taf Morgannwg policy. A Gibson advised that the two policies were not starkly different, with certain aspects of the Swansea Bay policy meeting some individuals needs much better.

The Committee Chair advised that she recalled a previous discussion being held in relation to the Health Roster system and it was agreed that the Medical Director would review when a decision had been made for Anaesthetics and the Emergency Department to not use the system.

A Gibson advised that the system had not been adopted by Anaesthetics as the Health Roster system did not allow for the system to roster against the Theatre System and it was considered that a significant amount of work would be required to develop a system which the service had limited control over. Members noted that as the move is made into a new Care Group system, the service would be encouraged to move onto one roster system only. A Gibson advised that in relation to the Emergency Department, the issues for the service in regards to Health Roster was that it did not allow for annualisation, particularly in relation to the Consultant element. Members noted that ongoing discussions were being held with the service on the need to have one system in place that allows for annualisation to be recorded.

In response to a query raised by the Committee Chair as to how the issues outlined would be tracked, and whether this was an issue that the Committee needed to monitor, A Gibson advised that the outcome of the recommendation was that the Committee needed to be provided with assurance that if for some reason the roster manager was absent, how would someone be able to understand a system that wasn't being used anywhere else within the organisation. A Gibson advised that in relation to how medical rota's were being managed moving forwards, this was being managed by the Medical Directors office as a central piece of work.

The Committee Chair queried whether the issues of two departments using two different systems would be addressed via the Follow Up Audit undertaken in this area, P Dalton advised that a follow up audit was not planned for this area and added that progress would need to be managed via the audit tracker. A Gibson advised that he would be happy to provide an update on progress in the next report and would look to include a paragraph which outlined why the services were using different systems.

In relation to the draft Medics Rostering Policy that was referenced in the report, C Hamblyn confirmed that this would need to be presented to the People & Culture Committee for formal approval.

Resolution: The report was **NOTED.**

Actions: Update to be provided in the next report on progress being made in relation to the Health Roster system and an explanation to be included as to why the Anaesthetics and Emergency Departments were using different systems.

Medics Rostering Policy to be presented to the People & Culture Committee for formal approval.

5.4 AUDIT WALES

5.4.1 Audit Wales Audit & Risk Committee Update

S Utley presented the report and highlighted the key points for Members attention.

Resolution: The report was **NOTED**.

5.4.2 Audit Wales – Structured Assessment

S Utley presented the report. Members were reminded that the report had also been presented to the March Board without the Management Response.

S May sought clarity as to what was meant in regards to the suggestion made that the Health Board should review the delegated upper financial limit for the Chief Executive. S Utley advised that when a review was undertaken of the Standing Financial Instructions across all Health Board's, this point was not that clear for Cwm Taf Morgannwg. S May asked S Utley if clarity could be provided as to whether this related to contracts or investments. It was agreed that S May and S Utley would discuss this matter further outside the meeting.

The Committee Chair advised that following the initial concerns she raised at the March Board regarding the findings, a discussion had been held with S Utley outside the meeting and a way forward had been agreed. S Utley welcomed the reflection from the Committee Chair which she had found useful for informing future reports

Resolution: The report was **NOTED**.

Action: Discussion to be held between Audit Wales and the Director of Finance in relation to the suggestion made that the Health Board should review the delegated upper financial limit for the Chief Executive and whether this related to contracts or investments.

5.4.3 Audit Wales Outline Audit Plan 2023

M Jones presented the report and highlighted the key points for Members attention.

Resolution The report was **NOTED**.

5.4.4 Audit Wales National and Local Report Orthopaedic Services

S Utley presented the report and highlighted the key points for Members attention. Members noted that there were some questions contained within the report for Board Members to consider.

C Hamblyn advised that the local management response was in the process of being finalised and had been deferred to the next meeting for further discussion.

I Wells made reference to exhibit 17 which appeared to be a good news story for the Health Board given that there were only 0.1% of patients waiting over 14 weeks for physiotherapy within the Health Board and added that this may be something that other Health Boards could learn from. The Committee Chair advised that this could be discussed further at the next meeting once the Management Response had been received.

Resolution: The report was **NOTED**.

5.5 INTERNAL AUDIT

5.5.1 Internal Audit Progress Report

P Dalton presented the report and highlighted that there were currently 8 areas of work in progress, with 4 nearing conclusion. P Dalton advised that in relation to the follow up review into the Patient Pathway Appointment Management Process, given that it had been indicated within the tracker that the majority of recommendations were being proposed for completion in June 2023, the timing of the follow up review may need to be revisited.

Members noted that in relation to the review of the National Incident Framework, there had been some delays in obtaining reports from Datix as a result of sickness absence within the Incident Team. E Samways advised it was hoped that these issues would be resolved this week to enable the review to be included as part of the Internal Audit Annual Opinion.

Members noted that timeliness of receiving management responses still remained as amber. P Dalton advised that Internal Audit were subject to an external quality assessment on the way in which it performs its work, which was undertaken every 5 years. Members noted that an external quality assessment had been undertaken and had concluded that Internal Audit had fully conformed to the public sector Internal Audit Standards. The Committee Chair welcomed this update and advised that this was an area within the Committee's Annual Self-Assessment where Committee Members indicated that they were not aware as to how this responsibility was discharged. P Dalton advised that there was also a section contained within the Internal Audit Annual Report outlining this process.

The Committee Chair requested that Committee Members were kept up to date as to when the follow up review would be undertaken in relation to the Patient Pathway Appointment Management Process.

Resolution: The report was **NOTED**.

5.5.2 Internal Audit Review – Board Awareness of Digital

M Lewis presented the report, outlined the recommendations that had been made and advised Members that a reasonable assurance rating had been given.

I Wells welcomed the report and advised that he was pleased to see that a reasonable assurance rating had been given.

Resolution: The report was **NOTED.**

5.5.3 Internal Audit Review – Reasonable Offer

E Samways presented the report and advised that 5 key recommendations had been made, 2 of which were high and 3 of which were medium, which had resulted in a Limited Assurance rating being given. Members noted that Management had accepted all recommendations and felt that the review had identified the issues that they were already known to the Health Board. Members noted that a follow up review would be undertaken given the limited assurance rating that had been allocated.

J Sadgrove welcomed the report which she had found to be helpful and timely in terms of the transformation that needed to be made.

C Donoghue advised that some of the target dates contained within the management response appeared to be ambitious and sought clarity from Internal Audit as to whether they received a level of confidence from the team as to whether the target dates would be achieved given the level of pressures within the system. E Samways advised that the Team had appeared confident and had already taken some steps to address some of the issues identified.

The Committee Chair advised that she felt that the management responses were complete and thorough and addressed the recommendations made. The Committee Chair also agreed that she felt that the target dates appeared ambitious.

Resolution: The report was **NOTED.**

5.5.4 Internal Audit Review – Bridgend Transfer of IT – Follow Up

M Lewis presented the report and highlighted that a follow up was undertaken of the current agreed actions. Members noted that a reasonable assurance rating had been allocated to this review.

I Wells made reference to the Management Action Plan and the reference made to issues requiring discussion at Quality & Safety Committee and added that it was not clear from the management response whether these issues had been passed on to the Committee for discussion.

I Wells also commented on the reference made within the report that if the Health Board upgraded to a 10GB link then this would enable the transfer of more services. I Wells advised that this was the first time he had heard of this and sought clarity on the position. It was agreed that a response to this query would need to be provided by the Digital Team outside the meeting. S May also advised that confirmation would need to be given by the Digital Team as to whether this would sit in either their capital or revenue plan for the year given that resources within the plan had now been set.

The Committee Chair sought confirmation as to whether there was a plan in place to appoint a permanent Head of Information Governance as opposed to relying on agency staff to undertake this role. C Hamblyn advised that she was aware that interviews for this role had recently been held, with the outcome awaited. Members noted that this had been added as a risk to the risk register and had been discussed at the Digital & Data Committee who had escalated their concerns to the Board. Members noted that discussions were being held with Digital Healthcare Wales as to what interim support they could provide to the Health Board in relation to Information Governance.

Resolution: The report was **NOTED.**

Action: A response to the query raised regarding the 10GB link to be provided by the Digital Team outside the meeting. Confirmation to be provided by the Digital Team as to whether this would sit in either their capital or revenue plan for the year given that resources within the plan had now been set.

5.5.5 Internal Audit Review – Board Assurance Framework

E Samways presented the report and advised that a substantial assurance rating had been allocated to the review. C Hamblyn recognised the wider team

approach to the implementation of the Board Assurance Framework and added that the report would continue to evolve moving forwards.

I Wells welcomed the report which confirmed that the development of the report was heading in the right direction and extended his thanks to everyone involved in its development.

The Committee Chair drew attention to reference made within the Audit Wales Structured Assessment in relation to the Board Assurance Framework which related to the use of the BAF as opposed to the construction of it. C Hamblyn confirmed that reference made to the BAF within the Structured Assessment related to increasing the visibility of the document and advised that the BAF would now be included for discussion at the Committee agenda planning sessions alongside the risk register to ensure that agendas were addressing the key issues being faced within the organisation. S Utley advised that this recommendation had also been made for a number of other organisations and added that the BAF now needs to be used to drive the business.

Resolution: The report was **NOTED.**

5.5.6 Internal Audit Annual Audit Plan 2023/2024

P Dalton presented the report which was a risk based plan developed following discussion held with Independent Members and the Executive Team. Members noted that the plan was flexible and would be able to meet the needs of the organisation as and when issues arise and noted that the Executive Director of People had requested an additional review area to be added to the plan which would be discussed further.

Members noted that the Internal Audit Charter had also been included with the Annual Plan and Members were being asked to endorse the Annual Plan and Internal Audit Charter for Board approval.

The Committee Chair advised that she was surprised to see that a follow up review on the Single Cancer Pathway had not been included in the plan for 2023/2024 and asked for a review to be undertaken outside the meeting to determine whether this was required given the limited assurance rating that had previously been allocated. E Samways advised that a data verification review linked to Cancer Pathways was undertaken and was followed up in 2022/2023 with a reasonable assurance rating being allocated on follow up. P Dalton agreed to review the position outside the meeting.

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

Action: Review to be undertaken to determine whether a follow up review was required during 2023/2024 in relation to the Single Cancer Pathway given the limited assurance rating that had previously been allocated.

6.0.0 ANY OTHER BUSINESS

C Hamblyn raised an item an item under Any Other Business in relation to the Temporary Amendment of the Model Standing Orders. Members noted that information had been received from Welsh Government in relation to the need to vary the standing orders in relation to the Annual General Meeting and noted that the Standing Orders would need to be temporarily amended to reflect that the AGM would need to be held by the end of September and not the end of July.

Following discussion, Members agreed to **ENDORSE FOR BOARD APPROVAL** the temporary amendment which will be managed via Chairs Urgent Action.

7.0.0 COMMITTEE HIGHLIGHT REPORT

8.0.0 How Did We Do?

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

9.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Wednesday 21 June 2023.

8.0.0 CLOSE

Agenda Item Number: 2.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk In Committee held on the 19 April 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

S Utley	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
S May	Executive Director of Finance
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Corporate Governance Manager (Secretariat)

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

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

1.2 Apologies for Absence

- No apologies for absence were received

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 MAIN AGENDA

2.1 Organisational Risk Register – Cyber Risks

C Hamblyn presented Members with the report which outlined the Cyber Security Risks that had been included within the risk register. Members noted that the Director of Digital was in the process of reviewing the wording of the risks to consider if they could be discussed during the public part of the meeting without identifying potential business vulnerabilities

Resolution: The report was **NOTED**.

3.0.0 ANY OTHER BUSINESS

There was no other business to report

4.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Wednesday 21 June 2023.

5.0.0 CLOSE

AGENDA ITEM
2.2.1

AUDIT & RISK COMMITTEE

AUDIT & RISK COMMITTEE CYCLE OF BUSINESS

Date of meeting	21/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

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

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

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

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

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

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

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

Audit & Risk Committee

Cycle of Business

(1st January 2023 – 31st December 2023)

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

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

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

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

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

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

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

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

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

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

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

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item 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.**
Advised at the meeting held on 12 December 2022 that this report would be presented to the June 2023 meeting	Additional Item	National Fraud Initiative progress and outcomes.	Local Counter Fraud Specialist	21 June 2023 Agenda item 4.1.1.
Email request received from the Facilities Governance & Compliance Manager on 3 February 2023	Additional Item	CTMUHB ISO14001 Certification Progress Report	Chief Operating Officer	19 April 2023 – **Deferred to 21 June 2023 -** Agenda item 2.2.3.

Email Request from the Assistant Director of Governance & Risk	Additional Item	A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report - March 2023	Medical Director	21 June 2023 – **Now deferred to 16 August 2023 as the report was not finalised in time for the June meeting.**
Request received from the Assistant Director of Governance & Risk	Additional Item	Standing Orders Breach Log	Assistant Director of Governance & Risk	16 August 2023 – New item to be considered by the Committee as a regular item.
Email request from the Assistant Director of Governance & Risk	Additional Item	Annual Report Timetable 2022-2023	Assistant Director of Governance & Risk	**Completed** – Received at the February 2023 Committee meeting

Agenda Item
2.2.3

AUDIT & RISK COMMITTEE

CTMUHB ISO14001 CERTIFICATION POSITION STATEMENT

Date of meeting	21/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	David Williams, Facilities Governance & Compliance Manager. Russell Hoare, Assistant Director of Facilities. Esther Price. Head of Commercial Procurement.
Presented by	Gethin Hughes, Chief Operating Officer. Russell Hoare, Assistant Director of Facilities.
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR NOTING

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

ACRONYMS	
EMS	Environmental Management System
CTMUHB	Cwm Taf Morgannwg University Health Board
BAB	British Assessment Bureau Ltd

1. SITUATION/BACKGROUND

1.1 This CTMUHB ISO14001 Certification Progress Report explains what the certification is, what the certification process entails and the Health Board's progress to achieving and maintaining it. The committee are asked to note the report.

1.2 ISO 14001:2015 is the international environmental standard that specifies requirements for controlling aspects of an organisation that have a significant impact on the environment, through an effective Environmental Management System (EMS). It is a requirement of Welsh Government that Health Boards in Wales are accredited to ISO 14001:2015. The accreditation is on a three-year cycle with surveillance audits every year for Cwm Taf Morgannwg University Health Board (CTMUHB) to ensure compliance.

1.3 In July 2021, CTMUHB had its final surveillance audit of the three-year cycle. Following completion of the audit, CTMUHB had successfully retained the ISO 14001:2015 accreditation for all healthcare sites.

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

2.1 Minor non-conformities – July 2021

Following completion of the July 2021 audit, two minor non-conformities were raised. Details of these minor non-conformities, together with actions, target dates and progress to mitigate are provided below.

Source	Type	Summary of Non-Conformance	Action	Responsibility	Target Date	Closed Date	Status	Progress to mitigate
Ext Audit	Minor	7.5 - EMS Document Control Log the EMS Document control log has not been maintained in full. Log is currently at Version 5 for the OCP (Operating Control Procedures) and the Operating Control. Procedure is at Version 7 verified by log entry and hard copy procedure. Documented information required by the environmental management system shall be controlled to ensure control of changes. Review Document Control Log and update to correct version if applicable.	Review Document Control Log and update to correct version if applicable.	Dave Williams / Richard Edwards	05/06/2023 (By next external recertification audit)	16/05/2022	Closed	Immediate Action - Document Control Log reviewed and OCP version corrected during audit - Completed. Follow-Up Action - Undertake an internal audit of the Document Log to ensure all document versions are included and referenced correctly. Internal audit of Document Log has been undertaken and no non-conformities raised - Completed. Closed.

Source	Type	Summary of Non-Conformance	Action	Responsibility	Target Date	Closed Date	Status	Progress to mitigate
Ext Audit	Minor	8.1 - Operational Control, Prince Charles Hospital. During the Site Tour of external areas and Waste containers it was observed that litter and an unmarked plastic bottle containing fluid next to a surface water drain had not been cleared up. Unused paint pots were also observed not locked away in external lock up, stacked on the top of the lock up. Maintain Schedule of litter picking activities as per PPM.	Maintain Schedule of litter picking activities as per PPM	Estates / Facilities / MCV ILG	05/06/2023 (By next external recertification audit)	16/05/2022	Closed	Immediate Action - Additional litter pick requested and undertaken during the audit - Completed. - Unmarked plastic bottle checked and liquid was water used by the waste team to wash hands. Estates Manager at PCH has agreed to install a hand sanitation station next to the temporary waste hold at PCH - Completed. - Used paint pots have been removed and disposed of, unused paint pots have now been locked away in the external lock-up. Also, PCH Facilities / Estates corridor has been cleared of unused equipment during audit - Completed. Follow-Up Action - Maintain Schedule of litter picking activities as per PPM and ensure that the PPM incorporates all required areas on sites. - PPM in place and schedule of litter picks is being maintained. Closed.

*2.2 **Contract renewal, process delays and implementation***

ISO14001 is a mandated accreditation. The final audit of a 3-year cycle undertaken by the previous supplier was in July 2021 and accreditation is valid for 12 months. The accreditation was due to lapse on 29 July 2022, unless a further audit cycle was contracted.

There is a 3-month lead in time required to schedule the accreditation audit post contract award.

Work began by the Facilities manager responsible for the contract David Williams, to progress a tender in January 2022. Resource capacity (facilities and procurement) constraints resulted in a delay until April 2022 before seeking a new supplier via a Multi quote process. Only one new service supplier submitted a bid for the contract. The subsequent SQT approvals process introduced further delays, beginning on 15-Jun-22 and being authorised by the Director of Finance on 22-Aug-22.

Due to the 3-month lead in time, it should have been recognised, prior to the end of April 2022, that the accreditation would lapse unless action was taken to expedite the process of securing a supplier. This was not escalated by Facilities with the Procurement Team nor to the Chief Operating Officer and therefore no mitigation was put in place to secure a supplier at an earlier stage to avoid the accreditation lapse.

The mandated ISO14001 accreditation lapsed on 29-Jul-22.

The contract was not awarded until 14 November 2022 (despite the SQT having being authorised on 23 August and the supplier set up on Oracle on 13 September) and a 3-month lead in time has resulted in the stage 1 audit being run from 27-Feb-23 to 02-Mar-23 and the stage 2 audit being scheduled for 05-Jun-23 to 15-Jun-23.

Notes: *A stage 1 audit was required due to the lapsed accreditation.*
The Stage 1 audit was successful with no non-conformities reported.

The Health Board will not therefore achieve ISO14001 accreditation until Jun-23, at the earliest. This means that there has been a minimum of 11 months during which the HB will not be accredited.

There was no contract tracker or regular meetings in place between Facilities and Procurement during the period to ensure that the contract was formally monitored and that matters were escalated to consider and enable mitigation.

In the interim period, the environmental management system and processes have been maintained by Facilities in accordance with ISO14001 requirements and standards.

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

Risks

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

3.2 The risks associated with a lapsed certification are that it could lead to reputational harm for the Health Board through not providing assurance to employees as well as external stakeholders that environmental impacts are being measured and improved.

3.3 Also due to the lapsed certification the Health Board has had to start the recertification process from the beginning as a new certification, with a Stage 1 Assessment required by our certification body British Assessment Bureau (BAB). This has added additional audit days and time and resource requirements to achieving the certification.

3.4 This risk is also included on the Facilities Directorate Datix Risk Register (Risk ID 5120), with details provided below.

ID	Locality	Service Group	Unit	Risk Domain	Title	Description	Controls in place	Rating (current)	Rating (Target)
5120	Corporate Function / Operations	Facilities Hub	Health Board wide Core Risk Assessment	Quality / Complaints / Assurance / Patient Outcomes	Maintenance of ISO14001 certification for CTMUHB	If: Not maintaining ISO14001 certification for CTMUHB Then: Loss of ISO14001 environmental certification for the Organisation. Resulting In: Organisation not being compliant with Welsh Government standards for Health Boards. A lapsed certification could lead to reputational harm for the Health Board through not providing assurance to employees as well as external stakeholders that environmental impacts are being measured and improved.	Recertification and Surveillance audits held by external certification body annually to ensure the Health Board is complying with the ISO14001:2015 clauses. In January 2022 work began to retender the next three-year cycle of the ISO14001 certification for CTMUHB. Unfortunately, due to contract difficulties the next recertification cycle has had to be postponed until the contract has been awarded to the successful certification body. This delay has taken the Health Board past its ISO14001 certificate expiry date of 29th July 2022 resulting in a gap in certification. It is anticipated that the contract will be awarded imminently and a recertification audit will be undertaken by the end of the financial year. Action: Achieve ISO14001 recertification for CTMUHB. Timescale: 31/07/2023. Facilities Directorate have continued to work with Procurement to award a new contract with a certification body as efficiently as possible. During this time the Facilities Directorate has ensured that the CTM Environmental Management System has been maintained ready for the ISO14001 recertification. The contract was awarded to the chosen certification body British Assessment Bureau Ltd (BAB) in November 2022 and Facilities Directorate has engaged with the certification body at the earliest opportunity to commence the recertification process. The recertification audit is scheduled to take place in 2023 as follows: • 27/02/2023 – 02/03/2023 - Remote Stage 1 Assessment Audit – Completed • 05/06/2023 – 15/06/2023 – On-Site Stage 2 Assessment Audit – On-schedule If the Stage 2 audit is successful then CTMUHB will have successfully gained ISO14001 recertification. The CTM Audit Committee is being informed of the Health Board's ISO14001 certification progress via progress reports. The risk rating was increased from low (4 x 1 = 4) to moderate (4 x 3 = 12) in October 2022 and based on the latest update with contract and assessment dates now in place, agreed that the risk will remain at the moderate rating (4 x 3 = 12) and be reviewed in 6 months' time or sooner if the certification result changes (DW 03/04/2023).	12	4

Lessons Learnt

1. The process should have been planned with sufficient time to ensure that the contract would be delivered on time.
2. A timeline from contract award to re-audit should have been clearly laid out to inform the retender.
3. There was no escalation regarding the impact of delays, which might have allowed mitigations to be put in place.
4. Communication and Engagement between Facilities and Procurement to improve to mitigate lack of escalation and missed opportunity for improved supplier management.
5. Improved planning and engagement within re-tendering timescales.

Actions

6. Facilities and Procurement have put in place a contract tracker to ensure that to ensure all contracts and renewals are formally monitored. This includes a timeline with sufficient time in place to ensure that contracts are delivered on time.

7. Monthly contract meetings have been scheduled between Facilities and Procurement to monitor contracts and to track renewal dates.

8. The Facilities team responsible for the ISO 14001 contract have been reminded of the importance of ensuring that this contract does not lapse and to prevent a reoccurrence.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.

	Report notifies the committee of ISO14001 certification progress only, no EIA required.
Legal implications / impact	Yes (Include further detail below)
	It is a requirement of Welsh Government that all Health Boards in Wales are accredited to ISO 14001:2015.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 This CTMUHB ISO14001 Certification position statement explains what the certification is, what the certification process entails and the Health Board's progress to achieving and maintaining it. The committee are asked to **NOTE** the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.1

ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
18/099	8/10/2018	Endoscopy JAG Accreditation Closure report to be presented to a future meeting.	Chief Operating Officer	January 2019 **Revised to:** October 2020 **Ongoing -** Action being led by Director of Operations. This matter is linked to JAG accreditation and updates will be provided to the Committee through the action log at each meeting Now October 2021 Now February 2023 Now April 2023 Now August 2023	**In progress** Review of each site is progressing. Capacity of operational team has been redirected to Planned Care Recovery activity and therefore pace of progress has been impacted. Timeframe readjusted and review date now set for August 2023.
5.3.4	13/02/2023	Internal Audit Review – Medical Variable Pay - Reports outlining the rates that had been agreed above cap to be reinstated and presented to future meetings of the Audit & Risk Committee.	Medical Director	August 2023	**In progress** The Medical Director has confirmed that these reports will be reinstated with the next report presented to the August 2023 meeting.
4.1	19/04/2023	Local Counter Fraud Report – Future reports to highlight percentage of targeted staff	Head of Local Counter Fraud	21 June 2023	**On agenda**

		that had attended training sessions.			
5.3	19/04/2023	Audit Recommendations Tracker - Final column of the trackers to be hidden or truncated. Full version of the document to be uploaded into the documents folder on Admincontrol with a truncated version being included within the papers. Cover report to include a summary of recommendations that were being proposed for closure. Hyperlinks to the audit reports to be included against each recommendation to make it simpler for Members to cross reference.	Corporate Governance Manager	21 June 2023	**Part Completed** Final column now hidden for the purpose of including with the papers for Members. Cover report amended to provide a summary of recommendations being proposed for closure. Further work required to include hyperlinks to audit reports within the audit recommendations trackers.
5.3.2	19/04/2023	Medical Rostering Progress Report – Update to be provided in the next report on progress being made in relation to the Health Roster system and an explanation to be included as to why the Anaesthetics and Emergency Departments were using different systems.	Medical Director	October 2023	**In progress** Report to be presented to the October 2023 meeting.

		Medics Rostering Policy to be presented to the People & Culture Committee for formal approval.			
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)**
5.2	24/10/2022	Audit Recommendations Tracker - Director of Corporate Governance to liaise with Audit Wales on the closure of the recommendations captured in the Clinical Coding Follow Up Review 03 audit.	Director of Corporate Governance	December 2022 **Now April 2023**	**Completed** Meeting now held between Audit Wales and the Director of Digital.
5.1	19/04/2023	Annual Review: Risk Management Framework - Section to be included within the framework regarding risk treatment options and objectives prior to submitting to the Board. Framework to be made more explicit regarding the strategy applying to all staff who hold a contract with the Health Board.	Assistant Director of Governance & Risk	25 May 2023	**Completed** Report amended and submitted to the Board meeting held on 25 May 2023 for approval.

		Cross reference to be made within the report to the Risk Management Policy which made reference to calibration and standardisation of risk scoring			
5.4.5	22/08/2022	Internal Audit Review Medical & Dental Rostering - Discussion to be held with the Medical Director outside the meeting in relation to the concerns raised by Members regarding the management response provided.	Director for People/ Medical Director	October 2022 **Now July 2023**	**Completed** A meeting was held between the Director of People and the Medical Director. The e-rostering for Anaesthetics (SAS Drs at RGH & PCH) and ED (alternative system to eJP that works for their sessions) issues remain and are part of the Job Planning workstream of the Medical Productivity Working Group. There is a good review process and Job Planning is currently being standardised across CTM with the QA panel reviewing all specialties and sites.
4.6	12/12/2022	Medical Rostering - Discussion to be held with the Medical Director outside the meeting in	Director for People/	April 2023 **Now July 2023**	**Completed** A meeting was held between the Director of

		relation to when and who made the decision to not use the Health Roster System within Anaesthetics and the Emergency Department. Discussion also required as to whether the system had been tested within these areas.	Medical Director		People and the Medical Director. The e-rostering for Anaesthetics (SAS Drs at RGH & PCH) and ED (alternative system to eJP that works for their sessions) issues remain and are part of the Job Planning workstream of the Medical Productivity Working Group. There is a good review process and Job Planning is currently being standardised across CTM with the QA panel reviewing all specialties and sites.
4.3	19/04/2023	Post Payment Verification Annual Report – Additional information in relation to practices 9 and 10 to be provided to Committee Members so that the Committee could understand what the issues were in these areas.	Post Payment Verification Manager	21 June 2023	**Completed** Additional information shared with Committee members by email on 19 May 2023.
5.5.4	19/04/2023	Internal Audit Review – Bridgend Transfer of IT – Follow Up – A response to the query raised regarding the 10GB link to be provided by	Director of Digital	21 June 2023	**Completed** Director of Digital has advised that the circuit was installed last year – the revenue tail now needs to

		the Digital Team outside the meeting. Confirmation to be provided by the Digital Team as to whether this would sit in either their capital or revenue plan for the year given that resources within the plan had now been set.			be picked up out of the monies allocated to digital for the 2023/2024 plan
5.5.6	19/04/2023	Internal Audit Annual Audit Plan 2023/2024 – Review to be undertaken to determine whether a follow up review was required during 2023/2024 in relation to the Single Cancer Pathway given the limited assurance rating that had previously been allocated.	Head of Internal Audit	21 June 2023	**Completed** Response from Internal Audit shared with the Committee Chair. Any limited assurance reports are followed up in the subsequent year. So it might be a matter of timing. For example, if a limited assurance report is issued after the subsequent years' plan is submitted, it won't be picked up in the formal document, but will be done as piece of work. However, I think this is a bit of a misunderstanding. In our 22/23 we did a follow up of single cancer pathway data quality and integrity, which was

					reasonable assurance. So any o/s recommendations will now be addressed through the IA recommendation tracker process.
5.4.2	19/04/2023	Audit Wales Structured Assessment – Discussion to be held between Audit Wales and the Director of Finance in relation to the suggestion made that the Health Board should review the delegated upper financial limit for the Chief Executive and whether this related to contracts or investments.	Audit Wales/ Director of Finance	21 June 2023	**Completed** Director of Finance met with Audit Wales to review the recommendation and check against the UHB's Standing Orders and Standing Financial Instructions which are consistent with the model Standing Orders and Standing Financial Instructions. It was agreed that this action would be closed at the next review.
4.2	19/04/2023	Procurement and Scheme of Delegation Report - Review to be undertaken of the narrative provided in relation to the Single Tender Action regarding Pulse Oximeters & Sedline Modules to ensure it was made clearer as to the rationale behind this request.	Director of Finance	21 June 2023	**Completed** Review undertaken and Director of Finance has provided the Committee Chair an update by email on 7 June 2023 as to the rationale behind this request

AGENDA ITEM
4.1

AUDIT & RISK COMMITTEE

Local Counter Fraud Update Report

Date of meeting	21 June 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Matthew Evans, Head of Local Counter Fraud Services
Presented by	Matthew Evans, Head of Local Counter Fraud Services
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR DISCUSSION / REVIEW

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

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

1. SITUATION/BACKGROUND

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

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

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

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

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

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

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

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 21 June 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	9
Ensuring that anti-crime measures are embedded at all levels across the organisation		
Inform and Involve	118	13
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	26
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.		
Hold to Account	320	45
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.		
TOTAL	616	93

4. STRATEGIC GOVERNANCE

The NHS Counter Fraud Authority have released a report outlining findings to the Thematic Engagement Exercise around Risk Based Local Proactive Work. Recommendations were made in response to findings for the Health Board. The Summary of Findings, Recommendations made and current position are outlined in the table below.

Organisation	Summary of findings	Recommendations	Current Position
Cwm Taf Morgannwg UHB	FRAs had been undertaken broadly in-line with GCFP methodology and had been recorded locally according to the local risk management policy. LPE's and FPNs had been recorded and at the time of the assessment a total of 2 had been recorded on Clue for the period 01/04/2021 to 01/09/2022	The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements	The Counter Fraud Team have developed a risk tracker that incorporates NHS Fraud Risk Descriptors, FPNs and IBURNs. Plans are in place to utilise the DATIX system to register and manage fraud risks. At point of review of existing fraud risk assessments or during completion of new risk assessments the GCFP required content is included.
		Outcomes from LPEs should be accurately recorded	All outcomes from LPEs are recorded on the Clue case management system.
		All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10	All FPNs have been actioned and recorded locally. FPNs are now logged on Clue case management system.

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 full year data from 2022/23.

5. INFORM AND INVOLVE

The Counter Fraud Team have made arrangements to launch the new All Wales Counter Fraud e-Learning Module. An awareness article accompanied by a guidance document advising on how to access the module will be released in June. Follow up

awareness is planned for each quarter and reference to the e-Learning module will be included in Counter Fraud literature going forward.

6. PREVENT AND DETER

The Counter Fraud Team are undertaking a comprehensive risk assessment around overpayments of salary. To inform this work a proactive exercise has been undertaken in this area. A report of findings is presented at Appendix 2.

The Counter Fraud Team are undertaking a risk assessment exercise around use of Health Board pool and fleet vehicles. The LCFS has met with Facilities and explored the current processes and procedures relating to car booking, car use, fuel card use, vehicle tracker availability and insurance. A sample has been selected for testing compliance with the procedures in place. Findings will inform the completion of fraud risk assessment in this area.

7. HOLD TO ACCOUNT

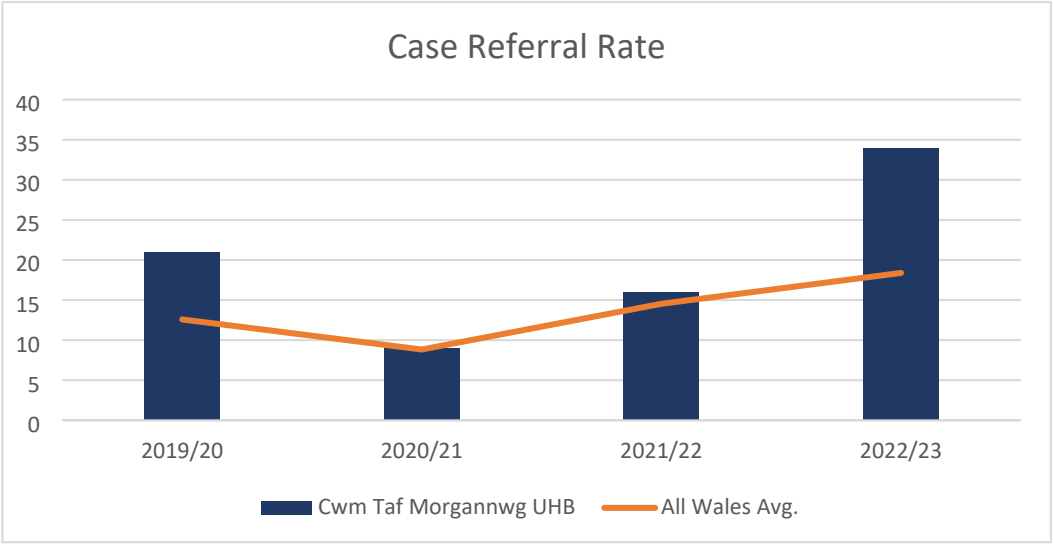
The status of the LCFS investigative caseload is summarised in Appendix 3 to the report. A summary of basic investigation KPI data is presented at outset of the appendix.
Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table.
The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries.
A table of Closed Cases is also presented to review outcomes of investigations.

Item 4.1 – Appendix 1

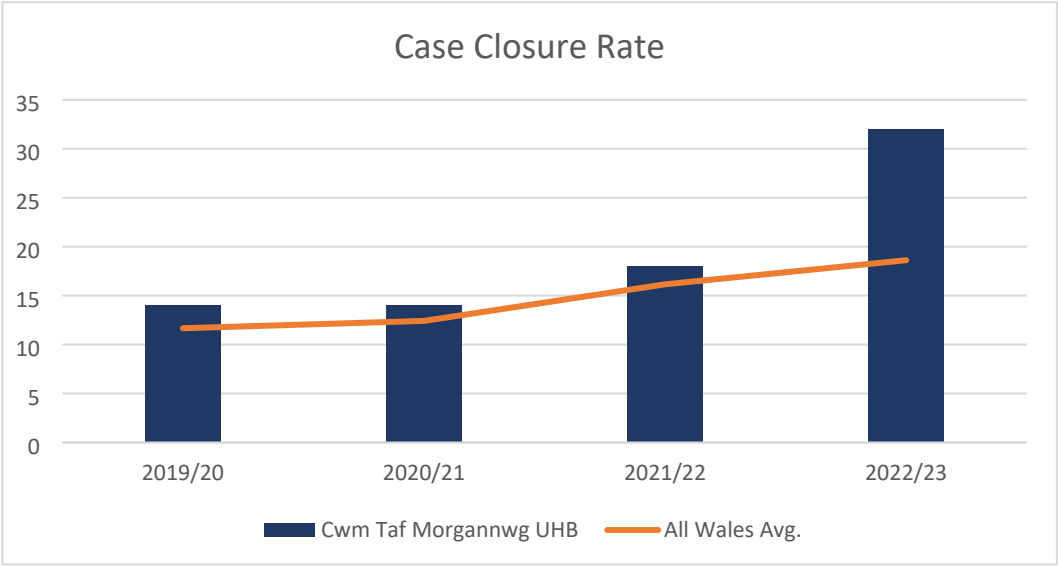
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Q1-Q3

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	21	12.6
2020/21	9	8.8
2021/22	16	14.5
2022/23	34	18.4



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	14	11.7
2020/21	14	12.4
2021/22	18	16.2
2022/23	32	18.6



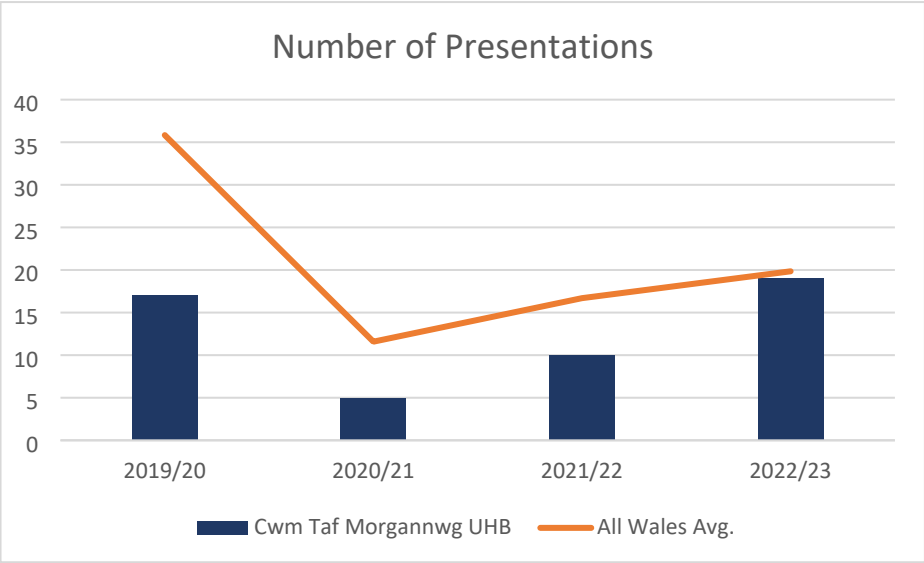
Counter Fraud Benchmarking Statistics – Q1-Q3

Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2019/20	11	21	14	18
2020/21	18	9	14	13
2021/22	13	16	18	11
2022/23	11	34	32	13

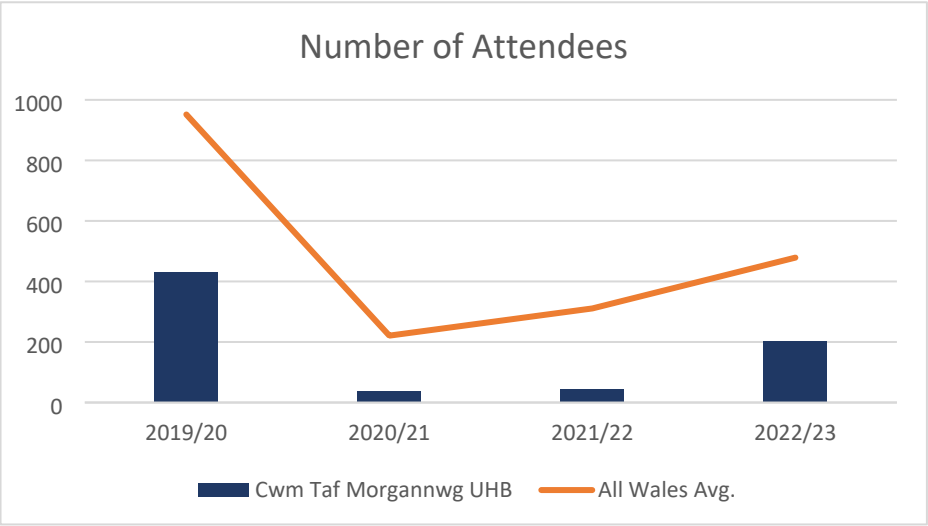
Sanctions	2019/20			2020/21			2021/22			2022/23		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	1	2	3	0	1	1	1	0	6	0	1	6
All Wales Avg.	1.2	2.3	3.3	0.8	1.8	1.6	0.4	4.0	3.0	0.7	2.8	4.4
All Wales Total	14	27	39	9	21	19	5	52	39	9	37	57

Counter Fraud Benchmarking Statistics – Q1-Q3

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	17	36
2020/21	5	12
2021/22	10	17
2022/23	19	20

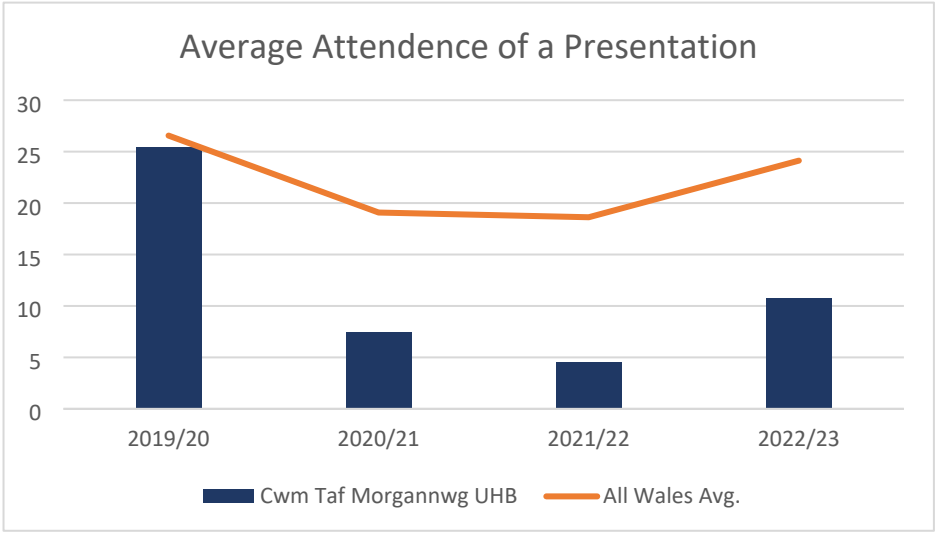


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	432	952
2020/21	37	221
2021/22	45	311
2022/23	204	479

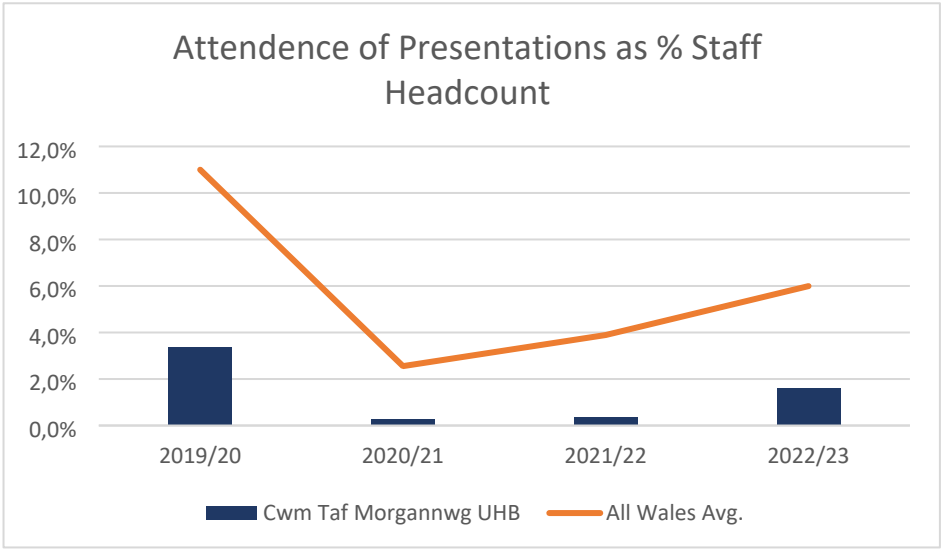


Counter Fraud Benchmarking Statistics – Q1-Q3

Average Attendance of a Presentation	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	25	27
2020/21	7	19
2021/22	5	19
2022/23	11	24

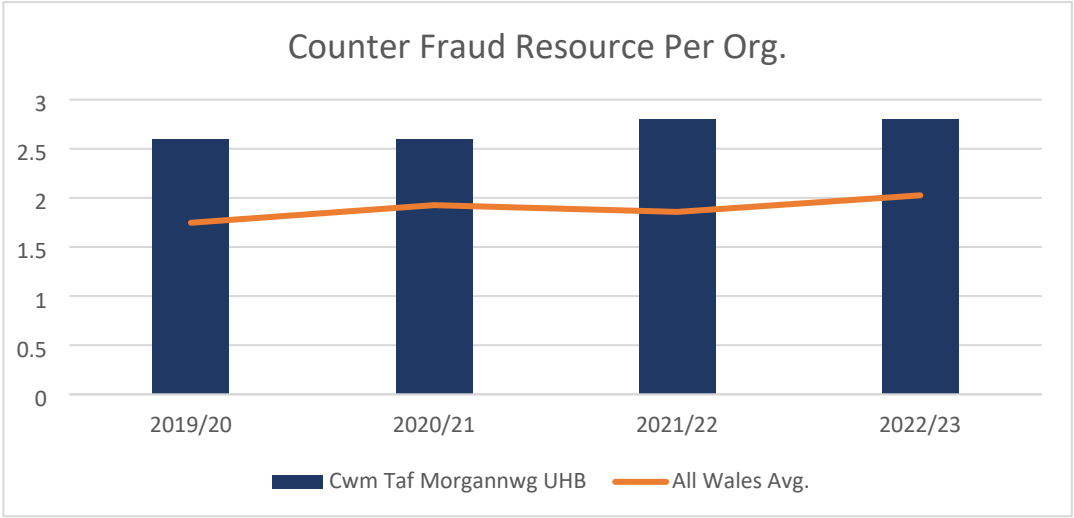


Attendance of Presentations as % Staff Headcount	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	3.4%	11%
2020/21	0.3%	2.6%
2021/22	0.4%	3.9%
2022/23	1.6%	6%

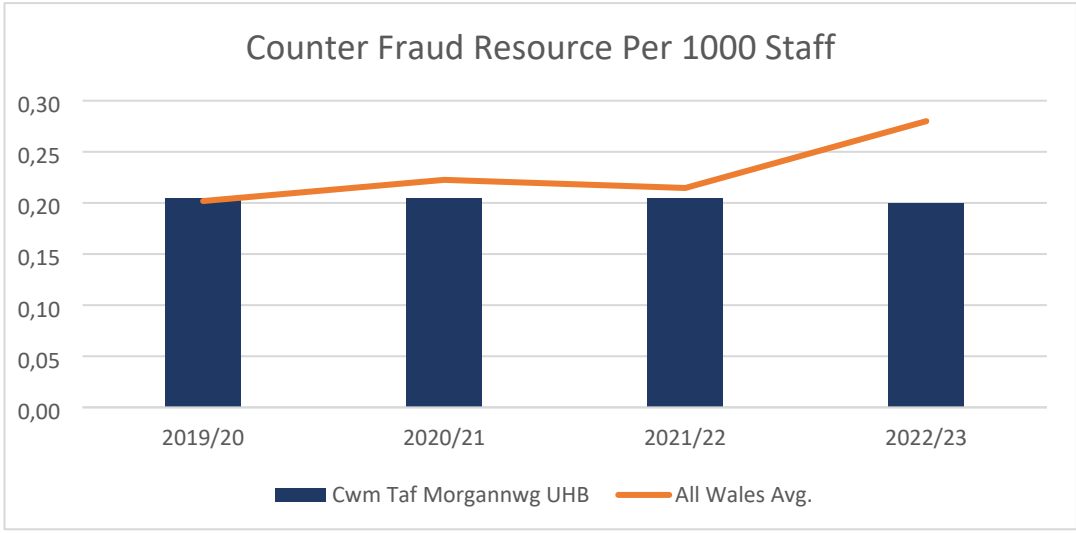


Counter Fraud Benchmarking Statistics – Q1-Q3

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



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



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

COUNTER FRAUD, BRIBERY & CORRUPTION

Proactive Exercise

Salary Overpayments

21 June 2023

Executive Summary

In response to an identified risk the Local Counter Fraud Specialist (LCFS) has undertaken an exercise to explore the current procedure around identifying and recovering overpayments of salary within Cwm Taf Morgannwg University Health Board (CTM UHB).

This report has been written with the "FP7 – Income & Debtors" policy in mind, which covers the system for reporting, recording and investigating all debts within CTM UHB.

In order to establish the Health Board's compliance with this procedure, research was conducted with the support of colleagues in different departments across the Health Board.

At the conclusion of the exercise the LCFS found that there was a need for improvement in manager training, the need to raise awareness with staff of their responsibilities, together with regular checks being conducted to identify any anomalies in departmental budgets at the earliest opportunity.

Introduction and Background

The Local Counter Fraud Specialist (LCFS) for CTM UHB identified a risk relating to overpayments of salary made by CTM UHB, and the means for discovering those overpayments.

There was often a substantial delay between the overpayment occurring and its discovery, which impacted on the process for recovering the debt owed to the Health Board. The LCFS therefore proposed to undertake a proactive exercise to identify the most common causes for overpayments occurring, the existing process for rectifying them, and what changes could be implemented in order to improve the process and reduce the occurrences.

Scope of Exercise

The exercise was undertaken to establish the most common causes of overpayment of salaries, the current controls in place for identifying when a staff member has been overpaid and the measures in place for recovering the debt owed to the Health Board.

In order to measure compliance of the payroll process, the LCFS requested the assistance of colleagues in various departments across the Health Board.

Method

The LCFS requested the assistance of the Finance department who were able to provide a spreadsheet which detailed all the overpayment of salaries resulting in debts up to December 2022. The spreadsheet contained data showing who owed money to CTM UHB due to an overpayment of salary, the reason the overpayment had occurred, value of overpayment, and whether any repayments had been made to reduce the balance outstanding.

The LCFS contacted NWSSP Payroll Services whereby a meeting was held with the LCFS and Payroll Services Team leaders for both payroll team and the overpayment team where they explained their process for discovering and recording overpayments of salary. NWSSP Payroll Services provided overpayments data covering the financial year 2022/23.

Contact was made with People Services Department to establish what training and guidance would be available for managers who have responsibility for updating staff records under their hierarchy.

LCFS met with the Learning & Development Team to discuss any training available for both managers in post and new managers around their roles and responsibilities.

Findings

Figures of Overpayments

In 2022/23 the Health Board had 532 identified overpayments of salary with a total Gross value of £1,456,848.

The majority of overpayments were caused by Health Board managers not submitting pay change or termination forms on time making up 54% of all overpayments. Payroll processing errors were the cause of 12% of overpayments.

The bulk of overpayments are addressed and recovered by way of reversals or salary deductions; 70% of overpayments were resolved in this way. Whilst this demonstrates the procedures and processes functioning for recovery there is an obvious impact on administrative resource to manage that process. Additionally, there is a tendency that higher value overpayments do not fall into that process and are then addressed by the Health Board's Debtors Team.

As of end of December 2022 the Health Board has a total debt value of £1,115,366 attributable to overpayments of salary. This represents an increase of 312% since 2018/19 with an average debt growth rate of 45% per year.

Further details of overpayments and related debt are included in the Appendix to this report for information.

ESR Manager Self Service

ESR (Electronic Staff Record) is a national electronic system, developed by the NHS for the purpose of managing staff information, and is used by all NHS Organisations across England and Wales.

The system contains several components, providing core functionality for Payroll & Pensions, Human Resources, Learning Management and Recruitment departments.

The system also contains Self Service functionality that provides NHS employees with the ability to manage their own data via 'Employee' level, or that of their team via 'Supervisor/Manager' level, through a simple browser-based interface.

The ESR (Electronic Staff Record) portal provides staff with guidance on how to carry out actions on the system and supports managers and supervisors with Self Service online Training.

There is also a link on CTM UHB SharePoint where staff can access ESR (Electronic Staff Record) Self Service guides which hold “How to Guides” for staff to follow.

The guides under Manager & Supervisor Self-Service cover how to change an employee’s assignment detail, action employee change of working hours and also processing a leaver.

When a new staff member joins the Health Board following the pre-employment checks having been completed, a New Appointment Form will be automatically sent to the recruiting manager named on Trac**.**

NWSSP website holds the link for the Trac Process Guide which provides direction for managers for processes such as staff enrolment etc. There is also information available on CTM UHB SharePoint for managers to access which will also advise them of the processes.

The New Appointment Form has to be completed and returned to NWSSP Payroll Services for the staff member to be entered on to the payroll system.

A Staff Exception Form came in to force 02.03.2020 and this replaced the Staff Changes Form. This form is used by managers to instruct the payroll department to makes changes to staff member’s payroll accounts as this function is not currently being utilised via ESR (Electronic Staff Record) Manager Self Service.

If a staff member is leaving the Health Board, a Termination Form will need to be submitted to Payroll Services by their manager.

There is a link on CTM UHB SharePoint for ESR (Electronic Staff Record) which is a dedicated page providing guidance to staff on where to locate the Staff Exception Form and how to submit the form to Payroll Services.

Further information is available on CTM UHB SharePoint under the useful information link which will direct managers to the Payroll Services site to be able to submit a New Appointment Form and the Staff Exception Form. These forms when submitted go directly through to Payroll Department to be actioned.

Managers can also locate the Termination Form via CTM UHB SharePoint under Forms & Templates/Payroll & Finance. This form once submitted will also go directly through to the Payroll Department to be actioned.

The above process is due to be modified with an implementation date of the beginning of June 2023 for managers to be able to amend employees change of working hours, change of location and extension to fixed term contracts directly via ESR (Electronic Staff Record) Manager Self Service.

Currently there is no plan to modify the process for submitting Termination Forms due to the fact this form not only notifies the payroll department of the staff member being terminated, it also notifies other departments such as IT. A decision has been made that it was a more appropriate method of actioning a staff member's termination as opposed to using ESR (Electronic Staff Record) Manager Self Service.

Finance Department

The Finance department provided the LCFS with the Financial Control Procedure "FP7" – Income and Debtors.

This procedure details the controls underlying the Health Board's Income & Debtors system and includes the process to follow for when an overpayment is identified. The procedure also provides the Finance team with guidance on how to deal with recovery of monies owed by staff members employed by the Health Board and those who have left but still have an outstanding debt.

The LCFS established that the Finance department issue budget holder dashboards on a monthly basis, whereby all budget holders have a Qlik dashboard. This dashboard is available to accountants and contains all financial data, with another that goes to budget holders which will only contain access to the cost centres they oversee. Both dashboards will contain a Staff in Post report, together with pay reconciliation data which would indicate any overpayments of salary issues.

The Finance department clarified that other than when the invoices are raised following a request from NWSSP Payroll Services, the only other way of identifying possible overpayment of salaries would be via an early year report provided by NWSSP Payroll Services.

The LCFS established that overpayment of salaries could also be caused due to errors by NWSSP Payroll Services input. Examples of this would be where a pay clerk has missed part of the process required to action a change on the payroll system. This error has not been picked up during the checking process resulting in staff being paid

full time hours when they were working reduced hours or receiving full time pay when they have been on maternity leave.

NWSSP Payroll Services

Payroll Team

The payroll team within NWSSP Payroll Services are responsible for actioning the Staff Exception Forms and Termination Forms submitted by managers within the CTM UHB. Once actioned should they discover any overpayments as a result of a change to a staff member's payroll account they notify the Payroll Services overpayment team. The Payroll Services overpayment team then process the information and calculate the gross and net amount owed, before forwarding all the information to the Finance department. The Finance department then raise an invoice, if the staff member has left the Health Board they liaise directly with the individual in order to recoup the money.

The payroll team covering CTM UHB is made up of a Team Manager, Team Leader and 8 pay clerks. The Team Manager reports to two Deputy Payroll Managers within NWSSP Payroll Services.

The process followed by payroll team is as follows:-

- Payroll Services use an admin call management system "ActionPoint" where staff e-mail in to and the e-mails are directed to a generic e-mail box. When a manager submits an electronic form to Payroll Services this is where it will be directed.

- Prior to 02.02.23. calls made to Payroll Services would be dealt with by staff in a contact centre, these staff members would either deal with the queries over the phone or log calls on the "ActionPoint" system that needed to be escalated to the payroll team. There would be occasions where calls received may not have been recorded on the "Action Point" system if for example, the individual had been put through to the payroll team.

- As of 02.02.23. all calls made to Payroll Services go directly to the payroll team with "Action Point" being utilised for receiving e-mails.

- All digital forms go via "ActionPoint" except for Termination Forms which are directed to the Team Manager and Team Leader. The termination forms are submitted by managers and a digital pending copy is automatically emailed through to Payroll Services. The form is then updated from pending to approved by the payroll support team, and a copy of the form is automatically emailed to the Team Manager and Team Leader. These forms are saved in to the work load folders and monitored.

- Should the payroll team receive information that a staff member is being paid when they should not be, they can suspend the payments and make contact

with the manager to request they submit the necessary termination form. Should this action be carried out the account will remain on suspend payment until the required termination form is received by the payroll team.

- Currently any new staff coming in to the payroll team are trained by another member of the team and are paired with experienced pay clerks.

- The team previously worked on AtoZ split, however, they now work on a daily rota for duties due to the call centre being disbanded and calls now coming back in to the payroll team. There is a checking process in place whereby each action is double checked by a different pay clerk to ensure there are no errors in the payroll process.

- Payroll team aim to action any forms received in to "Action Point" the same month they are received, however, some forms will have been received after they have committed the payroll and they will be actioned ready for the next month. The team have the ability to cancel a BACS payment up to the day before the pay day.

- A retro report is run once a month which can pick up instances where the overpayment has not been sent through for calculation by the pay clerk to the overpayment team.

- Payroll Team issue an overpayment notification form electronically to the payroll overpayments team in order for them to calculate any overpayment.

Overpayment Team

The overpayments team covering CTM UHB is made up of a Team Manager, Team Leader and 8 overpayment staff who also cover 7 other Health Boards. The Team Manager reports to a Deputy Payroll Manager within NWSSP Payroll Services.

Each Health Board currently have their own Overpayment Policy which the overpayment team have to adhere to.

The payroll team and overpayment team are separate, the overpayment team was set up approximately 8 years ago and prior to this they were all one team with all staff members doing the same work.

The process followed by the overpayment team is as follows:-

- The payroll team send a notification form to the overpayment team to notify of an overpayment of salary. This form is currently being standardised by the overpayment Team Leader. Notifications of overpayments are sent from the payroll team to the overpayment team electronically.

- The overpayment team have their own “ActionPoint” which is linked to a generic e-mail box where any documentation and queries are directed. This system has different folders set up with tabs showing the overpayment staff what each piece of work relates to and this is what they access to retrieve their work.

- Prior to 02.02.23 when the payroll team had a call centre, any queries received would be e-mailed through to the payroll team generic e-mail box. As the overpayment team would not have access to payroll generic e-mail box, information could be missed if not recorded on the “ActionPoint” system.

- The salary overpayments are calculated by staff in the overpayment team using a manual calculation, however there are tools available to support staff in working out calculations which can at times be complex.

- Once an overpayment of salary has been calculated, the overpayment team send a report to the Finance department requesting an invoice be raised. They also provide the Finance department with the letters to be issued with the invoice notifying the staff member they have been overpaid. When the overpayment team send the request through to the Finance Department they also issue letters to the manager recorded for the staff member on ESR advising of the overpayment and requesting they discuss the matter with the staff member. This may be an issue if the hierarchy on ESR is not correct as the appropriate manager will not receive the notification.

- All notifications of overpayments are issued to staff via the e-mail address held on ESR for staff in post and for those that have left the Health Board they will be printed out and sent in the mail by the Finance department.

- Currently any new staff coming in to the overpayment team are trained by another member of the team and are paired with experienced officers via a buddy system. Each Health Board the overpayment team cover will have a different process that the team have to follow. Staff receive refresher training when needed and the team are very hands on with support ensuring staff are up-to-date on changes they need to be aware of.

- The Team Manager and Team Leader carry out a DIP checks depending on work load. The team is currently split in to two separate team where they have one team on new overpayment requests and another on old overpayment requests.

Learning & Development

There are resources available on CTM UHB SharePoint around available training for Health Board staff.

As of April 2023 a new Corporate Induction was rolled out which is being delivered virtually to staff. All new staff will receive an email once they have joined the Health Board containing a welcome message and link to the We Are CTM – Your Induction.

The Learning & Development Team have also shared the link to staff already in post with the Health Board via a Staff Update and the link is also accessible via CTM UHB SharePoint page.

The new Corporation Induction is an online module with optional face to face follow-up sessions being rolled out in the near future.

The induction will direct staff as to administrative processes such as payroll, annual/sick leave etc. and will provide guidance on who they need to contact if they have any queries.

The Learning & Development Team are looking at developing a Manager's Toolkit in the future, however, at present there is no timeframes for when they would be able to deliver this.

Conclusion

The most common causes of overpayment of salary is line managers' non-compliance with submitting Staff Exception Forms and Termination Forms to NWSSP Payroll Services at the appropriate time leading to incorrect salary information.

The Health Board plans to roll out Managers Self Service to effect pay changes directly within the ESR system. This effectively makes it easier to make changes to pay but at the most basic level replaces the current system with similar means of completion.
Raising awareness amongst Managers of responsibilities and the impact of non-compliance with procedures appears to be paramount to addressing the main root cause of overpayments occurring. Development of a 'Managers Toolkit' being a one stop shop for Managers to gain guidance on discharge of duties including pay amendments/terminations would be beneficial.

An All-Wales Overpayment Policy Review Group has been set up with representatives from NWSSP Payroll Services, Finance Departments and Local Counter Fraud Specialists from Health Board's across Wales. The purpose of the Group is to agree an All Wales Overpayments Policy that NWSSP Payroll Services can consistency apply across all NHS Wales Organisations.
NWSSP have also established an All Wales Overpayment Digital Solution which is seeking to centralise the recovery of overpayments into one All Wales team.
Centralising the recovery of salary overpayments into one team can help streamline the process and increase efficiency. This will involve automating the creation of documents and communication with finance teams through a digital solution

Whilst these developments are welcome this only seeks to address the issue once an overpayment has occurred. Seeking to reduce the overall number of overpayments to a minimum should also be maintained as a goal at the local level.

The Counter Fraud Team intend to follow up this proactive work by formalising findings into a fraud risk assessment in line with NHS Counter Fraud Standards.

Actions are underway and there is consensus across NWSSP and Health Board stakeholders that this is an issue that needs to be addressed.

Appendix

Overpayment Data

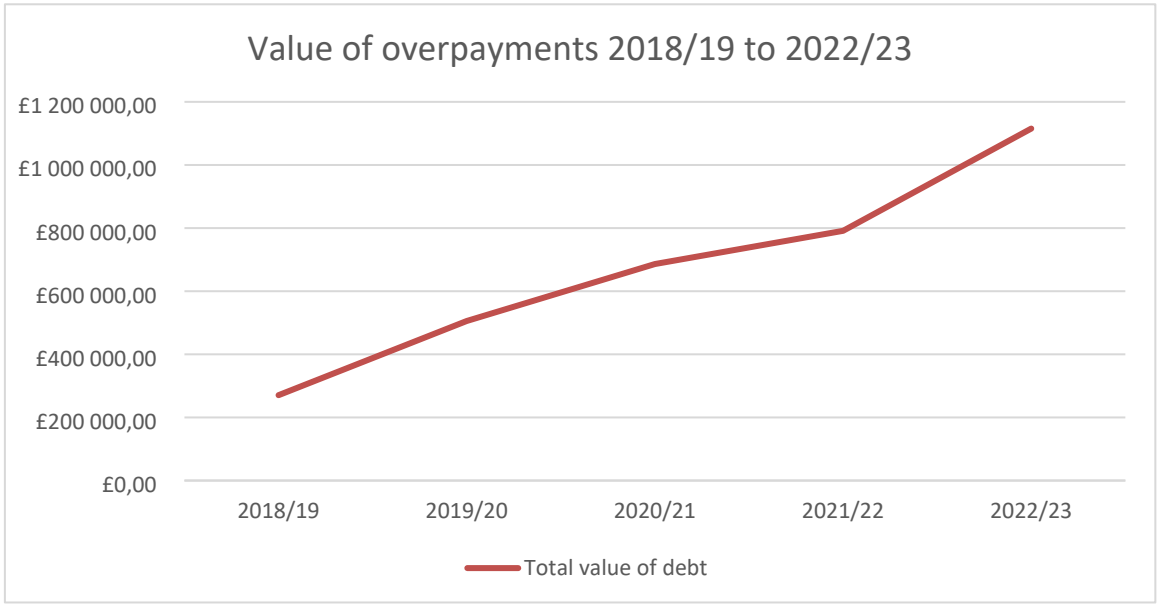
Overpayment Values	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total/Avg
Total OP (Gross)	£137,784	£139,485	£146,882	£72,209	£93,136	NO DATA	£201,610	£72,928	£173,460	£106,804	£160,421	£152,129	£1,456,848
Total OP (Net)	£94,869	£90,164	£98,277	£47,459	£60,646	NO DATA	£168,478	£58,455	£111,407	£70,206	£108,466	£103,959	£1,012,386
Number of OP	41	39	51	37	32	NO DATA	73	41	58	36	54	70	532
Avg. Value of OP (Gross)	£3,361	£3,577	£2,880	£1,952	£2,910	NO DATA	£2,762	£1,779	£2,991	£2,967	£2,971	£2,173	£2,756
Highest Value OP (Gross)	£27,079	£47,103	£14,026	£13,222	£23,269	NO DATA	£31,627	£20,270	£36,474	£22,464	£24,602	£29,636	

Health Board		
Late Termination	149	28%
Late Change/Notification	138	26%
Incorrect Hrs/Enh/OT	25	5%
Incorrect Pay Information	47	9%
Total	**359**	**67%**
Payroll		
Incorrect Pay Information	37	7%
Processing Error	25	5%
Total	**62**	**12%**

The Health Board had 532 identified instances of overpayment of salary in 2022/23 with an average value of overpayments being £2.7k. Just over half of overpayments related directly to Health Board Managers not completing pay amendment forms on time. A smaller but still significant proportion of overpayments were down to incorrect information being supplied to Payroll by Health Board Managers.
The total value of identified overpayments well surpassed £1 million. Around 70% of overpayments were recovered via reversals or salary deductions. Whilst this represents a swift recovery of the majority of overpayments there is an obvious impact on resource commitment to manage that process. Where it is not possible to reverse or deduct overpayments flow to the Debtors Team for recovery. The outstanding debt relating to overpayments has risen steadily since 2018/19.

Overpayment Debtors Data

Overpayment Debts	2018/19	2019/20	2020/21	2021/22	2022/23	% increase from 2018/19
No of invoices	185	360	432	499	653	253%
Total value of debt	£270,525.48	505,619.22	686,115.69	791,354.51	1,115,366.05	312%
Average value of debt	£1,462.30	£1,404.50	£1,588.23	£1,585.88	£1,708.06	17%
No over £1,000	60	113	180	223	275	358%
No over £2,500	30	49	80	103	133	343%
% increase in no from previous year		87%	36%	15%	41%	



Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Item 4.1 – Appendix 3

Counter Fraud Investigations Update Report

21 June 2023

Summary

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

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

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

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

Case Status

Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2023/24
7	0	16

Case Rates

Referrals Received 2022/23	Cases Under Investigation for Over 12 Months
8	1

Sanctions/Outcomes

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

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	A full committal file has been submitted to CPS for consideration for prosecution. Based on assessment of evidence charges are anticipated. A first review of prosecution file has been completed by CPS Prosecutor, an action plan was set and returned the same week. Further review has been undertaken by CPS and LCFS investigators have met with Prosecutors and charges have been decided. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are investigating potential criminal fraud offences committed against that organisation and assessing professional registration concerns.
INV/22/01138	18/08/2022	Non-completion of contracted hours and leave fraud	Evidence has been established of working patterns via digital and locally held records these are being assessed against timesheets and leave records. Approaches have been made to potential witnesses who have provided account. Further evidence was held by witness which will form part of investigation. An interview is being arranged to gain account from subject.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/22/01233	06/09/2022	Overpayment of salary	Enquires have established that subject had a fixed term contract related to Covid recruitment. This should have ended and subject continued to work for Bank. Enquiries have established an overpayment with gross value of £7766.33. An interview has been undertaken and account gained from subject. Following follow up enquiries a second interview was undertaken. During this interview the subject provided account that there was confusion around booking Bank shifts and completion of fixed term contract shifts and there was an honest belief that the shifts they were booking were being split. Subject stated they raised this with their manager at the time and was informed her payslips were correct. This was corroborated by the manager following interview. Assessment of case concluded that subject lacked dishonesty. A civil recovery was agreed and case will be closed once payments commence.
INV/22/01535	21/10/2022	Timesheet Fraud	Allegation received via the NHS fraud and corruption reporting line. Staff member alleged to be taking more SPA time than other staff and using SPA time to avoid completing additional shifts. Enquiries have uncovered that the subject has a high SPA usage but this is relative based on their part time status. It was established that there is no guidance on SPA allocation for part time vs full time staff and this is being addressed by the Director of Nursing. Assessment of this case has concluded with difficulties in establishing dishonesty. Case closure to be sought.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/00447	06/03/2023	Working Elsewhere Whilst Sick	Allegation highlighted via the National Fraud Initiative. NFI enquiries have established that a member of staff reporting sick to has worked 7 Bank shifts with another Health Board during the sickness absence. Enquiries are being undertaken to collate evidence around the sickness and bank shifts worked. Engagement with manager around sickness dates who stated that the sickness dates were incorrect. Therefore no working whilst sick fraud established. Due to incorrect ESR information however it appears that the subject has been overpaid approximately 1 month salary. This is being addressed via the normal overpayment recovery procedure.
INV/23/00505	15/03/2023	Overpayment of Salary	A staff member who has now terminated their employment with CTM UHB has been overpaid salary relating to maternity pay for the period 16.02.22. to 16.12.22 Gross £29,636.31. Investigation has been allocated to CFS Wales Financial Investigator to work jointly with LCFS due to criteria for Financial Investigations. Following initial enquiries, it is believed that subject has funds available to repay and has therefore not spent overpaid amount. Civil recovery underway.
INV/23/00883	10/05/2023	Overpayment of Salary	Subject has been overpaid maternity pay of net £7565.22. Initial enquiries have established clear guidance issued to subject around expected pay during maternity leave prior to commencement. Financial investigation support being gathered to assess case for further investigation.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/00945	17/05/2023	Prescription Fraud	A Health Care Support Worker is alleged to have stolen prescriptions and presented to Pharmacy in attempt to obtain 200 codeine tablets. South Wales Police are leading the investigation and have arrested and interviewed subject.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/21/00041	12/04/2021	Overpayment of Salary	After termination date was entered incorrectly by inputting 2020 instead of 2019 resulting in error in inputting termination information on the system. The subject continued to be paid for 12 months as a result with overpayment totalling Net £8336.70. Subject has failed to attend interview. Subject has denied receiving payments and has given bank mandate authority for Financial Investigator to access account information to assess. This has caused issues however with Bank not releasing information. Transaction data will be gathered Health Board side. A case conference was held with CFS Wales in March 2023 to discuss prosecution file, an action plan was agreed which included seeking arrest of subject to enable interview. South Wales Police were approached and declined to make arrest with their assessment that required necessity was lacking. Prosecution unable to proceed without interview and civil recovery has commenced.
INV/22/00707	21/06/2022	Leave Fraud	False information given in order to gain Special Leave. Investigation have established evidence corroborating allegation. This was shared with managers and parallel disciplinary and fraud investigations ongoing. The disciplinary process resulted in dismissal of the subject in this case. Given the low value and application

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			of disciplinary sanction the case was assessed as not in the public interest to proceed.
INV/22/01512	18/10/2022	Falsification of qualifications amongst care home staff	Anonymous allegation received via the NHS fraud and corruption reporting line. Enquiries have established that the care home in allegation has closed down. Information has been sought from Health Board regarding potential impact on any NHS funded services. Information has also been shared with Rhonnda Cynon Taf (RCT) Council for their consideration, RCT Council confirmed that the care home closed due to an HMRC winding up order. RCT subsequently had to step in to ensure continuation of service. Full details have been shared. Care Inspectorate Wales (CIW) have also been engaged. CIW had inspected this care home prior to closure and had knowledge of similar allegations as part of inspection however no paperwork was available to support this enquiry. No NHS fraud or loss was established as part of enquiries.
INV/22/01513	18/10/2022	Timesheet Fraud	Allegation that staff have been accessing their work rosters to add in additional hours. Enquiries have centred on the e-roster and full details of accesses and sign offs around the subject have been gained. The system has been found to allow alterations but not same person finalisation. System audit trails around

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			alterations and finalisation were examined with no adverse findings. No fraud was established in this case.
INV/23/00117	16/01/2023	Prescription Fraud	Patient presented falsified prescription for controlled drugs at a community pharmacy. Prescription found to be a genuine blank NHS script which was stolen from an independent prescriber at another pharmacy believed to have been handwritten by the person presenting. Police are investigating, LCFS is supporting via the drugs liaison officer and reviewing risk. Follow up on this suggests that the Police attended Pharmacy with intent to gain details to apprehend offender. Pharmacy advised that they only wanted a crime number and Police disengaged. This was raised with the Drugs Liaison Officer who advised to contact Officer in Case. Officer in case provided a detailed response as to why investigation did not proceed concluding that this was not in the public interest.
INV/23/00498	23/03/2023	Non-disclosure of Criminal Conviction and Theft	Allegation received via Fraud and Corruption Reporting Line. Allegation states that subject is using drugs from the wards they work on, is often sleeping in car for hours whilst on shift, has been stealing ancillary products from wards, and has a previous conviction. Enquiries have established subject is a bank worker. Information has been shared with WOD colleagues and discussions held with Nurse Bank Manager. No concerns were established regarding non-disclosure of criminal conviction. Further enquires with local manager

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			concluded that there are no concerns with regard to theft of items.
INV/23/00526	20/03/2023	Prescribing	Concerns over prescribing of Controlled Drugs, Shortec (Oxycodone). Patient representative presented two prescriptions for Shortec and stated to Pharmacist that their mother had told them not to take the two prescriptions to the same Pharmacy. The Prescriptions were dated the same day. A case conference was held with Medical Professional Standards, Pharmacy, Primary Care and Medicines Management colleagues. Information had also been reported to Police. Evidence at this stage suggested that these are genuine prescriptions. Action plan was agreed at this meeting for Professional Standards, Pharmacy, Primary Care to visit the prescribing practice to assess patient records. Any discrepancy found at that visit within records could be indicative of fraud and this would then be picked up for criminal investigation. No discrepancy would suggest professional prescribing issue and be dealt with under those processes. Police were in agreement with action plan. Following visit no discrepancies were found on patient records. Matter is being progressed via Professional Standards as a result and no fraud was established.
INV/23/00670	06/04/2023	Working Whilst Sick	Referral received via Fraud and Corruption Reporting Line. Subject alleged to have been working for own

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			private business whilst on sick leave from substantive position. Enquiries established that subject has taken no sick leave since commencing employment with the Health Board.
INV/23/00726	17/04/2023	Working Whilst Sick	Referral established via NFI system. Investigation established that subject had worked for 5 hours during a period of sickness. The reason for sickness was covid self-isolation. The secondary role was one that could be completed remotely for another NHS organisation. The primary role with the Health Board was part time with Monday being non-working day. The 5 hours working for secondary employer had been completed on a Monday. No fraud established in this case.
INV/23/00829	02/05/2023	False Timesheet	An agency worker submitted timesheets for work not completed. During initial enquiries it was established that there is an ongoing matter being addressed by NMC and another NHS Wales Counter Fraud Team. No financial loss was incurred by the Health Board in this instance and information was shared with Counter Fraud Colleagues and NMC who are progressing.
INV/23/00830	02/05/2023	Dual Working	Referral established via NFI system that identified a match for the subject as working a full time role with the Health Board and another Public Sector employee. Investigation established that the subject has properly

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			declared secondary role, there are no concerns around completion of secondary role in NHS time and that special leave is available under policy for secondary role should time be required for secondary role in usual NHS time.
INV/23/00995	23/05/2023	Computer Misuse	Subject is alleged to have downloaded unauthorised internet browser plugin "Hola Free VPN Proxy Unblocker" on to Health Board devices. Cyber Security Team picked up initial response and removed plugin from computers remotely. VPN extension plugin was disabled from use and subject advised and formally warned in relation to actions. No evidence of criminal intent was established during investigaiton.

National Fraud Initiative

Progress and Outcomes

Report ID	Report Title	Responsible Lead	Total Matches	Status	Closed Matches	Further Enquiries	Matches Outstanding
65	Payroll to Payroll	Counter Fraud	2	Opened	2	0	0
66	Payroll to Payroll		189	Opened	136	47	6
67.1	Payroll to Payroll - Phone Number		9	Not Opened	0	0	9
67.2	Payroll to Payroll - Email Address		1	Opened	1	0	0
68.1	Payroll to Payroll - Phone Number		14	Opened	10	3	1
68.2	Payroll to Payroll - Email Address		1	Opened	0	1	0
78	Payroll to Pensions	Pensions/Counter Fraud	130	Not Opened	0	0	130
80	Payroll to Creditors	Counter Fraud	12	Not Opened	0	0	12
81	Payroll to Creditors		8	Not Opened	0	0	8
700	Duplicate creditors by creditor reference	NWSSP -Accounts Payable	1080	Not Opened	0	0	1080
701	Duplicate creditors by creditor name		2	Not Opened	0	0	2
702	Duplicate creditors by address detail		56	Not Opened	0	0	56
703	Duplicate creditors by bank account number		102	Not Opened	0	0	102

Report ID	Report Title	Responsible Lead	Total Matches	Status	Closed Matches	Further Enquiries	Matches Outstanding
707	Duplicate records by reference, amount and creditor reference		18	Not Opened	0	0	18
708	Duplicate records by amount and creditor reference		4347	Not Opened	0	0	4347
709	VAT overpaid		54	Not Opened	0	0	54
711	Duplicate records by invoice number and amount but different creditor reference and name		84	Not Opened	0	0	84
712	Duplicate records by postcode, invoice date and amount but different creditor reference and invoice number		4	Not Opened	0	0	4
713	Duplicate records by postcode, invoice amount but different creditor reference and invoice number and date		5	Not Opened	0	0	5
750	Procurement - Payroll to Companies House (Director)	Counter Fraud	77	Not Opened	0	0	77
752	Procurement - Payroll to Companies House (Director)		50	Not Opened	0	0	50
9999	Multiple occurrence report		10	Not Opened	0	0	10

AGENDA ITEM
4.2

AUDIT & RISK COMMITTEE

PROCUREMENT & SCHEME OF DELEGATION REPORT

Date of meeting	21/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Owen James, Head of Corporate Finance
Presented by	Sally May, Executive Director Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR APPROVAL

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

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

1. SITUATION/BACKGROUND

1.1 Procurement Matters

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

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

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

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

d) Summary of contracts over £500,000

This report provides details of any such transactions within the period 01.04.23 to 31.05.23.

1.2 Purchase to Pay

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

1.3 Scheme of Delegation and Financial Control Procedures

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

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

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

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.04.23 to 31.05.23.

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

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

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Table A** below provides details of such actions during the period 01.04.23 to 31.05.23

Table A – Single Tender Actions 01.04.23 to 31.05.23

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1664	Revenue	Estates	Maintenance of life critical fire alarm systems across CTMUHB.	Morris Churchfield - Morris Line Engineering Limited	£89,830	a)	01/06/23

Reasons for approval:

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

b) Compatibility issue

c) Genuine 1 provider

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

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

None

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 01.04.23 to 31.05.23:

No contracts above £500,000 awarded during this period.

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to 31st March 2023.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 12 2022-23 achieving 95.4% (value 94.3%). This compares to 95.7% (value 93.3%) to Month 12 2021-22.

	0 - 30 Days		Total		%	
	Number	**Value**	**Number**	**Value**	**Number**	**Value**
Apr-22	20,667	46,929,829	21,611	49,682,932	95.6	94.5
May-22	19,217	43,766,897	19,796	46,596,405	97.1	93.9
Jun-22	25,864	43,490,528	26,670	45,686,653	97.0	95.2
Jul-22	17,617	36,630,680	18,805	39,207,371	93.7	93.4
Aug-22	25,176	40,169,264	26,188	41,979,225	96.1	95.7
Sept-22	15,971	40,186,028	18,535	43,957,740	86.2	91.4
Oct-22	15,379	38,744,175	17,396	41,928,025	88.4	92.4
Nov-22	27,952	61,336,526	28,645	63,848,835	97.6	96.1
Dec-22	28,584	75,075,031	29,113	76,887,619	98.2	97.6
Jan-23	21,966	54,801,133	23,335	61,217,475	94.1	89.5
Feb-23	23,446	62,686,157	24,207	67,236,495	96.9	93.2
Mar-23	34,706	63,200,018	35,606	65,699,304	97.5	96.2
YTD	**276,545**	**607,016,266**	**289,907**	**643,928,079**	95.4	94.3

The NHS invoice position continues to be challenging and shows that 80.9% (number) and 96.6% (value) of invoices were paid within 30 days to month 12 2022-23. (80% (number) and 96.1% (value) for the same period in 2021-22).

For 2023/24, the figures are first reported to WG for month 3, but the first month figures show that the PSPP target continues to be met.

Scheme of Delegation and Financial Control Procedures

Please see attached in Appendix 1, the updated Financial Control Procedure for FP1 – Capital Monitoring.

The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

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

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

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

3.1 N/A

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Yes If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Yes – available from Owen James – Head of Corporate Finance

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

The Audit & Risk Committee is asked to:

a) **NOTE** the position on procurement matters for the period 01.04.23 to 31.05.23;

b) **NOTE** the update regarding Purchase to Pay and achievement of PSPP target to the year-end 2022/23;

c) **APPROVE** the updated Financial Control Procedure for Capital Monitoring.

FINANCIAL CONTROL PROCEDURE: CAPITAL MONITORING

Initiated by:	Director of Finance
Approved by:	Audit Committee
Date approved:	~~20th January 2020~~TBC
Operational Date:	~~February 2020~~April 2023
Date for review:	~~February 2023~~April 2026
Distribution:	Executive Directors Board Secretary Directorate Managers

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

Freedom of Information Status: Open

CONTENTS

1 INTRODUCTION

1.0 This procedure aims to ensure that the University Health Board has robust controls to monitor and report on the timing and level of expenditure on capital schemes in the acute, community and primary care settings, by setting out the responsibilities of officers in relation to the appropriate use of capital funding. This procedure is applicable to both Cwm Taf Morgannwg University Health Board and the hosted service of Welsh Health Specialised Services Committee (WHSSC).

1.1 Where the term University Health Board is used this applies equally, unless otherwise specified, to WHSSC.

1.2 This procedure should be read in conjunction with the University Health Board's Standing Financial Instructions and other Financial Control Procedures.

1.3 The Director of Finance shall establish the capital resources available to the University Health Board in any given year and provide guidance as to the level of commitment that should be made against that funding.

1.4 The Director of Finance shall be responsible for all accounting arrangements around the capital programme. Compliance is required with the Capital section in the Manual of Accounts. The Director of Finance shall sign off all expenditure returns submitted to WG.

1.5 The Director of Finance shall normally assume the role of project owner for the capital discretionary programme, unless an alternative Executive Director is approved via the Executive Capital Management Group (ECMG).

1.6 An appropriate Executive level project owner will be agreed at ECMG for major capital schemes, with the Assistant Director of Planning (Capital and Estates) taking the role of Programme/Project Director.

1.7 Progress against schemes shall be monitored by ECMG.

1.8 ECMG shall approve a planned discretionary capital programme on behalf of the University Health Board, and oversee progress in the delivery of the overall capital programme.

1.9 Capital expenditure is defined by IAS (International Accounting Standards) 16 Property, Plant and Equipment as ***expenditure on items that:***

- are held for use in the production or supply of goods or services…
- are expected to be used during more than one period.

A tangible productive resource must have an expected life in excess of one year.

The capitalisation threshold has been determined as expenditure of £5,000 (including VAT where this is not recoverable) or more on:

- A discrete asset
- A collection of assets which individually may be valued at less than £5,000 but which collectively form a single capital asset because the items fulfil **all** of the following criteria:
  - the items are functionally interdependent
  - the items are acquired at about the same date and are planned for disposal at about the same date
  - the items are under single managerial control
  - each individual asset thus grouped has a value of over £250
- a collection of assets which individually may be valued at less than £5,000 but which form part of the initial equipping and setting-up cost of a new building

1.10 Items charged against the Capital Programme shall be in accordance with the above definition. Compliance is also required with International Financial Reporting Standards (IFRS), the Government FReM and the Capital section of the Manual for Accounts, on the identification of and accounting for, capital expenditure.

1.11 It is important for costs associated with a capital build/purchase that do not fall under the above definition to be identified from the outset. This includes ongoing costs such as depreciation, additional staffing costs, maintenance costs and consumables. These costs will need to be covered from revenue budgets and how this is to be achieved shall be included as part of the Business Case or Statement of Need.

2. CAPITAL GROUPS

~~2.1 Finance, Performance and Workforce Committee (FPW)~~

~~2.1.1 FPW will provide advice and assurance to the Board in the exercise of its functions.~~
~~FPW will perform appropriate scrutiny and review to a level of depth and detail not possible in Board meetings in respect of performance relating to:~~

- ~~Financial planning and monitoring including delivery of savings programmes;~~
- ~~Activity and productivity including operational efficiency and effectiveness;~~
- ~~Workforce;~~
- ~~Data Integrity.~~

~~The Committee will ensure that evidence based and timely interventions are implemented to drive forward improved performance thereby allowing the Health Board to achieve the requirements and standards determined for the NHS in Wales and as outlined within the Board's 3 Year Integrated Medium Term Plan.~~

~~2.1.2 The Committee membership consists of five independent members.~~
~~A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, an Independent Member will be nominated to Chair the Committee.~~
~~For effective governance, at least two Executive Directors, should be in attendance at the meeting.~~

~~2.1.3 The Finance, Performance and Workforce Committee shall be responsible for:~~

- ~~Ensuring all capital projects within the Major Capital Programme support the strategic and corporate objectives of the UHB.~~
- ~~Ensuring that all capital schemes are developed within the health community's strategic financial framework and can demonstrate affordability.~~
- ~~Ensuring the capital schemes deliver facilities that align with and support the UHB's clinical governance and health and safety strategies.~~
- ~~Ensuring that all major capital projects within the Major Capital Programme are delivered within the prescribed tolerances of agreed scope, budget, quality standards and timescales.~~
- ~~Receiving reports, and recommendations, from ECMG.~~

~~2.2~~2.2.1 Executive Capital Management Group (ECMG)

2.2.1 The Executive Capital Management Group will be an executive led group responsible for approving and monitoring the development and delivery of the UHB's capital programme and will meet on a monthly basis.
Progress on the major and discretionary schemes will be monitored through receiving reports by the Project Director (Assistant Director of Planning).
Progress against the Capital Resource Limit (CRL) will also be monitored via reports from the Head of Finance (Capital). Schemes at business case stage will be reported by the Director of Finance or other relevant lead executive. ECMG will report quarterly ~~on an exception basis~~ to the ~~Finance, Performance and Workforce~~ Planning, Performance and Finance Committee ~~and/or~~prior to ~~reporting to~~ the full ~~Board, as required~~Board . All business cases >£1m will also be taken through to the PPF and Board prior to submission to WG .

2.2.2 The group ~~membership~~ will consist of:
~~2.2.2~~

Members

- Director of Finance (Chair)
- ~~Director Clinical Services Operations~~Chief Operating Officer
- Director of Strategy and Transformation ~~Strategic Planning~~
- Medical Director or Director of Nursing
- Director of Digital
- ~~Assistant Director of Planning (Capital & Estates)~~
- ~~Assistant Director of ICT~~
- ~~Head of Capital~~
- ~~Head of Finance (Capital)~~
- ~~Head of Procurement (NWSSP)~~

~~Other officers as appropriate~~

Attendees

- Assistant Director of Planning (Capital & Estates)
- Assistant Director of ICT
- Head of Capital
- Head of Finance (Capital)
- Head of Procurement (NWSSP)
- Other officers as appropriate

2.2.3 Executive Directors will appoint a deputy, if unable to attend the meeting. The Deputy will have full delegated powers of authority, in place of the Executive.

2.2.4 The Executive Capital Management Group shall be responsible for:

- Approving a detailed discretionary capital programme plan, to meet corporate priorities, prior to the start of each financial year.
- Approving a future year's discretionary replacement programme.
- Approving a contingency programme should additional funds become available in year.
- Agreeing submissions, as appropriate, to the Management Board and Finance, Performance and Workforce Committee, depending on value and significance of scheme.
- Receiving reports, and recommendations, from Gateway Reviews and External Auditors.
- Formal reporting to WG.
- Receiving and evaluating reports from the Capital Monitoring Group, on progress of spend against the overall planned programme for discretionary schemes, and approve any appropriate variations.
- Receiving and evaluating reports on progress of spend against the overall planned programme for Major schemes, and authorise any appropriate corrective action.
- Examining any in year business justification cases, receiving and evaluating recommendations from the UHB's accommodation group, statements of need and other requests for discretionary capital support, and to prioritise and approve accordingly in line with the CRL available.
- Ensuring appropriate evaluation is undertaken on all schemes in line with the original benefits anticipated.
- Ensuring CRL compliance and receiving monthly updates on the ledger position.
- Ensuring all major capital investment projects are appropriately organised, resourced and managed in accordance with local and national mandatory capital planning procedures.
- Establishing longer term capital plans, ensuring sufficient flexibility within the programme to manage capital cash resources.
- Overseeing any property disposals or acquisitions.
- Develop processes for receiving all Business Cases and/or statements of need that comply with strategic and operational objectives in UHB
- Urgent applications for funds will require approval by the ECMG. However if due to time restrictions this is not practical then a decision can be made by the Director of Finance in accordance with the process for agreeing Statements of Need and will be noted at the next ECMG meeting.
- Any approvals will be processed subject to the Financial Limits set out in the Scheme of Delegation.
- A minimum of 23 Executive Directors will be required for a quorum.

2.3 The Capital Monitoring Group (CMG)

2.3.1 The Capital Monitoring Group will review, on a monthly basis, the approved discretionary capital programme and the relevant timing and

level of planned expenditure to ensure capital cash resources are spent within the year allocated.

2.3.2 The Capital Monitoring Group members will consist of representatives from

- Head of Capital (chair)
- Finance (Capital)
- Procurement
- IM&T
- Clinical Engineering (EBME)

2.3.3 The chair of the Capital Monitoring Group will be a member of ECMG.

2.3.4 The Capital Monitoring Group shall be responsible for:

- Formulating a detailed discretionary capital programme plan, prior to the start of each financial year.
- Formulating a future year's discretionary replacement programme.
- Formulating a contingency programme should additional funds become available.
- Prioritising and developing a programme for any additional in year allocations
- Reviewing differences between anticipated spend and approved allocation and the reason for the movement, including slippage.
- Make recommendations to the Assistant Director of Planning (Capital and Estates) who has delegated authority to agree variations of less than 10%. Any approvals will be processed subject to the Financial Limits set out in the Scheme of Delegation.
- Reporting performance of the capital programme to ECMG, recommending corrective action where appropriate and identifying any adjustments that will require approval.
- Scrutiny of new Statements of Need (SON) prior to submission to ECMG.

2.3.5 The group will report all amendments to approved allocations regardless of value to ECMG

2.3.6 The group will also have a role in monitoring compliance with procedures and report to ECMG any non-compliance.

3 CENTRALLY FUNDED CAPITAL PROGRAMME

3.1 General

3.1.1 Capital schemes may be funded directly from WG where:

- They are major capital schemes
- They are specifically earmarked and driven by WG (earmarked schemes)

3.1.2 A separate source of funding will exist for such schemes. They will therefore need to be shown as a separate category to the University Health Board's discretionary capital funds, but subject to the same monitoring and reporting processes.

3.1.3 The risk attached to these schemes will naturally be greater due to the size of the scheme (meaning any slippage or overspend will be more difficult to manage) or tight timescales and other constraints associated with earmarked funds. Monitoring and reporting processes will clearly need to reflect these additional risks.

3.1.4 It is the University Health Board's responsibility to ensure that a balanced audit provision of capital across discretionary programme, centrally funded projects, and major schemes is agreed on an annual basis to provide the required ongoing assurance to the Audit Committee and the Health Board.

3.1.5 Although it is the responsibility of the University Health Board to determine the extent of internal control in the organisation's systems, internal audit may contribute to internal control by examining, evaluating and reporting to management on the adequacy and effectiveness of that control.

3.1.6 Capital funded projects are frequently important to the strategic direction and success of an organisation, and therefore internal audit should be actively involved in providing assurance and advice. This will include scheduling reviews to deliver timely assurance around major project milestones, both during and on completion of schemes.

3.2 Major Capital Schemes

3.2.1 For any major schemes a business case must be submitted to Welsh Government for approval.

3.2.2 A business case must demonstrate that the proposed investment has been properly scoped and planned; offers optimum value for money; is commercially viable; affordable and achievable. In addition a case for any investments should show that the proposal has clearly identified service delivery benefits

3.2.3 For major investment proposals the Better Business Case approach using the 5-case model should be followed. Programmes should be developed and cost justified using Strategic Outline Programme (SOP) business cases. Major, novel or contentious projects should be developed and cost justified through three key iterations of the Business Case where formal approval to proceed is required; Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC).

3.2.4 A Strategic Outline Business Case (SOC) must be formally adopted as the initial stage of the business case process. The procurement process

must not commence without prior approval of the Welsh Government. The SOC shall include the elements required within the strategic context stage together with elements of the Outline Business Case (OBC) as detailed in the relevant Welsh Health Circular.

3.2.5 The business case process must follow the latest NHS Capital Programme guidance from agreement of the SOC to OBC and Full Business Case (FBC) stages. Project organisation and management, commissioning and evaluation will also be expected to follow guidance outlined within the NHS Wales Infrastructure Investment Guidance and any relevant Welsh Health Circulars.

3.2.6 The Director of Finance shall take the lead on business case processes. The lead can be delegated by the Director of Finance to another Executive Director in the preparation of individual business cases.

3.2.7 Any internal Health Board approvals will be processed subject to the Financial Limits set out in the 'Capital Schemes funded by Welsh Government' section of the Scheme of Delegation.

3.2.8 Detailed monitoring on progress and financial implications on major schemes, for the capital programme as a whole, will be carried out by ECMG.

3.2.9 The financial state of each major capital scheme must be reported to the Welsh Government on a monthly basis as part of the monitoring returns. This will also include a comment on any particular issues around major schemes. The Director of Finance shall be responsible for submitting the return.

3.2.10 The Business Justification Case (BJC) provides the University Health Board with a simpler, truncated approach for smaller and less complex investments. The shorter approach retains compliance with the major requirements of good corporate governance and details strategic context, case for change, option appraisal, procurement route, affordability and management. The BJC should be adopted as the standard approach for most schemes under £4million for which firm prices are available.

3.2.11 Before embarking on the preparation of the business case, NHS organisations are required to agree the nature, type and content of each business case with the WG via a scoping document.

3.3 Other Earmarked Schemes

3.3.1 These will be schemes driven centrally by the Welsh Government in response to particular initiatives.

3.3.2 The Welsh Government will determine the rules in respect of bidding or applying for funds and the processes to follow thereafter.

3.3.3 Any application for such funds must be approved by ECMG or, if time restrictions do not allow, by the Director of Finance in accordance with the process for agreeing Statements of Need.

3.3.4 Any additional monitoring processes determined by the Welsh Government must be complied with, as well as the normal monitoring processes in place for the Capital Programme. Progress will be reported to ECMG.

4 DISCRETIONARY CAPITAL PROGRAMME

4.1 Identification of Requirements

4.1.1 To comply with WG monitoring returns guidelines the discretionary capital programme shall be split into the following categories:

- Statutory Compliance (works schemes)
- Equipment Replacement
- Estates Requirements/Backlog Maintenance
- IM&T Equipment
- New Equipment/Service Redesign Schemes
- Other

4.1.2 Directorates will be requested to prioritise their requirements for new and replacement equipment as part of their Integrated Medium Term Plans (IMTP), having due regard to agreed service developments (linked to operational and strategic objectives) and asset register respectively. Bids will need to be risk assessed using the standard UHB template prior to submission. Directorate Managers will be required to submit a Statement of Need to support the bids which will also need comments from the Head of Clinical Engineering (EBME), Procurement, and if relevant IC&T, Estates and Radiology.

4.1.3 Proposals to replace existing equipment must identify the equipment being replaced by noting the Asset ID and the Net Book Value of the item as detailed in the asset register.

4.1.4 The Senior Finance Officer (Capital) will check the Net Book Value of assets identified by Directorates for replacement. Assets which are shown as not having reached the end of their designated life, and therefore having a positive Net Book Value, will **not** be replaced without an explanation as to the circumstances and an assessment that the need to replace is unavoidable.

4.1.5 Schemes shall not be aggregated and shall be specific to an area of work or contract to be let.

4.1.6 ECMG may require a Business Justification Case prior to approving any particular works scheme or equipment purchase in addition to a statement of need. Other work may also be requested to support any requirement (e.g. equipment replacement strategy). All equipment replacement schemes will need to have been reviewed and commented on by the Head of Clinical Engineering (EBME).

4.2 Statement of Need

4.2.1 A Statement of Need (SON) must be completed **prior** to the approval of any works scheme or equipment purchase as part of the Capital Programme.

4.2.2 The SON shall outline the requirements and state the benefits and impact of the investment upon the University Health Board.

4.2.3 The statement will need to include the following:

- Brief description of the proposal
- Brief outline of the benefits/consequences/risks to patients, staff & the University Health Board, linking to strategic and operational plans including the Directorate IMTP where appropriate
- An estimate of capital costs (including VAT) over each financial year should be sufficiently accurate and appropriately supported
- Details of ongoing revenue costs, and how they are to be funded
- Details of the procurement process (tendering, lead times etc). There should be sufficient information for Procurement to complete tender specifications
- Appropriate advice will need to be sought from other Departments to ensure the SON is completed fully and accurately. These will include, but not be limited to, individuals from Finance, Procurement, Estates, EBME, IC&T and Radiology
- If there are significant levels of estates work required then the Capital Planning department will also need to be consulted
- If medical equipment is required then the Clinical Engineering Department must be contacted.
- Confirmation as to whether advice has been sought from the relevant individuals/departments must be stated on the SON
- In general any equipment that is being replaced must be fully depreciated and beyond economical repair
- Clear identification of the staff leading the bid/scheme is required with the submission
- Bids will need to be risk assessed using the standard UHB template prior to submission
- If the SON is not appropriately completed or does not have adequate supporting documentation, then it may be returned to be reworked.

The SON form for equipment is shown in **Appendix 1** and the equivalent form for works schemes is shown in **Appendix 2**.

4.2.4 The Directorate Manager shall be responsible for the completion of a SON for any capital equipment or capital works scheme requested by them.

4.2.5 The Capital Management Group may request an option appraisal for the leasing of equipment as an alternative to purchase, prior to approval of a scheme/proposal. The Procurement Services team will assist with this process.

4.3 Business Justification Cases (BJC)

4.3.1 The Executive Capital Management Group may request that a BJC, be submitted before approval is granted. A BJC should follow the prescribed WG format as shown in **Appendix 3**

4.3.2 In preparing the costs of the bid and any option appraisal, advice should be sought from the Finance Department. Similarly, there will need to be liaison with the Procurement Department on any purchasing issues, including leasing options, and the Estates Department on any building or engineering works that may be required.

4.3.3 BJCs will be submitted to the Assistant Director of Planning (Capital and Estates) to be scrutinised prior to being considered by ECMG.

4.4 Capital Programme Approval

4.4.1 Once a statement of need is completed, it should be forwarded to the Head of Capital Planning and Capital Accountant who shall check it for completeness and raise any queries with the Directorate Manager prior to submitting to the Capital Monitoring Group for review. Subject to timing it may be necessary to carry out this process via email with the members of CMG.

4.4.2 Depending on timing, urgent statements of need or variations in planned spend can be submitted by the Head of Capital directly to the Director of Finance for review, and approval if appropriate, out of committee.

4.4.3 If the SON is for the future year's programme or for the contingency programme the review by CMG will need to take place at the time of submission. If there is a significant delay between submission and final approval then CMG member will need to re-visit the review for significant changes.

4.4.4 Any approvals will be processed subject to the Financial Limits set out in the 'Capital Schemes funded by Discretionary Allocation' section of the Scheme of Delegation.

4.4.5 If the scheme or equipment purchase is approved by ECMG, the minutes will record the authorisation to proceed.

ECMG may initially over-commit the programme against the sources of funds available in order to provide flexibility for proper cash management. The level of over-commitment will be based on advice given by the Director of Finance. However the Final Capital Resource Limit (CRL) for the year cannot be breached.

4.4.6 Each approved SON or BJC will form part of the initial planned discretionary capital programme for the year.

4.4.7 Once approved the Senior Finance Officer (Capital) shall contact the appropriate Directorate Manager, copied as appropriate to the Head of Capital and procurement, to confirm the job number(s) allocated for each of their schemes.

4.4.8 Equipment or Works Schemes identified during the year shall follow the same process as that for the original programme.

4.5 Procurement Process

4.5.1 Procurement of capital items must follow the competitive tendering processes within the University Health Board's Standing Financial Instructions and Financial Control Procedure on Requisitioning of Goods & Services. Advertisements must be placed in the Official Journal of the European Community (OJEC) for any proposed purchases or contracts exceeding the threshold in existence at that time. All capital tenders will be completed by electronic tendering.

4.5.2 Construction Projects over £10million in value will be procured via a National framework. Construction Projects over £4million but below £10m in value will be procured via a Regional Framework.

4.5.3 The Directorates shall be responsible for raising requisitions. Authorisation of all capital requisitions must be in accordance with the financial limits and ordering of goods and services policy.

4.5.4 The job number allocated to each scheme must be quoted on all requisitions.

4.5.5 The Head of Procurement shall only process capital requisitions that have been authorised by the Executive Capital Management Group. Any requisitions that have not been authorised will be rejected and returned to the originator.

4.6 Adjustments to the Capital Programme

4.6.1 It may be necessary during the financial year to adjust the approved allocation for capital schemes either as a result of savings or increased spends.

4.6.2 Adjustments to planned expenditure (both increases and decreases) must be reported to the Executive Capital Management Group for

approval. If a group meeting is not imminent, the Director of Finance shall be informed in writing as soon as there is an indication that a scheme's outturn expenditure may require adjusting.

4.6.3 The 'netting off' of schemes within a category or Directorate/Division is **not** permitted. However, if there are other schemes that will be completed under the approved amount, these should also be highlighted to the Group when seeking the additional approval.

5 Scheme of Delegation

Approvals will be processed subject to the Financial Limits set out in the 'Capital Orders and Payment Authorisation' section of the Scheme of Delegation.

5.1 Discretionary Schemes

5.1.1 For discretionary schemes the following is considered as an appropriate level of delegation:

- Assistant Director of Planning (Planning and Estates)
  - Approval of single variations up to £5k
  - Approval to be reported to ECMG
- Director of Finance
  - Approval of single variations up to £20k
  - Approval to be reported to ECMG
- ECMG
  - Approval of single variations over £20k
  - Approval to be reported to the Finance, Performance and Workforce Committee.

5.2 Capital Schemes Funded by Welsh Government (within approved sum)

5.2.1 For capital schemes the following is considered as an appropriate level of delegation.

- External Project Manager
  - Approval of single variations up to £5k with discussion and agreement with the Head of Capital.
  - Groups of variation should be managed within a monthly limit of delegate's authority, which shall be a maximum of £20k.

- Monthly financial reports shall be provided to the Head of Capital identifying the Project Managers' Instructions (PMIs) and the change to the quantified Risk account.

- Head of Capital
  - Approval of single variations up to a maximum of £20k, following discussion with the Assistant Director of Planning (Capital and Estates).

- Assistant Director of Planning/Programme Director (Capital and Estates)
  - Approval of Single variation up to a maximum of £50k.
  - The Programme Director to have delegated authority to approve variations of an urgent nature and seek approval retrospectively from the appropriate hierarchy.

- Director of Finance
  - Approval of single variation up to a maximum of £100k.
  - Approval to be reported to ECMG.

- ECMG
  - Approval of single variations over £100k.
  - Director of Finance to be one of the approvers.
  - Approval to be reported to the Finance, Performance and Workforce Committee.

5.2.2 The FCP in relation to electronic authorisation of orders is not affected by the above.

5.2.3 In the course of many schemes, variations to the scheme will be requested by a variety of users (e.g. nursing staff, medical staff, and statutory compliance personnel). It is proposed that, where these variations can be funded by the contingency risk pot, then the person authorised to approve that level of expenditure should seek advice from an appropriate level of management, relevant to the specific variation being requested.

• Changes up to £5k	Head of Department or equivalent
• Changes up to £25k	Directorate Manager or equivalent
• Changes up to £100k	Assistant/Deputy Director
• Changes up to £250k	Executive Director
• Changes up to £500k	Director of Finance
• Changes over £500k	Chief Executive
• Between £500k and £1m	Board
• Over £1m	Welsh Government

Users will be required to complete a risk assessment form, outlining the consequences of not approving the proposed change / variation.

6 LEASES

An entity is required to determine whether an arrangement is, or contains, a lease. A lease is an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time.

6.1 IFRS 16

~~A lease is present when the fulfilment of the arrangement depends on a specific asset and it conveys the right to use the asset.~~

~~6.1.1~~

IFRS 16 applies to NHS Wales bodies from 1 April 2022 (replacing IAS 17) and introduces a singular lessee accounting approach to the measurement and classification of leases, as well as a modified classification approach for lessors. ~~There are two classifications for leases namely Finance Leases and Operating Leases. Finance Leases should be treated as capital expenditure, whereas operating leases are treated as revenue expenditure and excluded from the Capital Monitoring procedures.~~

~~6.1.1~~

~~6.1 International Financial Reporting Standards~~

Commented [OJ(U-F1]: This section will require updating. I don't think we want 6.2 as a separate section, as the majority of leases will be deamed right of use asset, and no split between finance and operational lease. Maybe include the flowchart in the appendix?

~~6.1.1 IFRS 16 Leases was issued in January 2016 and is effective for annual reporting periods starting on or after 1 January 2019. It replaces IAS 17 Leases and related Interpretations.~~

~~6.1.2 NHS bodies will adopt IFRS 16 from April 2020.~~

~~6.1.3 IFRS 16 changes the accounting substantially for lessees. The new Standard eliminates a lessee's classification of leases as either operating leases or finance leases. Instead, almost all leases are 'capitalised' by recognising a lease liability and right-of-use asset on the balance sheet.~~

6.1.2 The new Standard eliminates a lessee's classification of leases as either operating leases or finance leases. Instead, almost all leases are 'capitalised' by recognising a lease liability and right-of-use asset on the balance sheet

6.1.3 There are two notable exemptions included in the standard which are for low value leases and short terms leases

6.1.4 A short-term lease is any lease that has a lease term of 12 months or less. In such instances the lessee shall recognise lease payments as an expense on a straight line or other systematic basis.

6.1.5 For WG group bodies it has been mandated to adopt a low value lease exemption threshold of £5,000 and exercise the recognition exemption for leases in which the underlying asset is determined to be of a low value

~~6.1.4 There is little change for lessors.~~

~~6.1.5 IFRS 16 introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value.~~

6.1.6 For all other leases ~~A lessee is~~there is a requirement to ~~required to~~ recognise a right-of-use asset representing its right to use the underlying leased asset and a lease liability representing its obligation to make lease payments.

6.1.7 ~~6.1.7~~ As a consequence, ~~a lessee recognises~~there will be depreciation of the right-of-use asset and interest on the lease liability.

6.1.8 The Capital Finance team shall ensure that an accurate record of all leases captured under IFRS 16 is maintained in the ProLease system and that appropriate funding is requested from Welsh Government.

~~**6.2 Finance Leases**~~

~~6.2.2 All finance leases must be treated as capital expenditure and therefore follow the same procedures as if the item had been purchased.~~

~~6.2.3 The Scheme of Delegation states that when entering lease arrangements:~~

- ~~Amounts of up to £25k can be approved by the Head of Finance (Capital).~~
- ~~Amounts of over £25k can be approved by the Director of Finance.~~

~~6.2.4 The Finance Directorate shall ensure that an accurate record of all leases is maintained.~~

6.2 ~~Information Required by Finance~~Process for Entering Into a New Lease/Lease Renewal

6.2.1 The process required for entering into a new lease or a lease renewal will not change significantly at this time as leases will still impact revenue budgets as normal.

6.2.2 Capital funding will however be required from Welsh Government equal to the Right of Use asset value and hence the **Capital Finance team**

will need to be notified of any new leases or lease renewals before they are entered into to ensure that appropriate funding can be obtained.

6.2.3 **Appendix 4** includes a flow chart to assess if a lease is likely to need Capital funding and the lease notification form that needs to be submitted to the Capital Finance Manager.

6.2.4 The Capital Finance Manager will submit quarterly returns to Welsh Government to request capital funding for leases starting in the financial year. Estimates of future year requirements are also requested. The level of information required is dependent on the value of the lease as well as if it is a renewal or a new lease. Further information will therefore be requested as required for the funding return.

7

~~6.3.1 The Directorate Manager shall be responsible for the collation of the following, with comments from the Head of Clinical Engineering (EBME) for medical equipment and advice where appropriate from the Head of Procurement:~~

- ~~Fair Value of the Equipment~~
- ~~Initial Deposit (if Applicable)~~
- ~~Annual Lease Charges~~
- ~~Primary Lease Term~~
- ~~Secondary Lease Term~~
- ~~Termination Payment (if applicable)~~
- ~~Estimated Residual Value (if any)~~
- ~~Maintenance Costs~~
- ~~Other Revenue Costs (e.g. Consumables)~~

~~6.3.2 The Directorate Manager and Procurement shall forward the details listed above, together with the financial details required for the purchase of the equipment to the Capital Accountant.~~

~~7~~ PROJECT BANK ACCOUNTS (PBA)

Welsh Government have instructed that from April 2020 onwards, any WG funded scheme valued at £2 million or over (net of VAT, insurance and other costs/overheads, preliminary/design stage costs) and for a duration longer than six months, will be required to set up a Project Bank Account (PBA).

7.1 PBA Governance

7.1.1 PBAs are ring-fenced bank accounts from which payments are made directly and simultaneously by a client to members of its supply chain.

7.1.2 PBAs have trust status which secures the funds in it and can only be paid to the beneficiaries ie the supply chain members named in the account.

7.1.3 The account is held in the names of the trustees; likely to be the client and lead contractor (but could also be members of the supply chain).

7.1.4 The advantage of trust status is that in the case of insolvency monies in the account due for payment to the supply chain is secure and can only be paid to them.

7.1.5 Two methods for operating a project bank account have been developed. These are the Dual Authority and the Single Authority.

7.1.6 The Single Authority approach requires that only the contractor is named on the bank mandate while the Dual Authority requires both the Client and Lead Contractor to be joint signatories.

7.1.7 Where 'compelling reasons' are identified not to apply a PBA, a decision report detailing those reasons must be completed and filed to allow for audit.

8 MONITORING OF EXPENDITURE

The approved capital programme will form the basis of the capital monitoring process.

8.1 Allocation of Job Details

8.1.1 The Senior Finance Officer (Capital) shall allocate a job number to each scheme within the capital programme upon the written confirmation that a scheme has been given approval.

8.1.2 The following details will be input into the capital monitoring system for each job:

- Brief description of scheme
- Main category heading
- Site & Department
- Total expected expenditure
- Timing of expenditure

8.2 Allocation of Expenditure to Job

8.2.1 The Financial Code used for all capital requisitions must include the job number within the analysis section of the code. This shall be the primary source of capturing expenditure against individual capital jobs.

8.2.2 The Senior Finance Officer (Capital) shall analyse all capital expenditure processed through the general ledger, and ensure that all expenditure is allocated to the correct job number. Any expenditure not allocated to a job number will be investigated and corrected.

8.2.3 The Senior Finance Officer (Capital) shall categorise the expenditure into cash payments and accruals, and input the expenditure onto the capital monitoring system on at least a monthly basis. A monthly expenditure statement shall be produced for each job, and for the programme as a whole.

8.2.4 The Senior Finance Officer (Capital) shall maintain a record of all retentions due and account for them appropriately. The record shall include the date at which the retention is likely to be paid and the likelihood of payment.

8.3 Reconciliations

8.3.1 The Senior Finance Officer (Capital) shall reconcile the expenditure statement with the General Ledger.

8.3.2 The Senior Finance Officer (Capital) shall produce working papers and schedules to identify:

- Cash spend
- Outstanding Creditors/Debtors
- Additions to Fixed Assets
- Disposal of Fixed Assets

8.3.3 The Capital Accountant shall review the reconciliations and sign and date them accordingly.

8.3.4 The Senior Finance Officer (Capital) shall reconcile the Capital Monitoring System with the Asset Register on a periodic basis.

8.4 Reporting

8.4.1 The Senior Finance Officer (Capital) shall produce a report that compares the current expenditure with the total planned expenditure for each job on a monthly basis.

8.4.2 This report will be presented to the monthly Capital Monitoring Group meeting. A summarised report will be produced for ECMG

8.4.3 ~~The Director of Finance shall report progress and spend position on the capital programme to the Management Board and WG.~~Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes.

ECMG is Chaired by the Director of Finance, the Director of Strategy and Transformation ~~and,~~ Chief Operating Officer and Director of Digital are also members. Reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. Quarterly capital reporting is taken through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects.

~~8.4.3~~ Business case over £1m will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas.

8.5 Adjustments to Jobs

8.5.1 The Senior Finance Officer (Capital) will only amend the planned spend for schemes upon receipt of approval from ECMG.

8.5.2 All adjustments will be reported to ECMG.

8.6 Brokerage

8.6.1 The Capital Programme as a whole must be managed in such a way that obviates the need to request capital monies to be brokered from one year to the next.

8.6.2 The Head of Capital shall identify any slippage in the planned expenditure for the current financial year, for both Discretionary and Major schemes, and advise the ECMG accordingly.

8.6.3 Every attempt shall be made to manage the slippage internally on Discretionary schemes, either through bringing forward schemes planned for the following year or introducing new schemes into the Programme.

8.6.4 Conversely, unexpected Discretionary capital spends may result in a request for additional funds in the current year, to be repaid the following year. Again, this shall only be considered where there is no other option available to the University Health Board (e.g. delaying other schemes etc)

8.6.5 Any over spends, under spends or virements between Major capital schemes must be reported to the WG at the earliest opportunity The Head of Capital, Estates and Facilities in the WG must be informed and Ministerial approval may be required in line with latest WG Capital Guidance..

8.6.6 Approval of any brokerage request to the WG cannot be guaranteed, and could therefore result in the loss of capital funding. It is therefore vitally important that the Capital Programme is monitored and managed in such a way that mitigates such risk.

9 TRANSFERS AND ACCOUNTING ADJUSTMENTS

9.1 Capital to Revenue Expenditure Transfers

9.1.1 Only expenditure that meets the definition of Capital Expenditure shall be included within the Capital Programme.

9.1.2 There may be instances where anticipated capital expenditure turns out to be revenue in nature when invoiced (e.g. cost is below £5,000). Such expenditure should be transferred to the relevant revenue expense account, and not be recognised within the capital programme.

9.1.3 The Director of Finance shall advise of any element within the planned spend on schemes that should be classified as revenue as early as possible to allow financial plans to be updated accordingly. The implications of these changes shall be reported to WG through normal reporting mechanisms.

9.2 Assets Acquired via Private Finance Initiative (PFI)

9.2.1 Where a capital scheme has been completed with private finance and it is determined to be within the scope of IFRIC 12 it will need to be accounted for as 'on balance sheet'. The capital asset should be recognised when it is first made available for use and in accordance with IAS 16.

9.2.2 Where there is an annual unitary payment from the NHS body to the operator, a finance lease liability is recognised for the same amount as the fair value of the asset. It is subsequently accounted for as a Finance Lease in accordance with IFRS16.

9.2.3 The Capital Accountant shall liaise closely with the Financial Accountant in order to determine the appropriate accounting entries for any PFI or Finance Lease assets.

10 EQUALITY IMPACT ASSESSMENT

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

Appendix 1

Cwm Taf Morgannwg University Health Board

Capital - Statement of Need
For New & Replacement Equipment

Directorate / Department:

Site / Location:

Brief Description of Proposal:

Before submitting a request for additional/replacement equipment, have all options for redeployment of existing equipment been investigated?

Brief Outline of:-

Is this equipment to support an existing way of working or a new development? -

If new how does this fit with the Directorates IMTP -

1. **Benefits of Equipment –**

2. **Risks of not proceeding –**

3. **Consequences (e.g. workforce/IT/financial) -**

Expected life of equipment (in years) :

Capital Cost (inc VAT): £

Revenue Costs:- (p.a) Details
Staff Costs: £
Consumables: £
Maintenance Costs: £
Is equipment internally maintained YES / NO
Other: £
Details of any training requirements that will be needed, costing and source.

How are these revenue costs to be funded:
(This form will not be processed unless full details of funding are supplied)

Details of Suppliers to be considered
Please give details of any suppliers/companies you wish to be considered as part of the quotation/tender process:

NAME
1.
2.
3.
4.

Prior to submission please contact Procurement/Clinical Engineering/IT/Radiology department/Estates and Capital Planning for advice with the following questions:-

PLEASE DELETE AS APPROPRIATE

OJEC advertisement required:	**YES / NO**	Tender / Quotation action required:	**YES / NO**
Single Tender Action Required:	**YES / NO**	Clinical Engineering agreement and PPQ Pass	**YES / NO**
Are there any IT requirements/implications	**YES / NO**	If YES have IC&T been involved?	**YES / NO**
Has advice been sought from Radiology	**YES / NO**	Has advice been sought from Infection Control Team	**YES / NO**

What is the Risk Rating

Existing Equipment Details:

Finance Asset No :	Make:
Year Acquired:	Model:
Location :	EBME No:

Name and contact details of person Leading the scheme:

Authorisation
Directorate Manager: **Date:**

Appendix 2

Cwm Taf Morgannwg University Health Board

Capital - Statement of Need (SON)
For Works

Directorate / Department:

Site / Location:

Brief Description of Proposal:

Brief Outline of:-

Are these works to support an existing way of working or a new development? -

If new how does this fit with the Directorates IMTP -

Benefits of works –

Current risk assessment –
(*Score current situation using CTUHB Matrix*)

Basis for risk rating (*narrative of risks)* **-**

Consequences (e.g. workforce/IT/financial) –

Capital Cost (inc VAT): £

Basis of Capital Cost –
(*company quote, capital/estates advice etc)*

Revenue Costs:- (p.a) Details

Staff Costs: £
Furniture and Fittings: £
Maintenance Costs: £
Energy/Utilities/Rates: £
Other: £

How are these revenue costs to be funded:
(This form will not be processed unless full details of funding are supplied)

If this scheme includes equipment replacement please provide details here including existing serial numbers etc –

Prior to submission advice must be sought from Estates, Capital Planning, IT and Procurement.

PLEASE DELETE AS APPROPRIATE

OJEC advertisement required:	**YES / NO**	Quotation / Tender action required: see guide attached	**YES / NO**
Single Tender Action Required:	**YES / NO**	Advice sought from Infection Control Team	**YES / NO**
Are there any IT/image/data storage requirements/implications	**YES / NO**	If YES have IC&T been involved?	**YES / NO**
Has advice been sought from Estates	**YES / NO**	Has advice been sought from Capital Planning	**YES / NO**

Project Start and Finish dates (indicative if not known) -

Cashflows:

Financial year	Amount	Additional Details
Year 1		
Year 2		
Year 3		

Name and contact details of person Leading the scheme:

Name: **Tel:**

Authorisation
Directorate Manager: **Date:**

CONTENTS **Appendix 3**

1. PURPOSE

State clearly what the Business Justification is in support of: typically - "*This is to seek approval of ... for £ …….. on …… in support of ……*

2. STRATEGIC CONTEXT

Please provide an overview of the context in which the investment will be made. In other words, the strategy, work programme, service, project or operation, which the investment supports.

3. CASE FOR CHANGE

i. Business Needs

Please provide the compelling reasons for investment in the required services or assets, with reference to:

a. the investment objects for the procurement; and,
b. the problems with the status quo

ii. Benefits

Please provide a summary of the MAIN benefits associated with the investment, distinguishing between qualitative and quantitative; cash releasing and non-cash releasing; direct and indirect to the NHS organization, as appropriate.

iii Risks

Please provide a summary of the MAIN risks associated with the investment, distinguishing between business and service risks during the design, build and operational phases of the project, as appropriate.

4. AVAILABLE OPTIONS

Please provide a description of main options (or choices) for investment, together with their relative advantages and disadvantages (SWOT analysis).

Please bear in mind:

a. that a minimum of **FOUR OPTIONS** should be included, including the "do minimum" or "do nothing" (unless there are compelling reasons to the contrary);
b. that these options may differ in potential business scope, service solution, service delivery, implementation and funding, depending on the nature of the investment; and,
c. that the investment appraisal for each option should be contained at Annex 1 and prepared in accordance with the tools and techniques set out in the Capital Investment Manual and Treasury Green Book.

5. PREFERRED OPTION

On the basis of the above, please:

i. state why the recommended option optimizes *Value for Money* (VFM); and,

ii. Describe the services and/or assets required.

6. PROCUREMENT ROUTE

Please state how the asset or service will be procured in accordance with EC/GATT rules and regulations.

This may involve the use of an existing contract; a call-off contract or framework agreement; or the requirement for a new procurement under the EC Services or Supply Directives.

7. FUNDING & AFFORDABILITY

Please indicate:

i. the capital and revenue costs of the proposed investment;

ii. how the investment will be funded; and

iii. Indicate any affordability gap (as appropriate).

8. MANAGEMENT ARRANGEMENTS

Please indicate how the investment will be delivered successfully with particular reference to:

i. project management arrangement

ii. business assurance arrangements (if applicable);

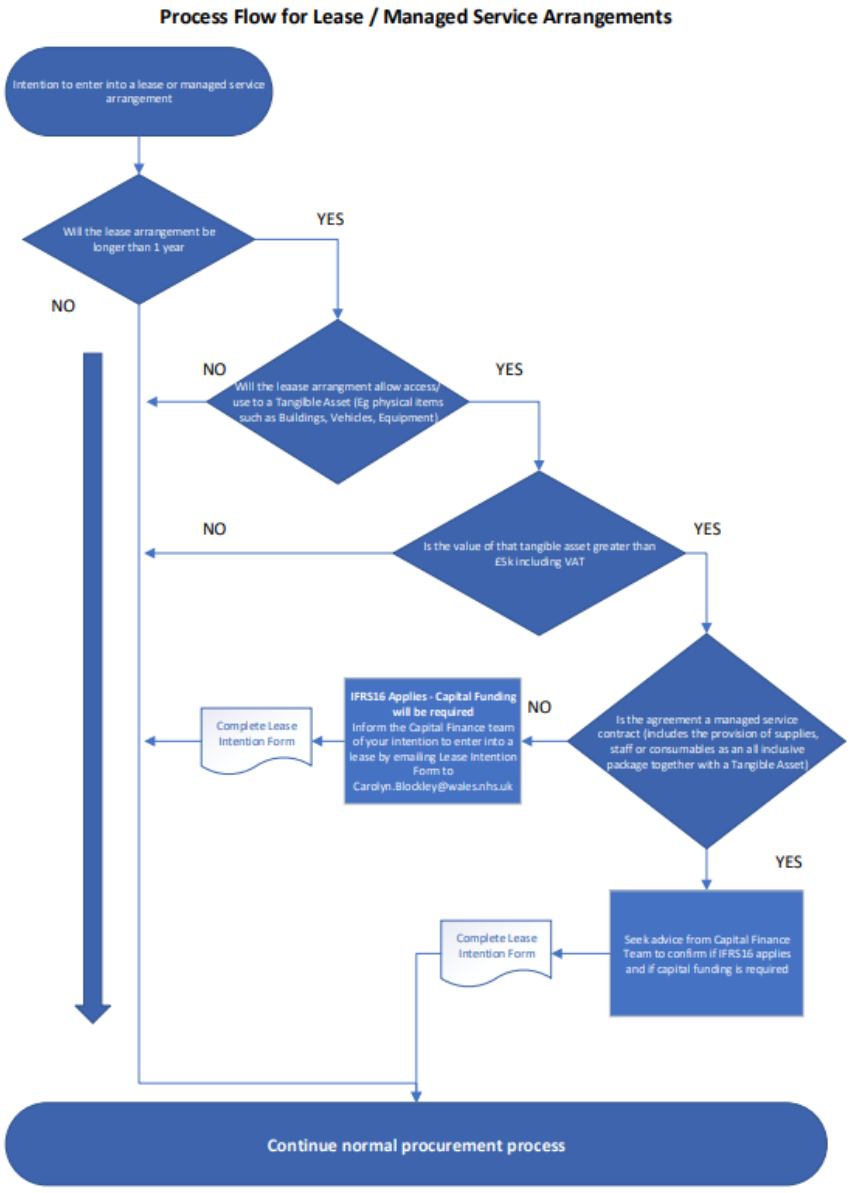
iii. benefits realization monitoring

iv. risk management;

v. post project evaluation (if applicable)

vi. contingency plans (if applicable)

Appendix 4


Process Flow for Lease / Managed Service Arrangements
Intention to enter into a lease or managed service arrangement
Will the lease arrangement be longer than 1 year
YES
NO
Will the leaase arrangment allow access/ use to a Tangible Asset (Eg physical items such as Buildings, Vehicles, Equipment)
NO
YES
Is the value of that tangible asset greater than £5k including VAT
NO
YES
Is the agreement a managed service contract (includes the provision of supplies, staff or consumables as an all inclusive package together with a Tangible Asset)
NO
IFRS16 Applies - Capital Funding will be required
Inform the Capital Finance team of your intention to enter into a lease by emailing Lease Intention Form to Carolyn.Blockley@wales.nhs.uk
Complete Lease Intention Form
YES
Seek advice from Capital Finance Team to confirm if IFRS16 applies and if capital funding is required
Complete Lease Intention Form
Continue normal procurement process

Lease Intention Form

Requester name	
Requester email address	
Department	
Lease Cost Centre (Revenue costs associated with the lease will still be charged here)	
Lease Subjective	
Lease description (including details of tangible assets(s) linked to the lease)	
Length of Lease (months)	
Value of Monthly lease payments excluding VAT	
Will VAT be added to the lease payments	Yes/No

AGENDA ITEM
4.3

AUDIT & RISK COMMITTEE

LOSSES AND SPECIAL PAYMENTS 01.01.23 TO 31.03.23

Date of meeting	21/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Daxa Varsani – Financial Accountant
Presented by	Sally May - Executive Director of Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance
Report purpose	FOR NOTING

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

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

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

1. SITUATION/BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2 The number of claims, both Medical Negligence and Personal Injury, continue 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 March 2023

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

Table 1

	31.03.23	31.12.22	31.03.22	31.03.21	31.03.20
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs (Note 1)	72,198	59,617	65,127	86,029	85,516
Redress Medical Negligence claims/costs	385	575	235	269	382
Personal Injury claims/costs	701	859	611	436	680
Recoverable from Welsh Risk Pool (Note 1)	(83,623)	(73,232)	(93,074)	(114,863)	(115,161)
Net claim provision	**(10,339)**	**(12,181)**	**(27,101)**	**(28,129)**	**(28,583)**
Permanent Injury Benefit (Note 2)	4,077	5,951	6,201	6,320	6,252
Net Provision	**(6,262)**	**(6,230)**	**(20,900)**	**(21,809)**	**(22,331)**
Number of live cases on losses system (LaSPaR)					
	31.03.23	**31.12.22**	**31.03.22**	**31.03.21**	**31.03.20**
Medical Negligence claims	334	339	299	309	279
Redress Medical Negligence claims	230	247	213	168	202
GP Indemnity claims	18	13	7	0	0
Personal Injury claims	129	130	113	110	113

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

Note 1: The increase in Medical Negligence cost is predominately attributed to one infant case, where it has been estimated a payment of damages of £10.6m, which is also reflected in the increase in recoverable amount from WRP.

Note 2: The HM Treasury announced the new discount rate of 1.7% applicable to the financial year 22/23 in December 2022. This replaced the previous discount rate of -1.3%. The overall increase in discount rate of 3% resulted in the reduction in the Permanent Injury Benefit provision for future payments.

The discount rate is the interest rate used to convert future cash flows into an equivalent one-off upfront sum or present value. The higher the discount rate, the lower the present value of a given future amount/provision for payments.

b) Expenditure incurred for the year to 31 March 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 (13.02.2023).

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
	31.03.23	**31.12.22**	**31.03.22**	**31.03.21**	**31.03.20**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	17,386	(282)	1,945	13,110	18,455
Redress Medical Negligence claims/costs	711	645	170	305	367
GP Indemnity	6	3	1	0	0
Personal Injury claims/costs	822	763	772	316	557
Recoverable from Welsh Risk Pool	(16,858)	190	(1,210)	(12,449)	(18,225)
Net claim expenditure (Note 3)	**2,067**	**1,319**	**1,678**	**1,282**	**1,154**
Permanent Injury Benefit	(1,707)	(42)	286	470	2,075
Other	1,427	1,232	570	609	407
Total Net expenditure	**1,787**	**2,509**	**2,534**	**2,361**	**3,636**

Note 3: The annual budget for net claim expenditure for 2022-23 was £1,785k, there is therefore an overspend of £283k.

c) Cash Write-Offs made for the period 1 January 2023 to the 31 March 2023

Table 3 shows the cash impact to 31 March 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 2 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 22/23

	01.01.23 - 31.03.23 £000	Previously Reported £000	Total 2022-23 £000
Medical Negligence (Appendix 1)			
Claims	2,621	2,694	5,315
Costs	2,302	2,180	4,482
Defence Fees	166	353	519
Medical Negligence Totals	5,089	5,227	10,316
Redress Medical Negligence (Appendix 2)			
Claims	235	205	440
Costs	10	40	50
Defence Fees	12	61	73
Redress Medical Negligence Totals	257	306	563
GP Indemnity (Appendix 3)			
Defence Fees	2	3	5
GP Indemnity Totals	2	3	5
Personal Injury (Appendix 4)			
Claims	18	134	152
Costs	128	256	384
Defence Fees	71	125	196
Personal Injury Totals	217	515	732
Permanent Injury Benefit (Appendix 5)	209	206	415
Permanent Injury Benefit Totals	209	206	415
Other (Appendix 6)			
Ex-Gratia	16	77	93
Debt Write Off	0	4	4
Loss of Cash	25	861	886
Ombudsman	0	5	5
Employment Matter	154	285	439
Other Totals	195	1,232	1,427
Total	5,969	7,489	13,458
Recovered from Welsh Risk Pool	(6,657)	(19,650)	(26,307)
Net Cash Write-Off	(688)	(12,161)	(12,849)

WRP Risk Sharing Agreement

2.4 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.

2.5 An overspend of £25.3m was shared between the Health Boards and CTM share was £3.3m.

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.

Welsh Risk Pool charge on late submission of reimbursement claims

2.1 As reported previously to the Audit & Risk Committee, the Health Board continues to work closely with the colleagues from WRP in resolving the matter relating to the timely submission of the Case Management Reports (CMRs) and Learning from Event Reports (LFERs) for the reimbursement of outstanding monies from WRP.

2.2 Following the review of procedures for the management of claims, redress cases and coronial investigations by WRP, an improvement plan was jointly developed by CTM and WRP. Good progress has been made in achieving actions detailed within the plan. However, there are still challenges in respect of timely submission of LFERs. This has been recognised and changes are being made with the responsibility for the facilitation of LFERs being realigned as part of the proposed changes to the new operating model in respect of quality, safety and governance.

2.3 Reports on due dates for CMRs are regularly undertaken and audited monthly to ensure all CMR are on target for submission when due. This process has enabled more effective tracking and monitoring of CMRs, with all CMRs continuing to be submitted on time. This will be further improved by implementation of dashboards on the datix system.

2.4 Work continues on the effective production and submission of LFERs, which will be supported when the new operating model for quality, safety and governance is implemented.

Actions taken are as follows:

- LFER How to Guide developed and shared widely
- LFER SOP developed
- Weekly reports run and disseminated on LFER status
- Spreadsheet compiled for the red/amber deferred cases which are problematic to track on Datix Cymru
- Ad hoc meetings with service areas in respect of LFERs status and barriers to providing evidence.
- Escalation of any barriers to relevant Executives
- LFER status captured and reported at weekly Executive Patient Safety meeting
- AMD engagement to assist with the LFER process
- Reconciliation of WRP data and CTM Datix Cymru data.

2.5 Submissions are reviewed by WRP and either deferred or approved at panel and final approval for reimbursement give at WRP Committee. The following has been achieved:

WRP Committees:	£000
July 22	£5,208
September 22	£2,902
November 22	£4,337
January 23	£5,867
March 23	£811
May 23	£629*
Total	£19,753

*The May WRP reimbursement amount noted above is net of £25k penalty charge that was applied in March and an additional £17.5k charged in May. Please see additional details in section 3 below.

2.6 Training on Datix Cymru enforces the need to complete the Datix system comprehensively including, action points and uploading evidence of actions taken. This should assist with LFER completion at a later date when Redress or a Claim is triggered.

2.7 RCA training includes the importance of the completion of LFERs in a timely manner, with the financial implications highlighted to staff.

Status

2.8 Total number of triggered LFERs (in process) = 186 cases (9 triggered during May). 118 LFERs have been submitted. Of the 118, total number of deferred LFERs = 85 (11 triggered during May).

2.9 Number of deferred cases where further information is outstanding is 53.

2.10 Of the 85 Red/Amber deferred cases recorded on the system, 31 have gone over the 6 months extension deadline date and can be at risk of permanent deferral or penalty.

2.11 The Legal Services team are working closely with Heads of Quality & Safety and Care Group Directors to address these cases. A target of outstanding information to the WRP on 8 cases per month is planned going forward. This trajectory will ensure the high risk LFERS are addressed before the next Committee.

2.12 WRP have informed the Health Board that they are no longer able to submit blank LFER's as a mechanism to extend the time available to conclude the learning process.

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

3.1 In March 2023, WRP applied a £25k relating to 8 cases where deferred information had been outstanding for more than 12 months (£3,125 per case).

3.2 In May 2023, WRP notified of a further 21 cases where the LFER had been deferred for over 6 months and where there was no evidence of activity on the file. The penalty per case was set at £2,500 per case. Subsequently, information on all 21 cases was submitted to the WRP and, as a result, the number of cases subject to the £2,500 penalty was reconsidered and reduced to 7, giving a total penalty of £17.5k in May.

3.3 The total penalties imposed in March and May 2023 is £42.5k. No funding has been set aside within our Annual Financial Plan for future penalties. It is therefore important that the ongoing work on the effective production and submission of LFERs removes this risk.

3.4 The new operating model for quality, safety and governance has built learning from events reports facilitation into the patient safety team. The Patient Care & Safety directorate believe that this new operating model will support sustainable improvement to be made in this area. The Audit and Risk Committee may wish to monitor progress for assurance.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Yes If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15)
Legal implications / impact	Yes (Include further detail below)
	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Audit & Risk Committee is requested to:

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

Medical Negligence Payments 01/01/2023 - 31/03/2023							Appendix 1
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
10RYLMN0014	0	12	1 150	0	1 162	49	1 210
12RYLMN0004	0	0	26	0	26	51	77
12RYLMN0035	1 200	10	0	0	1 210	156	1 366
12RYLMN0037	100	0	0	0	100	231	331
13RYLMN0005	0	3	0	0	3	20	23
13RYLMN0096	0	0	0	-500	-500	550	50
14RYLMN0200	0	0	0	-32	-32	57	25
15RYLMN0049	25	0	0	0	25	240	265
15RYLMN0106	0	1	0	0	1	40	41
15RYLMN0130	0	0	0	-77	-77	102	25
15RYLMN0133	0	0	-3	0	-3	96	93
15RYLMN0203	0	0	0	-41	-41	66	25
16RYLMN0074	0	0	-3	0	-3	92	89
16RYLMN0098	0	0	-3	0	-3	115	112
16RYLMN0144	0	0	0	-149	-149	174	25
16RYLMN0193	0	0	0	-186	-186	211	25
16RYLMN0203	0	0	0	-87	-87	112	25
16RYLMN0205	0	0	0	-1 279	-1 279	1 304	25
17RYLMN0081	35	0	10	0	45	5	50
17RYLMN0122	87	0	0	0	87	391	478
17RYLMN0157	0	0	0	-408	-408	433	25
17RYLMN0185	0	0	0	-704	-704	729	25
18RYLMN0064	3	2	0	0	5	930	934
18RYLMN0068	0	0	-3	0	-3	285	281
18RYLMN0069	4	0	0	0	4	7	11
18RYLMN0085	15	1	0	0	16	195	211
18RYLMN0106	0	2	0	0	2	11	13
18RYLMN0109	-20	0	0	20	0	25	25
18RYLMN0114	50	1	30	0	81	9	90
19RYLMN0021	0	3	0	0	3	9	12
19RYLMN0030	15	0	-7	0	8	61	69
19RYLMN0046	0	0	-3	0	-3	60	57
19RYLMN0056	40	1	0	0	41	110	151
19RYLMN0079	0	0	0	0	0	1	1
19RYLMN0087	58	0	0	0	58	55	113
20RYLMN0009	3	2	0	0	5	106	111
20RYLMN0014	50	1	0	0	51	52	103
20RYLMN0018	0	4	0	0	4	8	13
20RYLMN0021	20	0	0	0	20	138	158
20RYLMN0023	10	1	0	0	10	32	42
20RYLMN0027	80	0	0	0	80	14	94
20RYLMN0030	0	0	0	-29	-29	54	25
20RYLMN0033	0	4	0	0	4	9	14
20RYLMN0035	0	8	-9	-2 893	-2 894	2 919	25
20RYLMN0037	0	4	800	0	804	3	807
20RYLMN0099	0	0	0	0	0	3	3
20RYLMN0112	0	1	0	0	1	4	5
20RYLMN0116	50	11	285	0	346	86	432
20RYLMN0119	6	0	0	0	6	19	25
20RYLMN0121	40	6	0	0	46	508	554
20RYLMN0125	0	1	0	0	1	4	5
20RYLMN0129	0	0	3	0	3	216	219
20RYLMN0164	0	2	0	0	2	7	9
20RYLMN0166	0	0	0	-7	-7	32	25
20RYLMN0170	0	2	0	0	2	9	10
20RYLMN0171	42	1	0	0	43	76	118
20RYLMN0200	0	0	0	-27	-27	52	25
20RYLMN0201	0	0	0	-20	-20	45	25

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
21RYLMN0010	0	6	0	0	6	3	10
21RYLMN0016	20	0	35	0	55	2	57
21RYLMN0019	0	0	0	0	0	442	442
21RYLMN0023	0	4	0	0	4	6	9
21RYLMN0024	115	0	75	0	190	37	227
21RYLMN0028	0	6	0	0	6	3	9
21RYLMN0030	0	0	0	-134	-134	159	25
21RYLMN0035	0	4	0	0	4	0	4
21RYLMN0065	0	0	0	-15	-15	40	25
21RYLMN0079	0	-2	0	0	-2	4	2
21RYLMN0080	34	0	0	0	34	41	75
21RYLMN0098	0	1	0	0	1	10	11
21RYLMN0100	24	0	0	0	24	42	66
21RYLMN0117	0	0	22	0	22	18	40
21RYLMN0119	0	2	0	0	2	17	19
21RYLMN0148	0	0	0	0	0	8	9
21RYLMN0160	0	3	0	0	3	3	6
22RYLMN0007	0	3	0	0	3	4	7
22RYLMN0012	0	0	45	0	45	3	48
22RYLMN0027	40	0	15	0	55	1	56
22RYLMN0036	55	0	0	0	55	67	122
22RYLMN0040	0	0	35	0	35	7	42
22RYLMN0057	0	2	0	0	2	2	4
22RYLMN0091	0	0	10	0	10	0	10
22RYLMN0094	13	1	0	0	13	10	23
22RYLMN0110	0	1	0	0	1	2	3
22RYLMN0111	0	3	0	0	3	2	5
22RYLMN0112	0	7	0	0	7	2	8
22RYLMN0152	0	0	0	0	0	1	1
22RYLMN0154	0	0	50	0	50	2	52
22RYLMN0168	0	4	0	0	4	11	15
22RYLMN0169	59	0	0	0	59	74	132
22RYLMN0182	0	3	0	0	3	0	3
22RYLMN0188	0	0	3	0	3	11	14
23RYLMN0034	0	2	30	0	32	2	34
23RYLMN0035	0	3	0	0	3	0	3
23RYLMN0036	0	4	0	0	4	0	4
23RYLMN0040	0	1	0	0	1	1	2
23RYLMN0044	0	2	0	0	2	0	2
23RYLMN0046	0	2	0	0	2	0	2
23RYLMN0047	0	1	0	0	1	0	1
23RYLMN0051	0	2	0	0	2	5	7
23RYLMN0061	0	0	0	0	0	3	3
23RYLMN0063	0	1	0	0	1	0	1
23RYLMN0066	0	0	0	0	0	0	0
23RYLMN0071	30	0	28	0	58	1	59
23RYLMN0073	0	1	0	0	1	0	1
23RYLMN0075	0	0	0	0	0	2	2
23RYLMN0076	0	3	0	0	3	0	3
23RYLMN0079	0	2	0	0	2	0	2
23RYLMN0097	0	1	0	0	1	0	1
23RYLMN0098	0	1	0	0	1	0	1
23RYLMN0118	0	2	0	0	2	0	2
23RYLMN0128	0	3	0	0	3	1	3
23RYLMN0153	0	4	0	0	4	0	4
23RYLMN0201	0	2	0	0	2	0	2
Total 01/01/2023 - 31/03/2023	**2 302**	**166**	**2 621**	**- 6 568**	**- 1 480**		
Total						**12 423**	**10 943**

Redress Payments 01/01/2023 - 31/03/2023							Appendix 2
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLMN0124	0	0	23	0	23	12	35
19RYLMN0090	0	1	5	0	6	3	9
19RYLMN0109	0	0	2	0	2	6	8
19RYLMN0111	0	0	0	0	0	4	4
19RYLMN0124	0	0	0	-24	-24	26	2
20RYLMN0025	0	0	0	-6	-6	7	2
20RYLMN0065	0	0	15	0	15	10	25
20RYLMN0079	2	0	2	0	4	0	4
20RYLMN0082	0	0	0	0	0	4	4
20RYLMN0146	0	0	0	-4	-4	5	2
20RYLMN0155	0	0	0	-4	-4	6	2
20RYLMN0160	0	0	0	-3	-3	4	2
20RYLMN0187	0	0	8	0	8	4	11
20RYLMN0191	0	0	-1	0	-1	11	10
21RYLMN0069	0	0	3	0	3	2	5
21RYLMN0137	0	0	0	-2	-2	2	0
22RYLMN0018	0	0	1	0	1	0	1
22RYLMN0020	0	0	0	-5	-5	5	0
22RYLMN0024	7	0	0	0	7	0	7
22RYLMN0025	2	0	13	0	14	0	14
22RYLMN0026	0	1	0	0	1	4	5
22RYLMN0085	0	3	0	0	3	0	3
22RYLMN0107	0	0	17	0	17	6	23
22RYLMN0118	0	0	0	0	0	27	27
22RYLMN0119	0	0	0	0	0	2	2
22RYLMN0125	0	0	23	0	23	0	23
22RYLMN0134	0	0	0	-11	-11	11	0
22RYLMN0135	0	0	0	-1	-1	1	0
22RYLMN0137	0	0	5	0	5	0	5
22RYLMN0146	0	0	0	0	0	0	0
22RYLMN0184	0	0	16	0	16	3	19
22RYLMN0186	0	2	0	0	2	0	2
23RYLMN0002	0	0	11	0	11	0	11
23RYLMN0003	0	0	25	0	25	0	25
23RYLMN0020	0	0	1	0	1	0	1
23RYLMN0026	0	0	12	0	12	2	14
23RYLMN0028	0	5	6	0	11	0	11
23RYLMN0058	0	0	8	0	8	0	8
23RYLMN0059	0	0	1	0	1	0	1
23RYLMN0060	0	0	0	-4	-4	4	0
23RYLMN0090	0	0	11	0	11	0	11
23RYLMN0106	0	0	2	0	2	0	2
23RYLMN0108	0	0	22	0	22	0	22
23RYLMN0114	0	0	4	0	4	0	4
23RYLMN0115	0	0	3	0	3	0	3
23RYLMN0132	0	-0	0	0	-0	0	0
23RYLMN0145	0	0	0	-5	-5	5	0

23RYLMN0167	0	0	2	0	2	0	2
Total 01/01/2023 - 31/03/2023	**10**	**12**	**235**	**-67**	**190**		
Total						**176**	**366**

GP Indemnity Payments 01/01/2023 - 31/03/2023							Appendix 3
Case Reference	**Costs £000**	**Defence Fee £000**	**Claims £000**	**WRP reimbursement £000**	**Total £000**	**Previous Write Offs £000**	**Cumulative £000**
21RYLMN0055		2		-2	0	0	0
Total 01/01/2023 - 31/03/2023	**0**	**2**	**0**	**-2**	**0**		
Total						**0**	**0**

Personal Injury Payments 01/01/2023 - 31/03/2023							Appendix 4
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
16RYLPI0004	0	0	0	-20	-20	45	25
18RYLPI0010	0	5	0	0	5	44	49
18RYLPI0020	58	18	0	0	76	69	145
18RYLPI0031	0	4	0	0	4	21	25
18RYLPI0042	0	-5	0	0	-5	5	0
19RYLPI0017	0	6	0	0	6	5	11
19RYLPI0030	0	0	9	0	9	2	10
20RYLPI0021	0	2	0	0	2	6	8
20RYLPI0050	2	0	0	0	2	7	9
20RYLPI0052	0	1	0	0	1	0	1
20RYLPI0060	0	1	0	0	1	0	1
20RYLPI0061	0	0	0	0	0	1	1
21RYLPI0007	0	0	4	0	4	4	8
21RYLPI0017	0	6	0	0	6	12	18
21RYLPI0019	0	2	0	0	2	0	2
21RYLPI0032	0	3	0	0	3	11	14
21RYLPI0036	1	0	2	0	3	1	5
21RYLPI0040	0	0	0	0	0	1	2
21RYLPI0042	0	3	0	0	3	92	94
21RYLPI0043	0	0	0	0	0	1	1
21RYLPI0044	0	0	0	0	0	1	1
22RYLPI0001	0	0	0	0	0	1	2
22RYLPI0003	0	2	0	0	2	4	6
22RYLPI0006	0	0	0	0	0	1	1
22RYLPI0007	0	1	0	0	1	1	2
22RYLPI0010	0	-0	0	0	-0	0	0
22RYLPI0011	0	0	0	0	0	1	1
22RYLPI0020	0	0	0	0	0	1	1
22RYLPI0022	0	1	0	0	1	1	1
22RYLPI0024	0	0	0	0	0	3	4
22RYLPI0026	0	1	0	0	1	0	1
22RYLPI0027	0	0	0	0	0	1	1
22RYLPI0028	0	1	0	0	1	1	2
22RYLPI0030	0	0	0	0	0	6	6
22RYLPI0033	0	0	0	0	0	3	4
22RYLPI0035	0	0	4	0	4	6	10
22RYLPI0036	0	0	0	0	0	1	1
22RYLPI0037	0	0	0	0	0	1	1
22RYLPI0038	0	0	0	0	0	1	1
22RYLPI0039	0	0	0	0	0	0	1
22RYLPI0041	0	1	0	0	1	2	2
22RYLPI0043	0	0	0	0	0	1	1
22RYLPI0044	0	1	0	0	1	1	2
23RYLPI0001	1	1	0	0	2	0	2
23RYLPI0002	0	0	0	0	0	1	1
23RYLPI0003	0	0	0	0	0	1	1
23RYLPI0005	1	1	0	0	1	0	2

23RYLPI0006	0	0	0	0	0	0	1
23RYLPI0007	0	0	0	0	0	1	1
23RYLPI0008	0	0	0	0	0	1	1
23RYLPI0009	0	0	0	0	0	0	0
23RYLPI0010	0	0	0	0	0	1	1
23RYLPI0012	0	0	0	0	0	0	1
23RYLPI0014	0	0	0	0	0	0	1
23RYLPI0015	0	1	0	0	1	0	1
23RYLPI0016	0	0	0	0	0	0	1
23RYLPI0017	0	1	0	0	1	0	1
23RYLPI0018	0	0	0	0	0	0	0
23RYLPI0019	0	0	0	0	0	0	1
23RYLPI0020	0	1	0	0	1	0	1
23RYLPI0021	0	0	0	0	0	0	1
23RYLPI0024	0	0	0	0	0	0	1
23RYLPI0028	0	0	0	0	0	0	1
23RYLPI0029	1	1	0	0	1	0	2
23RYLPI0030	0	1	0	0	1	0	1
23RYLPI0031	0	0	0	0	0	0	1
23RYLPI0032	0	1	0	0	1	0	1
23RYLPI0033	0	0	0	0	0	0	0
23RYLPI0034	0	0	0	0	0	0	0
23RYLPI0035	0	0	0	0	0	0	0
23RYLPI0037	64	0	0	0	64	75	139
23RYLPI0038	0	0	0	0	0	0	0
23RYLPI0039	0	0	0	0	0	0	0
23RYLPI0040	0	0	0	0	0	0	0
23RYLPI0041	0	0	0	0	0	0	0
23RYLPI0042	0	0	0	0	0	0	0
23RYLPI0044	0	0	0	0	0	0	0
23RYLPI0046	0	0	0	0	0	0	0
23RYLPI0047	0	0	0	0	0	0	0
23RYLPI0049	0	0	0	0	0	0	0
Total 01/01/2023 - 31/03/2023	**128**	**71**	**18**	**-20**	**197**		
Total						**445**	**642**

Permanent Injury Benefit 01/01/2023 - 31/03/2023

Appendix 5

Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	7	238	245
02RVEPI0001	3	66	69
02RVEPI0003	5	174	179
02RVEPI0004	4	119	123
03RRSPI0020	25	851	876
03RVEPI0028	7	261	268
04RRSPI0009	7	230	238
04RRSPI0024	6	160	166
05RRSPI0020	3	79	82
05RRSPI0021	6	191	197
05RVEPI0033	10	292	302
05RVEPI0034	3	86	89
08RVEPI0009	7	189	195
10RYLPI0070	4	107	111
11RYLPI0065	11	244	254
12RYLPI0059	4	73	77
13RYLPI0020	2	38	40
13RYLPI0050	7	142	149
98RVEPI0005	0	7	7
19RYLPI0022	22	307	329
20RYLPI0032	5	37	43
20RYLPI0033	2	16	18
20RYLPI0034	4	25	29
20RYLPI0035	11	74	85
20RYLPI0036	8	51	59
20RYLPI0037	3	17	20
20RYLPI0038	6	42	48
20RYLPI0039	5	31	36
20RYLPI0040	11	78	89
20RYLPI0041	8	52	60
20RYLPI0042	4	25	29
Total 01/01/2023 - 31/03/2023	**209**		
Total		**4 300**	**4 509**

Other Payments 01/01/2023 - 31/03/2023			Appendix 6
Case Reference	**Type**	**Details**	**Amount £000**
23RYLEG0226	Ex-Gratia	Loss of Personal Effects	0,03
23RYLEG0227	Ex-Gratia	Loss of Personal Effects	0,72
23RYLEG0228	Ex-Gratia	Loss of Personal Effects	1,70
23RYLEG0246	Ex-Gratia	Loss of Personal Effects	0,04
23RYLEG0247	Ex-Gratia	Loss of Personal Effects	0,39
23RYLEG0264	Ex-Gratia	Loss of Personal Effects	0,38
23RYLEG0265	Ex-Gratia	Loss of Personal Effects	0,32
23RYLEG0263	Ex-Gratia	Damages to Personal Effects	0,13
23RYLEG0276	Ex-Gratia	Poor Service	0,25
23RYLEG0229	Ex-Gratia	Retirement Gratuity	0,10
23RYLEG0230	Ex-Gratia	Retirement Gratuity	0,20
23RYLEG0231	Ex-Gratia	Retirement Gratuity	0,20
23RYLEG0232	Ex-Gratia	Retirement Gratuity	0,21
23RYLEG0233	Ex-Gratia	Retirement Gratuity	0,25
23RYLEG0234	Ex-Gratia	Retirement Gratuity	0,28
23RYLEG0235	Ex-Gratia	Retirement Gratuity	0,28
23RYLEG0236	Ex-Gratia	Retirement Gratuity	0,29
23RYLEG0237	Ex-Gratia	Retirement Gratuity	0,29
23RYLEG0238	Ex-Gratia	Retirement Gratuity	0,32
23RYLEG0239	Ex-Gratia	Retirement Gratuity	0,33
23RYLEG0240	Ex-Gratia	Retirement Gratuity	0,35
23RYLEG0241	Ex-Gratia	Retirement Gratuity	0,36
23RYLEG0242	Ex-Gratia	Retirement Gratuity	0,37
23RYLEG0243	Ex-Gratia	Retirement Gratuity	0,46
23RYLEG0244	Ex-Gratia	Retirement Gratuity	0,47
23RYLEG0245	Ex-Gratia	Retirement Gratuity	0,29
23RYLEG0248	Ex-Gratia	Retirement Gratuity	0,39
23RYLEG0249	Ex-Gratia	Retirement Gratuity	0,34
23RYLEG0250	Ex-Gratia	Retirement Gratuity	0,42
23RYLEG0251	Ex-Gratia	Retirement Gratuity	0,21
23RYLEG0252	Ex-Gratia	Retirement Gratuity	0,29
23RYLEG0253	Ex-Gratia	Retirement Gratuity	0,39
23RYLEG0254	Ex-Gratia	Retirement Gratuity	0,32
23RYLEG0255	Ex-Gratia	Retirement Gratuity	0,35
23RYLEG0256	Ex-Gratia	Retirement Gratuity	0,26
23RYLEG0257	Ex-Gratia	Retirement Gratuity	0,22
23RYLEG0258	Ex-Gratia	Retirement Gratuity	0,25
23RYLEG0259	Ex-Gratia	Retirement Gratuity	0,37
23RYLEG0260	Ex-Gratia	Retirement Gratuity	0,41
23RYLEG0261	Ex-Gratia	Retirement Gratuity	0,35
23RYLEG0262	Ex-Gratia	Retirement Gratuity	0,29
23RYLEG0113	Ex-Gratia	Retirement Gratuity	-0,42
23RYLEG0218	Ex-Gratia	Retirement Gratuity	-0,35
23RYLEG0266	Ex-Gratia	Retirement Gratuity	0,32
23RYLEG0267	Ex-Gratia	Retirement Gratuity	0,26
23RYLEG0268	Ex-Gratia	Retirement Gratuity	0,41
23RYLEG0269	Ex-Gratia	Retirement Gratuity	0,29

23RYLEG0270	Ex-Gratia	Retirement Gratuity	0,34
23RYLEG0271	Ex-Gratia	Retirement Gratuity	0,37
23RYLEG0272	Ex-Gratia	Retirement Gratuity	0,34
23RYLEG0273	Ex-Gratia	Retirement Gratuity	0,24
23RYLEG0274	Ex-Gratia	Retirement Gratuity	0,42
23RYLEG0275	Ex-Gratia	Retirement Gratuity	0,35
23RYLEM0009	Employment Matters	Employment Matters	129,29
23RYLEM0010	Employment Matters	Employment Matters	13,00
23RYLEM0011	Employment Matters	Employment Matters	11,02
23RYLLC0002	WRP Penalty	WRP Penalty due to late submission of LFERs (relating to total of 8 cases)	25,00
23RYLMN0211	Ombudsman	Damages	0,15
Total 01/01/2023 - 31/03/2023			**194,89**

AGENDA ITEM
5.1

AUDIT & RISK COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	21st June 2023
FOI Status	Public
If closed please indicate reason	Not Applicable – Public Meeting
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Paul Mears, Chief Executive
Report purpose	FOR REVIEW & APPROVAL

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

Committee/Group/Individuals	Date	Outcome
Service, Function and Executive Formal Review	April / May 2023	RISKS REVIEWED
Operational Management Board – Phase 1 Risks Scoring 20 and above	19th April 2023	RISKS REVIEWED
Executive Leadership Group	15th May 2023	RISKS REVIEWED AND MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee	24th May 2023	ASSIGNED RISKS REVIEWED
Digital & Data Committee	12th June 2023	ASSIGNED RISKS REVIEWED
Health, Safety & Fire Sub Committee	15th June 2023	ASSIGNED RISKS REVIEWED

ACRONYMS

1. SITUATION/BACKGROUND

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

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

2.1 At the Operational Management Board meeting on the 19th April 2023, a targeted review of risks scoring 20 and above (escalated to the Organisational Risk Register) was undertaken and Care Group Director Teams were tasked with specific review actions. Improvement in terms of mitigation, moderated scoring and timeframes will hopefully be evident over the next few reporting periods.

2.2 The Care Group Highlight Reports received a the Operational Management Board will now include a specific risk update in terms of 'new, closed, de-escalated' risks for the Organisational Risk Register.

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2023. **412** members of staff trained to date. There have been targeted in person sessions with Primary Care Teams during May and June 2023.

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

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 **NEW RISKS**

Financial Stability Risks

- Datix ID 5425 – Failure to achieve financial balance in 2023-2024. Risk score of 20. This risk replaces Datix Risk ID 5153.
- Datix ID 5427 - Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023-2024. Risk score of 20. This risk replaces Datix Risk ID 5154.

Digital & Data

- Datix ID 5437 - Dual Deployment at CTM of both RISP and LINC Programmes Systems. Risk Score of 16.

3.2 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period

Digital and Data

- Datix ID 4671 - Lack of a resilient and performant Digital Network Infrastructure and Assets. Risk increased from a 15 to a 16.

b) Risks where the risk rating DECREASED during the period

Patient Care & Safety – Central Function

- Datix ID 4908 – Failure to Manage Legal cases efficiently and effectively. Risk de-escalated from a 16 to a 12 in March 2023. Further assurance was sought from Board Members and therefore further rationale has been captured to support de-escalation.

Medical Directorate – Central Function

- Datix ID 5214 – Critical Care Medical Cover. Risk score reduced from a 20 to a 12. Risk was robustly reviewed by the Medical Director this period where risks 4590 and 4798 were amalgamated.

Diagnostics, Therapies & Health Sciences

- Datix ID 4920 - Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales. Risk score reduced from a 15 to a 12.

Children and Families Care Group

- Datix ID 5014 - Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital. Risk score reduced from a 16 to a 12.

Health, Safety & Fire – Central Function

- Datix ID 4315 - Non Compliance of Fire Training – Provision. Risk score reduced from a 16 to a 12.
- Datix ID 2787 - Absence of a robust Health Surveillance Programme for employees. Risk score reduced from a 16 to a 12.

Digital & Data

- Risk ID 4887 - Retrieval and filing of case notes in the POW Medical Records Library. Risk score reduced from a 20 to a 15.

Rationale for changes captured in Appendix 1.

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

All Care Groups

- Datix ID 4253 - Ligature Points - Inpatient Services. Risk closure placed on hold in March 2023 as further assurance was required in terms of the completion or Capital and Estates actions. This has been received and is captured in Appendix 1. Risk Closed.

Medical Directorate – Central Function and Diagnostics, Therapies and Specialties

- Datix ID 4590 – Critical Care Pharmacist Resource. Risk Closed.
- Datix ID 4798 - Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and

Princess of Wales Hospital. Risk Closed.

Financial Stability Risks

- Datix ID 5153 – Failure to achieve financial balance in 2022-2023. Risk Closed.
- Datix ID 5154- Failure to reduce the planned recurrent deficit of £28.0m at the end of 2022/23. Risk Closed.

Unscheduled Care Group

- Datix ID 4512 - Care of patients with mental health needs on the acute wards. Risk Closed.

Diagnostics, Therapies and Specialties Care Group

- Datix ID 5323 - Fluoroscopy Room has become Obsolete. Risk Closed.

Rationale for closure captured in Appendix 1.

3.4 **MATTERS TO NOTE**

There are two Digital & Data risks (Datix IDs 4664 and 4671) which have been redacted due to business sensitivities. These are being received in the private session of the Committee.

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

Consequence						
	5			4253 3337 4768 4772 2987 3993 4887	4080 3826 4664 5276	
	4				4458 4148 4337 3008 4743 4906 4809 4753 4679 3131 4671 5437 4152 3585 3133 1133 4752 4922 4479 4417 5374 5254 5036	4491 4632 4071 4721 4103 4841 4827 4907 4780 4922 5267 5427 5425
	3					3638 4691 4732 5207 4699 4672 4691 2808 5040 4217
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Committee are asked to:

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

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5425 (Replacing 5153)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2023/24. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 23/24 Context: The context is that the draft financial plan for 22/23, . This planned deficit is also dependent on the delivery of efficiency savings of £27.3m which is a significant step up in savings compared to recent	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	New risk escalated to the Org Risk Register May 2023 - replacing Risk ID 5153	28.04.2023	28.04.2023	31.05.2023
5427 (Replacing 5154)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	New risk escalated to the Org Risk Register May 2023 - replacing Risk ID 5154	28.04.2023	28.04.2023	31.05.2023
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to the new system supplier will be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review the new system suppliers revised delivery plan. There has been several meetings between Health Boards, LINC Programme and Commercial Providers. At a meeting held on the 13th December it was agreed by NHS that deployment would be sequential and in the original running order. Health Board configuration meeting scheduled with Commercial supplier for 10th January 2023. Update May 2023 - Concerns around viability of proposed implementation plans have been widely discussed and escalated. The next LINC Programme Board is scheduled for the 9th May 2023 where further discussions will take place.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	5.5.2023	31.5.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Establish a Timeline for CTMUHB - the timeline will have a few elements and uses and will continue to evolve as information is archived. This Timeline does not include the Health Board Information as this requires the archiving of documents in order to populate it. Archiving Information against the Timeline is yet to commence as the current Covid-19 Information Manager resigned from the role and left the Health Board at the end of August. Recruitment for a successor to the role was unsuccessful and therefore the pace of progress in developing the Health Boards Timeline and gathering key documentation centrally is being significantly impacted which could be detrimental to the Health Board being able to efficiently and effectively respond to requests from the Inquiry. The AD for Governance & Risk is exploring other options for resourcing this role including project management support. Following a briefing meeting with Legal Counsel it was clear that the Health Boards focus should be on the timeline and documentary evidence at this stage which has heightened the risk in terms of the resource afforded to the preparedness for the inquiry. Legal Counsel advised the Health Board to pause the introduction of the All Wales Reflection document at this stage of the Inquiry. At the Covid-19 Pandemic Inquiry Working Group on the 11th October the likelihood of this risk was increased from a 4 to a 5 based on the above risk factors. Update May 2023 - The Health Board has successfully appointed to the Covid-19 Information Manager position with a planned commencement date of the 30th May 2023. The likelihood of this risk will be revisited once the new post holder has commenced and has undertaken an initial assessment of the Health Boards preparedness.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	28.4.2023	30.06.2023
4780	Executive Director for People	Central Support Function -Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training Then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to Incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tonteg is on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role.	Mitigating action is to increase the establishment within the Manual Handling Team by at least one extra Trainer, one extra Assistant and another Risk and Safety Officer. Update 3.5.2023 - Business case as part of People Services IMTP and waiting for a decision on funding, Discussions underway with Director of Nursing to look to support training due to Bank and overseas recruitment drive. Meeting to take place on the 12th May 2023.	Health Safety & Fire Sub Committee	20	C4 x L5	4 C2xL2	↔	06.08.2021	3.5.2023	30.06.2023
4827	Executive Director for People		Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses e.g. Covid, flu, etc; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	SBAR completed outlining the requirements regarding Fit Testing. 03/05/2023 - Further meeting undertaken with new Deputy Director of Nursing in relation to releasing staff from the Vaccination Team to support Fit Testing. Meeting to take place in 3 weeks to look at options for achieving this.	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	3.5.2023	30.06.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety 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.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023.Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each specialty now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	28.10.2022	30.11.2022
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update April 2023 - New Service Level Agreement signed with Tenovus Cancer Care, for a telephone call back system to provide additional support to patients. It is a service to support the patients who are waiting/improve the patient experience. There is no additional mitigation that has been added this month. Next review 31.5.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	28.04.2023	31.05.2023
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety 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	In terms of recruitment the following actions are underway over the next 6-12 months: • Meeting with Executive Director for People held on 24.11.2022 to discuss Medical Workforce (MWF) recruitment (including PAs, Specialist's) • Liaising with Care Group Medical Directors regarding their Care Group workforce planning and strategy • Once the Health Board identifies the gaps from the Medical Workforce Productivity Programme group on the establishment work stream it can then target specific areas with either Consultant, Specialist, MG cover • A report is also being prepared on British Association of Physicians of Indian Origin (BAPIO) for international recruitment. These are risks that will continue due to the National workforce availability. The Health Board will need to tackle these issues in a variety of ways – there is no one solution. The approaches include –recruitment, job planning (compliance and standardisation), establishment, new ways of working (MDT and expanding alternative roles), ADH spend and national rate cards, sickness rates, all of these impact on the workforce and are part of the programme. As the Health Board now has a planned stepwise programme it is dealing with the matter with more clarity and direction.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	09.03.2023	30.04.2023
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.	Update December 2022 - There has been a significant decrease in >104 week stage 1 waiting list subsequent to additional weekend activity. At the beginning of November 2022 we were reporting 1869 RTT cases >104 weeks, The Health Board has carried out 66 additional sessions, primarily addressing cataracts and General Ophthalmology. Scheme extended into January. Consequent to this piece of work, all stage 1 cataract conversions will be sent to C&V during February and March for assessment and procedure. C&V are providing capacity for 500 stage 4 patients, CTM currently have 228 stage 4 conversions >104 weeks and this number will increase whilst we continue with the weekend activity. Validation work is being carried out in tandem with the booking of weekend work and RTT rules. Progress has been made with the regional programme, an Option Appraisal presentation has been circulated to all HB's to include 6 delivery models for local preference ranking. All options are being explored and evaluated against a set of agreed criteria. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	23.12.2022	30.1.2023
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update May 2023 - The CTM Stroke Strategy Group has agreed an integrated action plan with a number of short, medium and long term actions, some of which have resource implications. Progress is being made in a number of areas: - SOP and patient pathway developed for stroke patients presenting at RGH - WAST agreement to advise patients on acute stroke site locations - Ring-fencing of stroke beds ongoing • Continued CTM-wide stroke consultant rota • Ongoing regional developments with C&VUHB continue. CTM consultant in post as Clinical Lead for Stroke for the South Central Wales Stroke Delivery Network. Developments underway to capture patient outcomes and experience data. • Prescribing nurse and specialist pharmacist have been identified to support the initiation of the AF and BP project in Primary Care. Work is progressing on implementation. A primary care nurse will work locally with those at risk to raise awareness of the signs and symptoms of stroke. - Radiographer approved CTAs now operating on all 3 acute sites, reducing delays in thrombectomy - Implementing CT perfusion (CTP) scanning to extend the window of thrombolysis and thrombectomy - Development of new stroke thrombolysis and thrombectomy pathway underway in response to new stroke guidelines, published in April 2023 - WHSSC commissioned thrombectomy service hours extended from 08:00-00:00 from 2nd May 2023. Awaiting confirmation of date for 24/7 service - Discussions between CTM, Stroke Association and Public Health Wales resulted in agreement to run FAST campaign in Wales from 27th April 2023 - Social media campaign funded by CTM Public Health for local FAST campaign	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	11.05.2023	11.06.2023
4664	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	**IF**: The Health Board suffers a major ransomware attack. **Then**: there could be potential data loss and subsequent loss of critical services. **Resulting in**: Catastrophic service loss to all clinical and business services adversely impacting on population health management, patient care, business continuity, health and wellbeing of staff, organisational relationships, substantial financial risk and the UHB's other routine and improvement work - culminating in a culture of mistrust of the Health Board and all things digital leading to the likelihood of the opportunities that present from digital transformation being less likely to be achieved.	This Detail is captured in the In Committee Report due to business sensitivities	This Detail is captured in the In Committee Report due to business sensitivities	Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26/05/2021	24.04.2023	26.05.2023

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4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures / Safety Fencing	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients having unrestricted and inappropriate access on the site. **Resulting In:** absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	Funding Bid for approx. £385K has been submitted by Estates Update April 2022: The Car Park Security Fencing in the Bridgend Locality is now largely complete with minor 'snagging issues' to close off. Door systems in Ty Lidiard CAMHS have been upgraded to include an alarm system on the Mag-lock doors. If the Mag-lock does not engage within a set time frame, then an alarm will sound. Multi storey Car Park at Princess of Wales Hospital has had anti-climb security fencing fitted. This was a WG Capital scheme and is awaiting final project sign-off to complete the works. The only outstanding area is the stairwell which will require more detailed technical design work to identify a solution. That work has commenced and once complete the works can be tendered. This will require further funding in 22/23 Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACMG. This work should commence in the early autumn completing within the financial year. Update October 2022 - Deputy COO Acute Services to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	1.11.2022	31.12.2022
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update September 2022 – Risk reviewed by Nurse Director for Unscheduled Care, risk to be closed owing to multiple changes to structures and reporting systems since original risk was opened. Risks to be reviewed and understood against new frame work outlined by the Six Goals Board local governance, quality and safety feedback mechanisms and unscheduled care quality and performance reporting mechanisms. Risk will be closed once the detail has been agreed and new risk superseding this current risk. Update 3.11.2022 - mitigations to improve flow and discharge at POW now being addressed through workstreams 2, 3 and 4 of the UEC 6 goals programme, with rapid focus on reducing lost bed days due to discharge delays, formal launch of D2RA model and pathways Dec 22, along with launch of e-whiteboards/discharge referral forms. Update 25/04/23 - review of this risk performed by the USC SMT improvement plans in place as part of 6 goals improvement programme however this programme is not yet in implementation stage. Targeted improvement trajectories in place for USC group relating to 4hour ambulance delays and patients waiting over 12hours within the department which will improve overcrowding. This remains an ongoing risk for all three ED's and will be reviewed regularly as implementation of targeted improvement takes place. New review date 30/07/23	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	25.04.2023	30.07.2023
4907	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	Update April 2023- New operating model in respect of quality, safety and governance almost fully implemented. Legal Services Manager now in post. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full Duty of Candour implementation.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	28.04.2023	30.06.2023
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Director of Nursing & Quality	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) **Then:** The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in:** The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends • Targeted approach to areas of specific concern reported via finance, workforce and performance committee The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Nurse Roster Policy now approved, ratified and implemented in December 2023. This includes KPIs which will allow monitoring of effective roster management. Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work- provides more rigor to roster management at ward/ department level.	NURSE ROSTERING Nursing Productivity Group actions are progressing well through this forum. Registered Nurse Off contract agency in hours and out of hours forms have been in place for two months – there has been a noticeable reduction in usage and thus spend on off contract Registered Nurses. Workforce and finance teams are working together to provide joint metrics and monitoring of agency usage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group. SAFER CARE Roll out continues on all sites. ENHANCED SUPERVISION Corporate nursing team are due to undertake focused work on areas who have a high number of HCSW agency requests to understand the demand in terms of whether HCSW's are required to support the supervision of an individual or group of patients, whether the requests are related to the increase acuity or due to high sickness/vacancy rates and/ or poor fill rate from bank HCSW requests. The risk score for this risk has been increased to 20 in January 2023 due to the fact that severe operational pressures in the clinical areas, including the opening of several different areas of unfunded beds and frequent "boarding" of additional patients on some wards mean the frequency of the likelihood which was scoring 4 ((Frequency: At least weekly) is now scored at 5 (Frequency: At least daily). This score will be reviewed in March 2023 Update 11/05/2023: The Health Board are linking into National Retention Work-stream and contributed to drafting the National Framework. In line with NHS Wales the Health Board have implemented Exit Questionnaires and supporting interviews, where appropriate. Undertaking "Coffee mornings" for spouses of CTM UHB employees to undertake an assessment of eligibility to apply for the registered nurse adaptation process. The Corporate Nursing team working with People Services on focussed aspects of recruitment and retention. The Corporate Nursing team is collaborating with the University of South Wales, in relation to International recruitment of Student Nurses to their undergraduate programmes. Undertaking Mobile Recruitment Fairs to support student streamlining. School Career Fairs – to attract younger people into the profession and also promoting the Apprenticeship Scheme.	Quality & Safety Committee	20	C4xL5	C4xL3	↔	25.10.2022 (It should be noted that although the new reframed risk opened in October 2022 the previous iterations of this risk - Datix ID 4106 and 4157 were opened on the 01.06.2015 and 01.01.2016 respectively)	11.5.2023	11.06.2023
5437	Director of Digital	Central Support Function - Digital & Data Function	Assistant director of therapies and health science	Improving Care	Core Business, Business Objectives, Environmental & Estates Impact and Projects Including systems and processes, service and business interruption	Dual deployment at CTM of both RISP and LINC Programme Systems	If: There is no change to the current implementation plans of both the RISP and LINC Programmes solutions then there will be a deployment overlap at CTM. Then: Necessary workforce deployment resource, including IT expertise, will need to be shared between deployments. Resulting In: Sharing of limited resource needed to deploy products within specified timeframe, which could result in errors or delayed implementation. Any delays to implementation threatens the ability to provide pathology and radiology services both locally and nationally.	Escalated to Executive Leadership Group. Raised at National Imaging Programme Board.	May 2023 - Raise at April LINC Programme Board. Continue to monitor as LINC Implementation plan remains in draft form to date.	Digital & Data Committee	16	C4xL4	4 (C4xL1)	New Risk Escalated May 2023	14.04.2023	14.04.2023	30.05.2023
3131	Chief Operating Officer	Diagnostics, Therapies 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.	Long Term Mortuary Capacity Plan. (5 year lease of additional capacity based at PCH has been approved by Executive leadership team in November 2022. Additional unit delivered and preparation and equipping underway to go live by the end of January.) Ongoing discussions with the Coroner have resulted in a 1 year reprieve of post mortems by CTM staff but continuing use of Mortuary space at PCH for external Medical examiners to use from January 2023. SLA being drawn up. Plan to implement electronic white boards for mortuaries in 2023-24. April 2023 - DTS Care Group have advised that they have consciously reduced the risk as the Health Board is past the winter peak where we anticipated major issues and the 5 year rental on the new unit providing an additional 85 spaces at PCH site mitigates and reduces the risk. The Health Board continues to have the Nutwell units as additional (rather than being used as daily capacity as they were prior to January 2023) should there be a surge. The Care Group are comfortable that this risk may be dynamic but consider there is strong mitigating action in place that has been well supported and recognised by the executive team. Should the situation deteriorate the Care Group will make sure they review and amend and escalate as appropriate.	Quality & Safety Committee	16	C4xL4	C3xL2	↔	05.03.2018	23.3.2023	31.5.2023

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5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Service Director - Diagnostics, Therapies and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Blood Bank Capacity Plan Due date 1.12.2022 Demand & capacity review Due Date 31.07.2023 Workforce redesign Due date 31.07.2023 Dedicated Pathology IT resource Due Date 31.7.2023 Accommodation review Due Date 31.07.2023 Novation of Equipment to the Managed Service Contract Due date 3.7.2023 Update April 2023 - Risk score reduced to 16 to reflect current position, this is dependent upon ongoing review and continued investment from the HB.we have consciously reduced the risk to 16 as we have had funding to year end to continue the outsourcing and there is a tentative commitment for a significant amount to continue the outsourcing through 2023-24 which we are comfortable that it allows us to reduce the risk on that basis. We will keep this under review and should the situation change we will update the risk register and adjust the risk assessment appropriately.	Quality & Safety Committee	16	C4 x L4	6 (C3xL2)	↔	02.03.2022	23.3.2023	31.05.2023
5254	Executive Director of Nursing.	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety 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 April 2023: New operating model in respect of quality, safety and governance almost fully implemented. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full Duty of Candour implementation. Local impact assessments across Wales are almost complete, which will form the basis for the National Impact Assessment.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	27.04.2023	30.06.2023
5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Estate/ Infrastructure	Fulfilling our environmental and social duties	**IF:** the health board's decisions fail to reflect our values or consider the long term environmental or social impact **Then:** we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles **Resulting in:** negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTM Decarbonisation Group which will have oversight and delivery of CTM's decarbonisation agenda • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases	Build environmental and social impact sections into Health Board project paperwork/cover sheets to ensure these have been considered as part of decision making processes. Timeframe: 28.06.2023 Update April 2023 - Risk reviewed no change to above mitigation and review period.	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	13.04.2023	30.06.2023
4479	Executive Director of Nursing & Midwifery	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs is place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. Update 3.5.2023 - Update 03.05.23 business case still being developed due to delays in tender returns and analysis. However scheme being subject to strategic review in light of consideration of the benefits of a regional solution	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	3.5.2023	3.7.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress. Update September 2022 - Nurse Director Review 7/9/22: Unscheduled care group to review immediate workforce resource across all three acute sites by end of October 2022. Actions to then be decided in terms of immediate measures for distribution of staff, governance lines to be agreed (nursing, AHP and Medical) and immediate plan for winter months to be agreed and acted upon. Medium term and substantive plans for workforce requirements and innovations to be worked through as part of six goals board and advanced practice board.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	12.10.2022	07.03.2023
3008	Chief Operating Officer	Children and Families Care Group	Raised by Obstetrics in PCH.	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 7. Ask other HB`s their MH requirements SBUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling.	Organisational plan for compliance training. Update April 2023 - Risk reviewed. Bespoke training module in development and ready for roll out 2023. Risk score will be adjusted once numbers trained increases.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	17.04.2023	30.06.2023

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3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	**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 April 2023: Action: Use reporting template to monitor attendance. Complete. Action: Med Device Trainer to review with another UHB what can be delivered via e-learning to support some elements of this subject. Timescale: 31/05/2023. Medical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the UHB. As of Dec 22 the current Medical Gas training details for CTMUHB are as follows: Total Staff Requiring Training - 2287, Staff Trained - 168, Compliance Percentage - 7.34%, Untrained Staff - 2119. No significant increase in compliance. Attendance still poor for this subject matter, Med Device Trainer reviewing with another UHB what can be delivered via e-learning to support some elements of this subject, such as refresher training, however attendance would be required for initial training (WG 21/02/2023). The current risk rating will remain unchanged until Medical Gas Training Compliance increases significantly. As this remains at high risk, a review will be completed in 3 months. Review Date: 31/05/2023	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	30.3.2023	31.05.2023
3585	Chief Operating Officer.	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. Update February 2023 - Commencement of capital works in ED which will include a second, disabled access patient toilet. This will be situated within the main department and will be accessible for within the clinical area.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	06.02.2023	30.04.2023
4148	Executive Director of Nursing & Midwifery	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**IF:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2023 review of this risk the control measures have been revisited and streamlined. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog. - Welsh Government have agreed to a change of use of current 22/23 funding to appoint an agency to clear the current backlog. This agency includes Best Interest Assessors and section 12 Doctors to undertake assessments. - The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised. - A further part time and full time Best Interest assessor were appointed in December 2022, their induction is now complete and they are fully integrated into the DoLS team.	The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUHB have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLs Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLs authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. Update April 2023 - The Government have announced that LPS will not be progressed during this Parliament. However, Welsh Government are committed to strengthening DoLS and continuing to raise awareness of the Mental Capacity Amendment Act 2019. Therefore, further funding is available to CTMUHB to help reduce the DoLS backlog and provide training and awareness for MCA. A proposal has been submitted to retain the additional Best Interest Assessors and Mental Capacity act Practitioners. In addition, to utilise funding to appoint an agency to clear the current backlog of DoLS, this will include the use of s12 Doctors. Should funding be approved, the backlog of DoLS will be cleared within approximately two months. It has been confirmed that this funding is recurrent, which will allow CTMUHB to sustain a model that continues to complete DoLS in line with statutory guidance.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	20.04.2023	20.06.2024
4152	Chief Operating Officer	Diagnostics, Therapies 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. Update April 2023 - PCR funding bid for 2 biochemists - FITT testing - new vetting criteria	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	17.04.2023	15.05.2023
4337	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	**If:** The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers **Then:** The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	**Key Controls** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems **Gaps in Control** The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. SBUHB have no process in place to incorporate the needs of Bridgend users in their developments. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems Numerous delays in NHS Wales progressing open architectural approach Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Update April 2023: Integrate Bridgend ICT Systems within CTM - Work ongoing, estimated 2 years from April 2023 Additional Funding for ICT Integration of Bridgend - WPAS funding for resource, workstream started Nationally led. estimated timescales arrive at 2025.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	24.3.2023	28.07.2023

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4458	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	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Update September 2022 Update – UEC Six Goals Improvement Programme now commenced – workstream 2 (integrated front door) – rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-discharge referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	3.11.2022	31.12.2022
4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Head of Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Module D PMVA Training Provision / Programme Delivery - Meeting to be arranged with Senior Managers within Mental Health to review the management, coordination and delivery of PMVA training. in late March when revised PMVA report completed. Meeting has taken place and Mental Health colleagues are reviewing how best this training provision can be supported by them. Further meeting scheduled for late April 2022. Senior Managers have devised an audit to all specialist clinical areas identifying their violence and aggression mandatory requirements. The PSA has been provided with some audit but this work is incomplete. A further meeting is yet to be arranged. Module D PMVA Training Provision / Programme Delivery - Meeting to be arranged with Senior Managers within Mental Health to review the management, coordination and delivery of PMVA training. in late March when revised PMVA report completed. An Audit has been devised and disseminated to Senior Managers to complete to determine the mandatory violence and aggression training requirements. To date 17/06/2022 6 completed audits received. Contact via email to RGH 13/06/22 for their audits. Once received all audits a report will be drafted. Meeting has taken place and Mental Health colleagues are reviewing how best this training provision can be supported by them. Further meeting scheduled for late April 2022. Senior Managers have devised an audit to all specialist clinical areas identifying their violence and aggression mandatory requirements. The PSA has been provided with some audit but this work is incomplete. A further meeting is yet to be arranged. 31/05/22 Still awaiting mandatory training audits to complete the report and rearrange the meeting. Timeframe: 26.8.2022 Update January 2023 / February - Discussions are still underway with Mental Health and draft Business case developed and discussed - Timeframe 31.3.2023. Module D PMVA Training Provision / Programme Delivery: Meeting in January 2023 where draft business plan reviewed. Head Nurse nominated to work with PSA to review the programme. To date private training provider to deliver 3 ,2 day refshers and 2 4 day courses to address the training compliance shortfall train to commence from March 23. TNA to be revised ,Mental Health staff groups identified on ESR to be revised. Business plan to be revised with a recommendation to continue with contacted band 4 nurses to deliver the training program. Next meeting scheduled for February 28th 2023. Timeframe 28.7.2023 Update May 2023 - Risk reviewed no change to score or risk mitigation.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	28.03.2023	31.08.2023
4906	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety 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 April 2023: The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams, with Patient Safety Improvement Managers taking a lead of facilitation and assisting Clinical Service Groups with improvements and learning from events. This transition came into place in April 2023. Training and a buddy system has been implemented to support this transition. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. Better LFER reports are available per care group to allow for better oversight by the Care Group triumvirate. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs. Quality assurance procedure now in place to ensure learning is of the required standard. Increasing the approval rate. The approval rate is being monitored via the Executive Patient Safety meeting.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	27.4.2023	27.06.2023
4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update April 2023 - Management of Security Doors in All Hospital Settings : Not specific to MHLD Care Group but all actions implemented and reviewed regularly to ensure they are sustained. Deep dive on actions and, risk assessments and mitigations scheduled for April Integrated Performance Meetings.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	31.1.2023	31.3.2023
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Head of Service - Employee Health Wellbeing Service (Occupational Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	**If:** the Health Board is not providing TB vaccination to staff **Then**: Staff and patients are at risk of contracting TB **Resulting in**: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update for May 2023 - A new process has been mapped which needs to be ratified with the Occupational Health Dr provision, Specialist Respiratory Nurse Team and Pharmacy before training and implementation of TB screening can take place. A meeting is being arranged to progress.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	21.04.2023	30.06.2023
4671	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	**IF**: The Health Board suffers regular local and/or national network issues and/or outages to critical clinical and business systems or performance issues in accessing and using systems. **Then**: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated. **Resulting in**: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks. Mistrust by staff of the ICT systems and services they are using	This Detail is captured in the In Committee Report due to business sensitivities	This Detail is captured in the In Committee Report due to business sensitivities	Digital & Data Committee	16 ↑ 15 in May 2023	C4 x L4	9 (C3xL3)	↑ to a 16 in May 2023	26/05/2021	31.3.2023	28.7.2023

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2987	Executive Director of Finance	Central Support Function - Estates Improvement Project	Central Support Function - Estates Improvement Project	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has been completed and the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated (remediated c2000m2 of c18000m2). In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN. Ongoing maintenance of fire systems. Increased knowledge on site of the fire issues, fire training, Initial works carried out on areas as part of the scheme already.	Ground and first floor Phase 2 major project approved by WG to address the fire notification on PCH. In progress with completion due 2026 / 27. Annual reviews as to remediation progress are held with SWF&RS and the Health Board is required to evidence continued progression in the shortest timescale. If satisfied SWF&RS issue an annual extension letter against the FEN. The current extension runs to the 31/07/23. The Phase 2 programme has now reached a point where c 6000m2 of FEN accommodation has been handed to the contractor (Apr 2023) to be remediated, having now decanted these areas to alternate fire compliant accommodation. Update Apr 23 - Phase 3 Update - The need for further capital investment is recognised and is on the Health Board list of schemes. Phase 3 FBC funding request was submitted to WG and approved in February 2023 with design user groups commencing April 2023. The intention being the final Phase 3 plans are drawn up in a timely fashion so the FBC can be submitted to WG in order that the project can be progressed when the works funding becomes available and programmed to overlap with later stages of Phase 2.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	15	C5xL3	6	↔	29.11.2017	20.04.2023	30.06.2023
2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	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.	Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022. September 2022 Update – it was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift to for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker. In addition, Welsh Government has announced that there will be funding for ND services across Wales over the next few years. The funding will be allocated to Regional Partnership Boards for distribution in-line with Regional Integration Fund aligned to the six national models of care with emphasis on taking a whole system approach with education, social care, health and 3rd sector working to deliver new models of care. October 2022: Risk remains unchanged however, review underway with Clinicians. Next review 31.12.2022. Next review scheduled for 1.3.2023 regarding mitigating action - Consideration required for further investment in service. April 2023 - Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	25.04.2023	31.05.2023
3638	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Inspiring People	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Pharmacy & Medicines Management - Training & Development Infrastructure	**IF:** the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented **Then:** the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. **Resulting in:** a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	This CTM Pharmacy issue that has stalled at various times in the past which has added to delay. Initially started in 2018 as an SBAR propose increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority, as part of the PRIMARY CARE pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. As such is in place and continues to run. Funding approved for primary care lead pharmacist - commenced in post April 2019.SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up. SECONDARY CARE elements were not supported in the IMTP prioritisation process	Update May 2023: Risk remains; workforce redesign will take a phased approach in addressing the risk. Managed by Chief Pharmacist. Review point mid June 2023.	People & Culture Committee	15	C3 x L5	6 (C3xL2)	↔	02.01.2018	05.05.2023	05.07.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022. Progress has been made in identifying a preferred short term decant option for theatres which has a high level costing attached. Paper drafted for ELG consideration prior to further WG discussions to enable the commencement of detailed design work and a business case submission to secure WG funding. WG have requested an options review be urgently undertaken on this as the preferred decant option is indicatively costed at £50M. The ILG are confirming availability for a management review of alternative options for delivery prior to a stakeholder session. Post this a report will need to be prepared for and discussed with WG to determine the way forward in terms of business case processes and timings. Update September 2022 from Capital & Estates - initial meeting with WG indicated that further work required to follow up on alternative options to the 6 theatre modular build so follow up WG meeting being arranged for late October / early November. Supply Chain partner reengaged to undertake more detailed engineering and design works. Update November 2022 - Risk remains unchanged as the options work is ongoing and meeting with WG is likely to be at the end of November with an outcome to the options review being discussed at that meeting. It is expected that this meeting will confirm the preferred way forward. Updated Dec 22 - WG and SWFRS meetings deferred until January due to potential crossover of enabling and decant options with the planned procurement of the BA site in Llantrisant. Clinical engagement and option appraisal session planned for the 11th January to confirm preferred options for provision of decant theatres to support the main works taking place. Mobile theatres (revised design) have been visited and are being reconsidered as an option.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	3.5.2023	3.7.2023
4672	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	**IF:** The Health Board is not able to record information accurately and reliably, with complete and up to date information **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update August 2022 - Consideration being given to Cessation of creating scanned records for any more new patients enabling scanning capacity to be put towards address backlog of active patients who already have a record in the scanning system - Development of a Health Board coding strategy for the development of the profession developed and being taken forward - Natural Language Programming (NLP) and data linkage being used to autocode targeted spells, improving levels of coding completion, based on Snomed-CT - Adoption of data level standards based architecture, - Coding transformation plan, - Opportunity for bi-directional real time integration between primary and secondary care available - National Data Resource (NDR), Clinical Data Repository (CDR) and integration programme Update October 2022 - Consideration being given to Cessation of creating scanned records for any more new patients enabling scanning capacity to be put towards address backlog of active patients who already have a record in the scanning system - Development of a Health Board coding strategy for the development of the profession developed and being taken forward, which underpins the coding transformation plan - Natural Language Programming (NLP) and data linkage being used to autocode targeted spells, improving levels of coding completion, based on Snomed-CT identified as increasingly successful and cost effective - Adoption of data level standards based architecture, - Opportunity for bi-directional real time integration between primary and secondary care available but requires tactical decision by UHB Board - National Data Resource (NDR), Clinical Data Repository (CDR) and integration programme UPDATE 28/10 ICT Risk meeting - no further update	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	22.10.2022	01.12.2022

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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	Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022 Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place. Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	07.09.2022	03.10.2022
4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then**: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	Update April 2023: SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/05/2023. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. 10 stage press received completed software upgrade. We are now ready for the installation of the software upgrade to the 13-stage press. All items needed for the upgrade have been received by the supplier. The in-house electrical work has been completed. The supplier has provided an installation date for the end of March 2023- beginning of April 2023. This will allow the installation of the new chemical system to be installed prior to the upgrade. The upgrade comes as part of a new chemical contract between NWSSP and Ecolab who will be providing the equipment as part of the contract. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the software has been installed. Review Date: 31/05/2023	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	13.04.2023	31.05.2023
5040	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	**IF:** The Health Board can not integrate new applications into its digital architecture in a timely fashion **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered **Resulting in:** delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity {much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC} and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB appointment process has commenced. WG funding for £7m awarded to support PAS integration 24/8/22 UPDATE 28/10 ICT Risk meeting - no further update October 22 - National Data Resource Programme has accelerated plan to open up the architecture, with API management procured for all of Wales & implementation date set for Jan 23 - will be limited in nature. National Funding received from WG for PAS integration work to create a second team supporting data migration. CTMUHB & DHCW appointment process has commenced. Included within this is a post for PAS integration developer.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	22.10.2022	02.12.2022
3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups established and aligned to this Programme board. 4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 5. Deployment order in place for all existing WCCIS mental health staff users 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8.CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 9. Project manager has been recruited. This role is leading on the development and implementation plan. 10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables. Patient Safety Controls: • CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. • CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. • Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. • RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical record keeping and monitor ongoing IG process/ workstreams (Meeting date in November to be confirmed).	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Business Case pending approval. 2. Director of Digital, CTMUHB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager. 3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case. A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available. Update April 2023 - Use of Welsh Community Care Information System (WCCIS) in Mental Health Services : The HB has committed to rollout of v5 within 2023/24. The Director of Digital will be the SRO, working closely with the Service Director as digital and operation have to be aligned on the implementation process. The Programme Board is due to convene May 2023.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	28.04.2023	31.05.2023
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A scoping document case to be prepared and submitted to Welsh Government -COMPLETE scoping Document submitted and agreement to commence a Strategic Outline Business Case received. 3. Develop a strategic outline business case. Timescale March 22 currently scoping the configuration of a future focused mental health unit - paused due to pandemic 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5.work paused due to pandemic. Resource to be identified to progress business case process 6. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop to take place early 2023. 7. Recruitment has taken place for Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommencing a new capital business case for a new Mental Health Unit. COMPLETE Update April 2023: A Quality Improvement Programme in relation to inpatient care is being developed and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop is scheduled to take place on the 26th April. Estates escalation review undertaken in all 4 CSG areas. Estates strategic review in development which will align with RPM capital funding. RTE and Bridgend have significant opportunities for rationalizing and improving estate.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	25.04.2023	01.06.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority Update April 2023 - No changes made bar next review date as cost of living crisis still relevant.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	13.04.2023	30.06.2023
4699	Director of Digital	Central Support Function - Digital & Data (Information Governance)	Chief Information Officer	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	**IF:** The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care **Then:** There will be a loss of trust and confidence in the Health Board from its patients, population, staff and 'care providing partners' and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. **Resulting in**: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	**Key Controls:** - Adoption and implementation of All Wales IG and Data protection policies, - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc) - Mandatory training in Information Governance with auditing functionality (such as NIIAS) built in to monitor compliance, - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI -Professional (clinical) training and approach to maintain an accurate and timely medical record **Gaps in Controls:** 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom if Information and Subject Access Requests	Cyber and Data Protection Improvement Plans being taken forward. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking with other organisations in Wales undertaken. (SB have 9wte, CTM 2.5wte funded, 1.5 wte now --> 0.5wte by end of Sept.) Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Update May 2023: Capacity within the Information Governance team is still a significant issue. Due to capacity, our ability to meet business as usual activities and addressing the recommendations of the ICO Audit Action plan is leading to delays in completion of activities. There have been three unsuccessful attempts to recruit a new Head of Information Governance. A new re-banded Job Description has been produced and will be readvertised in May 2023. Additional resources will be added to the Digital & Data Directorate to add additional capacity to the team during 2023/2024. Next review end of July 2023.	Digital & Data Committee	15	C3xL5	12 C3xL4	↔	18.06.2021	15.05.2023	31.07.2023
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function - Infection, Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	No IPC resource for primary care	**If** there is no dedicated IPC resource for primary care. **Then:** the IPC team is unable to provide an integrated whole system approach for infection prevention and control. **Resulting In:** non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	Update 11/05/23 - IPC Nurse Consultant, HARP Team has not commenced honorary contract with CTM as yet. Meeting arranged between Lead IPC Nurse and Nurse Consultant end May 2023. Deputy Executive Director of Nursing to undertake strategic review of IPC service.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	11.05.2023	11.7.2023
4721	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	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. No change to mitigation or risk score. Update September 2022 - Following review of this risk scoring by the COO the consequence score has been reassessed as a 3. This risk remains under constant review.	Quality & Safety Committee	15	C3xL5	12 (C3xL4)	↔	28/06/2021	11.10.2022	30.11.2022
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption	Retrieval and filing of case notes in the POW Medical Records Library	IF: The Medical Records Filing library at Princess of Wales is full to capacity making it very difficult for staff to retrieve and or file case notes. THEN: Risk of unable to manoeuvre mobile racking, therefore unable to access case notes Risk of fire as case notes close to source of ignition Risk of Fire Service or HSE closing access department Very High risk of upper limb injury Risk of notes falling from height causing injury (some case notes are in excess 8.3kg) Risk of Fire Service or HSE closing access to department RESULTING IN: If we could not retrieve any case notes, Consultants would be unable to make clinical decisions impacting on patient care. If the whole library was affected, this would impact 100 of thousands of patients care. Admissions/Outpatients would have to be cancelled staff refusing to continue to work in unsafe environment. Multiple and serious injuries to staff, possibly death.	(The case notes are very tightly packed on shelves. Mobile racking is failing due to age, lack of maintenance, and weight Case notes are being stored inappropriately on floors under desks, and insecurely at height. The working environment is congested, with no dedicated storage space for large ladders. Significant force is required to retrieve each file (123.N - this is 3 times higher than what is considered to be high force).) Broken Racking at Bridgend Offsite Stores - Repairs have been carried out with damaged racking in Bridgend North Rd Offsite stores. Temporary use of container deployed on site. Broken Racking at POW - On each occasion the racking has failed, the engineer has been able to repair it (£500 + VAT) but it continues to fail. Please see progress notes for more information. Access to this specific racking is permitted to Supervisors only, who only access it once a day. The Filing Library is closed to non-Medical Records staff, aside from the Porters who require access for emergency OOH admissions. Task and Finish group establish to address the above risks. Capacity has been identified at Glanrhyd and noticed served to SBUHB to vacate. It is hoped that we will be able to relocate notes to this area in mid-July, which will address the immediate H&S issues. Currently waiting for procurement process to be completed.	Update May 2023 - Relocation of case notes has taken place, these notes are now in storage at Glanrhyd hospital site. This has helped the situation in medical records Bridgend but still does not allow for sustainable growth of notes into the future. In response to this the destruction of notes embargo due to the infect blood enquiry has now come to an end and a piece of work is needed to understand the resource needed to scope and undertake destruction of suitable notes to future support the storage risk around patient notes. Based on this latest mitigation position the likelihood score has been reduced to a 3.	Digital & Data Committee & Quality & Safety Committee	15 ↓ 20	C5xL3	10 C5xL2	↔	27.10.2021	3.5.2023	3.6.2023

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
4908	Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in**: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Meetings with Care Groups to be established in respect of complaint responses to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. Update September 2022 - Benchmarking exercise completed, which demonstrates low staffing to workload capacity with counterparts across Wales. Invest to save bid has been drafted with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review and workshop is being held in Sept 2022 to review skill mix in the claims handling team. Update October 2022 - Invest to save bid has been completed and submitted for consideration, with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review. A workshop has been held with the Legal Services team to review ways of working moving forward into the new operating model. Update December 2022: - Invest to save bid was unsuccessful, therefore alternative funding options being explored. Some limited capacity will be realised in the new operating model for quality, safety and governance. CTM commissioned Legal and Risk to provide assistance and direction on the historic redress cases, however L&R have no capacity to take these over. Therefore, will have to be dealt with in turn, as part of the backlog.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	8 (C4xL2)	Invest to save bid was unsuccessful, therefore alternative funding options being explored. The new operating model is now at implementation phase with any vacancies being advertised. Once in post, there will be some extra capacity. An action plan to prioritise older cases has been developed. Extra capacity will be used to focus on the backlog in readiness for the implementation of Duty of Candour. Risk score has been reduced as a result of the above mitigation. At the Q&S Committee on the 16th March, members considered it premature to de-escalate this risk score as the action plan has not been completed. This has been deferred back to the risk owner for consideration on the 17.3.2023. Further rationale for de-escalation added as follows: Update April 2023: New operating model in respect of quality, safety and governance almost fully implemented. Legal Services Manager now in post. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full DoC
5214 (Capturing risks 4590 and 4798 which are now closed)	Executive Medical Director / Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Medical Cover	**If**: Critical Care workforce issues across Medical, Therapies and Pharmacy teams. Requirements for standards set out in national GPICS documents - Critical Care provision. Unable to sustain 3x level III units across CTM due to these workforce issues. Need to provide a sustainable model to drive quality of care for patients. Mitigate the impact of Critical Care changes on other specialties. Agreement for new outline mode 2x Level III and 1x Tier 1 unit. **Then**: Critical Care Leadership group established to drive programme with pan-CTM CC group representing all sites to support CC Leadership. Colleague awareness that need them all as well as expanding the MDT workforce, including delivering care in new ways. Options appraisal with robust business case to support the clinical needed changes to the current model. Workforce integral to business case. Agreed funding in place and recruitment of Middle Grade tier currently happening at POW. **Resulting in**: Workforce in Critical Care integral to planning and model development. 2 year interim model to enable broader CTM plans with long term model to be determined. Recruitment process to change to sell the new model approach to fill funded gaps. PMO to support the model planning and implementation. Clear timeline of activity for CC Leadership to deliver stages of programme.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. 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.	Update 12.4.2023 - 3 Critical Care related risks (4590, 4798 and 5214) combined. RR score reflected to overall score of 12. The risk of workforce establishment (and all the factor related to that) have been incorporated into the Medical Workforce Productivity Group. This group is chaired by the Medical Director who is responsible for this risk. The MPWG reports monthly and is overseen and accountable to the Value and Effectiveness Committee and the Transformation Board. As such it is under close scrutiny on a continual basis. By this process any areas of increased risk will be highlighted rapidly and addressed.	Quality & Safety Committee People & Culture Committee	12 (C4xL3) reduced from a risk score of 20	8 (C4xL2)	Update 12.4.2023 - 3 Critical Care related risks (4590, 4798 and 5214) combined. RR score reflected to overall score of 12.
4920	Executive Director of Therapies & Health Sciences	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	**If:** clinical capacity remains significantly reduced due to staff sickness and vacancies **Then:** clinical service delivery will be negatively compromised. **Resulting in:** increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily Update September 2022 - Last review 30.8.22 next rv 31.10.22. No change to mitigations, recruitment in progress, and improvement in staffing is expected by November. Update October 2022 - No change to mitigations, recruitment still in progress. Update 28.12.2022 - two vacancies are anticipated to be recruited to March 2023 following the return of maternity leave and retire and return employee. Ongoing discussion with staff member temporarily re deployed due to Long COVID regarding returning to substantive post. Review 31.3.2023 Update February 2023 - No change for this period, next planned review is due 31.3.2023. Update April 2023: risk deescalated to a score of 12 (consequence score of 3, and a probability score of 4), as new staff are being recruited and staff are returning from maternity leave and sickness absence.	Quality & Safety Committee	12 (C3xL4) reduced from a risk score of 15	12 (C3xL4) Target score is being revised hence the risk has not been closed.	As a result of the following update the risk likelihood has been reduced. risk deescalated to a score of 12 (consequence score of 3, and a probability score of 4), as new staff are being recruited and staff are returning from maternity leave and sickness absence.

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
4315	Executive Director for People	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance of Fire Training - Provision	Insufficient staff (Fire Officers) available to provide mandatory face to face fire training. **IF** Limited number of places available due to the restrictions posed by social distancing so the amount of staff that can be trained at one time has been significantly reduced. **THEN** Risk of injury or loss of life from smoke inhalation, burns. Prosecution from the Fire Authority for not meeting the requirements of current legislation(RRFSO. **RESULTING IN** Legal action by an individual against the UHB should an incident occur and staff not suitably trained.	Fire Officers are trying to provide training when they and suitable rooms are available. The training is based on a risk based approach and follows the approved Training Needs Analysis. However due to the restrictions posed by social distancing the amount that can be trained at one time has been significantly reduced. Learning & Development is currently working with the Health Board Fire Officers to reinstated the fire element of Corporate Orientation, so progress is being made to address those who have had no CTMUHB fire training at all. Fire Officers in conjunction with the Nurse Education Lead continue to provide face to face training for these staff.	April 2023 - Appointment made to recruit Fire Officer in the Merthyr area and is due to start on the 9th May 2023. This risk will be reviewed further to establish if further resource is required.	Health Safety & Fire Sub Committee	12 (C4xL3) reduced from a risk score of 16.	C4 x L2	As a result of the following update the risk likelihood has been reduced.: April 2023 - Appointment made to recruit Fire Officer in the Merthyr area and is due to start on the 9th May 2023. This risk will be reviewed further to establish if further resource is required.
2787	Executive Director for People	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of a robust Health Surveillance Programme for employees.	**If:** there is no monitoring in place for staff who work in areas of the organisation where known health risks could develop e.g. Hand, Arm Vibration (HAVs), noise, skin conditions such as contact dermatitis, respiratory etc. **Then:** then this means that the organisation may not be able to identify the areas and departments within the organisation that require Health Surveillance intervention. Should a reportable incident occur CTMUHB will be liable to criminal repercussions by the HSE **Resulting in:** it not being possible to develop a robust HS programme for the organisation without this baseline intervention as required by the Health & Safety Executive (HSE). Criminal Actions by the HSE.	OH linking with H&S to re-establish the skin surveillance programme. Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme.	Update April 2023 - Report provided to last Health, Safety and Fire Committee outlining work to address this risk. SOPs have been developed for Respiratory, HAVs, Noise and Skin Surveillance.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	C4 x L2	As a result of the following update the risk likelihood has been reduced.: Risks. Update April 2023 - Report provided to last Health, Safety and Fire Committee outlining work to address this risk. SOPs have been developed for Respiratory, HAVs, Noise and Skin Surveillance.
5014	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital	**If** patients present at the ED at the RGH with obstetric and gynaecology related issues there is a risk that there could be delays in treatment and transferred required to hospitals with obstetric and gynaecology services. **Then** they will need to be transferred to a site with the appropriate services **Resulting In** a delay in the provision of appropriate care and treatment and this could lead to in-utero death, neonatal injury or disability, death of a pregnant lady due to blood loss and a loss of reproductive ability.	Pathways in place and subject to regular review. WAST is aware of the patient pathway and the need for O&G patients to go straight to PCH. Patients self presenting at the RGH ED would be prioritised for transfer to PHC Emergency cases would receive immediate general surgical care from non O&G specialists	Update May 2023: Children and Families Care Group have reviewed this risk and advised that any incidents are investigated and learning used to update SOPs e.g. The obstetric SOP is frequently reviewed to incorporate learning and improvements. There is a meeting on the 25th May to meet and review Gynae and Obs pathways between the Care Group and ED in RGH . The Care Group have revisited the scoring for this risk and determined that the liklihood should be reduced to possible. It is possible hat it could happen and when it does the consequence could be major.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	C4 x L2	As a result of the Children and Families Care Group review and current mitigation the liklihood of this risk occurring has been re-assessed and reduced. Therefore this risk is de-escalated from the Organisational Risk Register.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4253	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	**Bridgend Locality:** The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	**Bridgend Locality:** o action plan developed with support from the head of nursing within the ILG. o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied Update 25.5.2022 - Major Works complete and official handover undertaken on the 25th May 2022 with contractor. Risk scoring reduced from a 20 to a 15. The Target Score has not been met as there are still works to complete internally with Estates. Bridgend 28.10.22 All anti-ligature works in PICU, Ward 14, Angleton have been completed and areas handed over subject to completion of a few outstanding snags by the contractors. Work is awaiting final sign-off. Review end of December 2022 with a review of revisiting the risk score. Update May 2023 - From a capital perspective they have undertaken all the required anti ligature works to which this original risk referred and these have all been signed off by estates.	Quality & Safety Committee Health, Safety & Fire Committee	Jan-23	Risk Closed 13.1.2023 - Health Board Capital works department have signed off all of the schemes connected to the anti ligature work. On Hold in closure section. This will not be removed from the Organisational Risk Register whilst sufficient assurance is sought to the satisfaction of the Audit & Risk Committee. Confirmation received that the capital works have been completed. Consideration at the Audit & Risk Committee in April 2023. **May 2023 -** to close as confirmation of works completed received.
4590	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Pharmacist Resource	**If:** additional resource is not identified to increase the critical care clinical pharmacy service **Then:** there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. **Resulting In:** an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. INCLUDED in the Reconfiguration Group work for sustainable model. New Chief Pharmacist aware o f issue and forming part of their evaluation of Pharmacy model across CTM. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022. Update August 2022 - Currently 40% gap in staff in post vs standards (1.5 wte) across all acute sites. Funding agreed for RGH and staff recruited into post. Currently non-recurrent. Funding request submitted within IMTP. UPDATE DECEMBER 22 - new Reconfiguration Group to address all workforce shortfall issues (inc Pharmacy), also part of new CP plans	Quality & Safety Committee	May-23	Risk Closed as amalgamated into Datix Risk ID 5214 - captured in the de-escalat5ion section of the Organisational Risk Register/
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies and Specialties Care Group	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. Update 16-9-21 Continuing with therapy business case as actions below. No other updates	Discussions with all 3 critical care units regarding repurposing of funds to develop SLT posts. Nursing leaders aware and case being taken to next Operational Management Board. Three separate organisational critical care risks for workforce (medical, therapies, pharmacy) on Risk Register. Single combined risk has been drafted.	Quality & Safety Committee	May-23	Risk Closed as amalgamated into Datix Risk ID 5214 - captured in the de-escalat5ion section of the Organisational Risk Register/

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
5153	Executive Director of Finance & Procurement	Central Support Function - Finance	Financial Stability Risk	Failure to achieve financial balance in 2022/23.	**IF:** The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2022/23 (including funding for Covid response costs and Exceptional items) . **Then:** The Health Board will not be able to deliver a break-even financial position for 2022/23. **Resulting in:** Potential deficit in 2022/23 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. The context is that the draft financial plan for 22/23, submitted to WG at the end of April, has three elements : A core plan which has a planned deficit of £26.5m, excluding Ongoing Covid response costs of £32.3m and Exceptional Items of £19.0m. Assumed non - recurring funding for the Covid and Exceptional costs has yet to be confirmed by WG. Delivery of the Core plan is also predicated on a the delivery of efficiency savings of £17.3m which is a significant step up in savings compared to recent years.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Further discussions needed with Welsh Government to understand the likely funding position for 22/23. Update September 2022 Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid response costs. Update 24.10.2022 - Position remains as reported for September 2022. No change to risk score. Update 3rd Jan 2023. The funding position for 22/23 in relation to Exceptional items and ongoing Covid -19 response costs has now been clarified by WG. The forecast Core plan overspend for 22/23 at M8 is still £26.5m and there is no change to the risk score.	Planning, Performance & Finance Committee	May-23	Risk Closed as replaced by Datix Risk ID 5425 as included on the Organisational Risk Register as a "New Risk".
5154	Executive Director of Finance & Procurement	Central Support Function - Finance	Financial Stability Risk	Failure to reduce the planned recurrent deficit of £28.0m at the end of 2022/23.	**IF**: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the expected available funding for 2023/24. **Then**: The Health Board will not be able to develop a break-even financial plan for 2023/24 and deliver it . **Resulting in:** Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Update October 2022 - The M6 YTD position is a £14.6m deficit. This represents a £1.4m adverse variance compared to 6/12th of the £26.5m Core plan deficit. The M6 Savings position is forecasting £17.5m of Savings in 22/23 but only £10.4m on a Recurrent basis. (Savings target for 22/23 = £17.3m). The forecast underlying recurrent deficit at 31/3/23 is now £34.9m. This position represents a £6.9m deterioration from the planned recurrent deficit of £28.0m and is due to the forecast shortfall in recurrent savings delivery in 22/23. Further develop the savings planning processes via the Value and Efficiency programme. Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid response costs. Update 3rd Jan 2023 - The M8 YTD position is a £18.0m deficit. This represents a £0.3m adverse variance compared to 8/12th of the £26.5m Core plan deficit (£17.7m). The M8 Savings position is forecasting £17.5m of Savings in 22/23 but only £10.6m on a Recurrent basis. (Savings target for 22/23 = £17.3m). The forecast underlying recurrent deficit at 31/3/23 is now £47.6m. This position represents a £19.6m deterioration from the planned recurrent deficit of £28.0m and includes: forecast shortfalls in recurrent savings delivery in 22/23 (£6.7m) and forecast recurrent overspends in Care Groups and directorates (£11.0m). The key actions are to further develop the savings planning/recovery planning processes via the Value and Efficiency programme and the Financial Plan for 2023/24.	Planning, Performance & Finance Committee	May-23	Risk Closed as replaced by Datix Risk ID 5427 as included on the Organisational Risk Register as a "New Risk".
4512	Chief Operating Officer	Unscheduled Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	**If:** there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; **Then:** patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; **Resulting in:** incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	May-23	Update 24th April 2023, risk has been reviewed and updated, no longer a site risk and individual risk assessments are completed on patients should there be delays, this will capture the impact and actions for the patient therefore progressed to closure.

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
5323	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fluoroscopy Room has become Obsolete	IF room 3 in POW is not replaced THEN there will be situations where there is no interventional Radiology service at POW (during maintenance and potential break down of Room 6) RESULTING IN having to transfer very unwell patients to other hospitals, pressure on staff and services at other sites to accommodate. Overall poorer patient experience and potentially outcomes.	Utilising Room 6 to its full capacity Some Barium lists being performed at RGH when possible	Completion of SON to support replacement of Room3 - Timeframe 27.1.2023 30.1.23 RGH has list every other Friday SON submitted, initial agreement to fund new room Welsh Government funding received in 22/23 to procure new equipment - currently in storage. Detailed design work completed for new room and works out to tender. Works expected to be undertaken over the summer and completed by autumn	Quality & Safety Committee	May-23	Updated April 2023 - SON submitted and has been approved and is progressing. initial agreement to fund new room 17.4.23 Patients continuing to transfer to RGH - Equipment purchased, awaiting building works at POW. Target score met.

AGENDA ITEM
5.2

AUDIT & RISK COMMITTEE

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Date of meeting	21/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Officer
Presented by	Emma Walters, Corporate Governance Manager
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

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

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

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

2.1 Internal Audit (NWSSP)

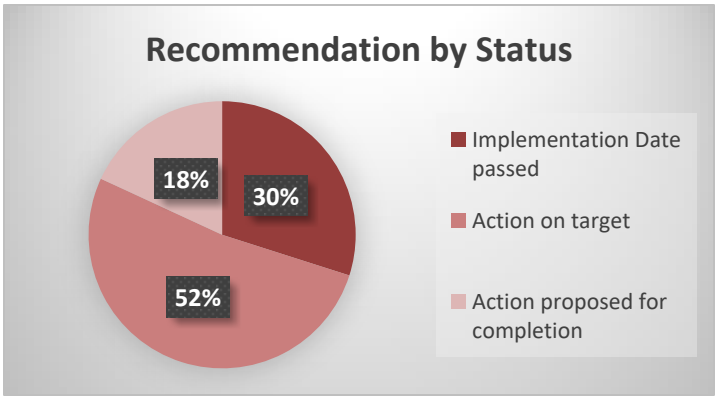
2.1.1 Since the last meeting the following changes and updates are noted:

- **4 NEW** Internal Audit Reviews have been added to the Audit Recommendations Tracker:
  - Board Awareness of Digital – Two recommendations;
  - Reasonable Offer Process – Seven recommendations;
  - Bridgend Transfer of Informatics Services Follow Up Review – Two recommendations;
  - Board Assurance Framework – Five recommendations.

- **23** Internal Audit recommendations have been completed and are proposed for **CLOSURE**, these are:
  - Digital Operating Model 2.1;
  - Concerns 4.2;
  - Princess of Wales Theatres Fire Safety Works 1.2;
  - Nurse Agency Usage 01, 02, 03 and 04;
  - Prince Charles Hospital Redevelopment Governance Audit 03;
  - Welsh Language Standards Compliance 04 and 06;
  - Continuing Health Care and Funded Nursing Care 1.2;
  - Board Awareness of Digital 2.1;
  - Bridgend Transfer of Informatics Services Follow Up 2.1;
  - Financial Systems 06;
  - Wellbeing 5.1, 2.1, 3.1, 3.2 and 4.1;
  - Board Assurance Framework 2.1, 2.2, 3.1 and 3.2.

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 to 30% compared to the April position which was at 64%.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High	**33**	9	19	5
Medium	**77**	26	40	11
Low	**17**	3	7	7

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**6**	0	2	4
Director of Finance	**22**	2	18	2
Chief Operating Officer	**35**	19	15	1
Director of Nursing	**10**	8	1	1
Director of Digital	**8**	0	5	3
Director for People	**22**	8	3	11
Director of Strategy & Transformation	**15**	0	14	1
Medical Director	**9**	1	8	0

Implementation Date Extended by					
Priority	TOTAL	More than 24 Months	18-24 Months	12-18 Months	6-12 Months
High	17	1	0	4	12
Medium	54	6	6	12	30
Low	7	2	1	1	3

2.2 External Audit (Audit Wales)

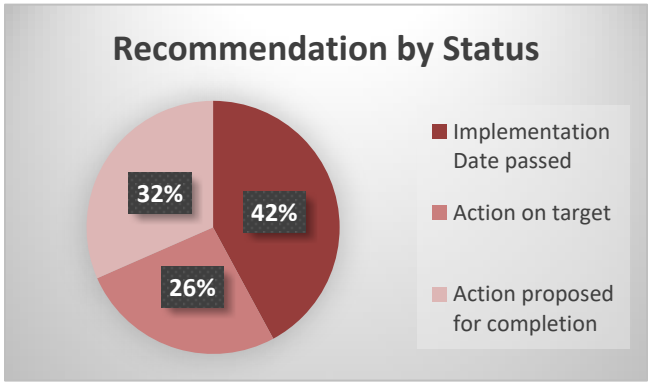
2.2.1 Since the last meeting the following changes and updates are noted:

- **1 NEW** new External Audit Review has been added to the Audit Recommendations Tracker:
  - Structured Assessment 2022 – 10 recommendations.

- **12** external audit recommendations have been completed and are proposed for **CLOSURE**, these are:
  - Follow Up Outpatients Not Booked R2;
  - Clinical Coding Follow Up Review 01 and 03;
  - Audit of Account Addendum 2021/22 R2, R5, R6, R10 and R11;
  - CTMSB SLA Review R1 and R2;
  - Structured Assessment 2022 R2 and R8.

2.2.3 **Current Position**

The tables below provide a summary of the current position in relation to External Audit Recommendations. You will note that the percentage of recommendations whereby the implementation date has now passed has improved slightly to 42% compared to the 60% reported to the April 2023 meeting.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High/Medium/Low	**38**	16	10	12

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**4**	0	3	1
Director of Strategy & Transformation	**13**	9	2	2
Chief Operating Officer	**1**	0	0	1
Director of Finance	**9**	1	2	6
Director of Digital	**3**	0	1	2
Director of Nursing	**5**	4	1	0
Director for People	**2**	2	0	0
Medical Director	**1**	0	1	0

Implementation Date Extended by					
Priority	**TOTAL**	More Than 24 Months	18-24 Months	12 - 18 Months	6 -12 Months
High/Medium/Low	**11**	3	4	1	3

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.2 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

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

4 IMPACT ASSESSMENT

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

5 RECOMMENDATION

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

CTM Interna [date]

Red -
Orange -
Yellow - Action
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
Concerns 1.2	feb-22	Limited	A comprehensive set of Standard Operating Procedures should be developed setting out the process to follow from the point a concern or complaint is received though to the provision of a response. The SOP should include concerns from all sources such as those received via the dedicated email accounts, those made in person or issues raised via local MPs or MSs. The responsibilities of the Corporate Concerns Team and the ILGs should be clearly set out.	High	Review the PTR Guidance alongside the CTM structures to identify what Standard Operating Procedures are required and develop and implement to support the new process.	Director of Nursing	Interim Head of Concerns, Redress & Legal	jun-22	Now September 2022 Now January 2023 Now February 2023 Now May 2023 Now July 2023		In progress	June 2023 Update: A full set of Standard Operating Procedures for the Management of Complaints have been developed. These have been shared at the weekly executive catch up, the team and with Internal Audit as part the review of the previous audit. These procedures reflect the centralisation of the complaints and a clear process of escalation. The overarching Concerns policy has been drafted and following consultation will be presented to the Q&SC (July 2023) for approval.	April 2023 Update - Recommendation: incomplete, open/yellow. New SOPs devised. A meeting was held with the Assistant Director of Risk and Corporate Governance to discuss the ratification process. Timetable shared with Managers. The agreement is that the overarching policies will go to the Quality & Safety Committee in May 2023. SOPs can be agreed upon at Q&S Executive Meeting.
Concerns 3.1	feb-22	Limited	3.1a A training programme should be developed and rolled out across the Health Board to ensure that staff are suitably trained for the roles they are performing in relation to the Concerns process. 3.1b A training needs analysis should be undertaken in each ILG and for corporate teams to identify the staff that fall into the three levels of training outlined in the Concerns Training Plan. The PADR process could be used in the future to help identify training needs.	High	3.1a CTM Concerns Management training programme to be developed encompassing Putting Things Right, the Once for Wales Concerns Management System and Welsh Risk Pool procedures, more specifically Learning from Events Reports. 3.1b Training Needs Analysis Template to be developed following development of Concerns Management training programme. To be shared with the ILGs for completion and identification of all staff who should receive the training.	Director of Nursing	3.1a Interim Head of Concerns, Redress & Legal 3.1b Interim Head of Concerns, Redress & Legal/ILG Heads of Quality & Safety	3.1a April 2022 3.1b June 2022	Now January 2023 Now February 2023 Now May 2023 Now September 2023		In progress	June 2023 Update: Updated action reflected in updated internal audit report: Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training. Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board. Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis. The delay in the recruitment of new staff has been impacted and delayed due to the revised Operating model.	April 2023 Update - Recommendation: incomplete, open/yellow. 3.1a - Training has been delivered on concerns management via Incident Management training and Complaints Management training. Complaints policies/procedures have been updated in line with the new operating model and are in the process of ratification. A workshop has been held for the newly centralised concerns handlers, to ensure quality and consistency. CTM attends the All Wales Duty of Candour Education and Training network. A raft of education and training materials have been developed and are now available on the Health Boards SharePoint site. 3.1b - Training Needs analysis will be undertaken on completion of the prospectus with the newly formed care groups.
Patient Pathway Appointment Management Process Follow Up 1.1	jun-22	Limited	Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	Chief Operating Officer	ILG Directors of Operations / Head of Information	aug-22	Now December 2022 Now January 2023 Now April 2023 Now June 2023		In progress	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.
Patient Pathway Appointment Management Process Follow Up 1.3	jun-22	Limited	On receipt of the outcome reports, management within the CSGs should ensure that they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data or making the errors. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action.	Chief Operating Officer	ILG Acute Services General Managers	aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.
Patient Pathway Appointment Management Process Follow Up 1.5	jun-22	Limited	Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	High	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	Chief Operating Officer	ILG Directors of Operations / Head of Information	sep-22	Now February 2023 Now June 2023		In progress	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.
Patient Pathway Appointment Management Process Follow Up 2.1	jun-22	Limited	Management should ensure that the correct data detailed within the closed pathway reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.

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Patient Pathway Appointment Management Process Follow Up 2.2	jun-22	Limited	Management should ensure that closed pathway reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that the patients are put onto an open pathway. In addition, closed pathways reports should be sent on a regular basis to staff within Bridgend ILG, or checks should be made to ensure managers are accessing this data for themselves.	High	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.
Patient Pathway Appointment Management Process Follow Up 2.3	jun-22	Limited	On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS.	High	ILGs will ensure that they undertake this action	Chief Operating Officer	ILG Acute Services General Managers	aug-22	Now December 2022 Now February 2023 Now June 2023		In progress	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.
Patient Pathway Appointment Management Process Follow Up 2.4	jun-22	Limited	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	sep-22	Now February 2023 Now June 2023		In progress	June 2023 Update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.
POW Theatres Fire Safety Works 1.1	aug-22	Limited	Management should formulate a Project Board immediately, with appropriate terms of reference and attendance as the accountable body for project delivery (as part of defined project governance).	High	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	Immediate	Now November 2022 Now January 2023 Now March 2023 Now April 2023 Now June 2023		In progress	June 2023 Update - An options paper for the decant has been developed and is undergoing strategic review prior to submission to and discussion with WG. The next review with SWFRS is 19th June and they will expect the HB to have a confirmed decant option to be reviewed with WG. Once this has been agreed the business case will need to be redrafted and the Project Board meetings can commence. In preparation of this draft Agenda and TOR have been drafted just waiting for confirmation of approved decant solution	April 2023 Update - There is a meeting on 27th March involving the COO,SRO and DoF to consider the best way forward for decant options, post this a revised timeline around, meetings, structure and programme for delivery can be developed
Digital Operating Model 1.1	nov-22	Limited	An appropriate steering and ownership governance tier should be established that enables stakeholders to own, steer and oversee the delivery of digital objectives.	High	Accept A new governance and ownership arrangement will be created to align to the Health Board Transformation Change Programme and delivery board created as part of the Care Group Model Implementation.	Director of Digital	Director of Digital	Qtr. 3 2022/2023	Propose Qtr. 2 2023/2024		In progress	June 2023 Update: On track. New Digital Strategic Leadership being recruited to. These will enable support for new Governance model	April 2023 Update - Work has commenced on the relationship of Digital Groups with the new Care Group Governance Model. On Track for completion in Qtr. 2023/2024
Digital Operating Model 2.1	nov-22	Limited	The Digital Clinical leadership structure should be revised and improved. • The CNIO role should be formalised; and • a network of digital clinical leaders should be established that mirrors the Health Board structure to ensure that each area as a defined leader who can act as a conduit and help embed digital.	High	Accept Digital Clinical Leadership will be developed and formally recognised as part of the Strategic Leadership Group within the Digital & Data Directorate. A new set of roles & capabilities will be identified as part of the new Digital & Data Governance arrangements.	Director of Digital	Director of Digital	Qtr. 3 2022/2023	Propose Qtr. 2 2023/2024		Completed	June 2023 Update: New Digital Clinical Network Meeting has been formed, chaired by CCIO. Propose to close.	April 2023 Update - Work has commenced on the relationship of Digital Groups with the new Care Group Governance Model. On Track for completion in Qtr. 2023/2024

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Radiology Service Review 6.1	des-22	Limited	In order for absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates.	High	All superintendents will be advised of the need to maintain comprehensive and accurate documentation in relation to each episode of sickness absence and ensuring that all documentation is completed in a timely manner in line with the Managing Attendance Policy. A request will be made to workforce for Sickness/Absence Management Training.	Chief Operating Officer	Site Superintendent Radiographers	31st December 2022	Now February 2023 Now April 2023 Now August 2023		In progress	June 2023 update - RGH sickness training delivered to five members of staff, three outstanding. Coordination of dates challenging with clinical responsibilities.	April 2023 Update - Sickness Training Updates are currently being arranged with People's Services for staff on all 3 DGH sites. Training delivered to PCH staff 08/03/23 & 13/03/23 POW staff. Awaiting a training date for RGH staff.
Radiology Service Review 9.1	des-22	Limited	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. We acknowledge that the service will always need to prioritise clinical activity, but in order to achieve set targets, the service should develop an action plan outlining a realistic approach to tackle the backlog, prioritising those with future increment dates. Consideration must also be given to developing a sustainable way of maintaining PDR compliance rates once the backlog has been cleared. As part of addressing the backlog, staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	High	An action plan will be developed to address the backlog of PDRs and establishing a sustainable system of maintaining PDR compliance in line the with WG and Health Board targets. Robust monitoring arrangements at corporate and at Care Group level will need to be implemented. All staff will be reminded of the importance of having a PDR, including the need for pay progressing, and the need to engage meaningfully in the process.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographer	jan-23	Now March 2023 Now May 2023 Now August 2023		In progress	June 2023 Update - small increase in compliance. Compliance has improved in RGH/POW. Work to be undertaken with PCH team.	April 2023 Update - The site leads have developed a programme to undertake PDRs. POW are 100% compliant. RGH/PCH staff are working to pay progression dates. The new admin manager is currently undertaking a programme of PDRs. Ongoing due to clinical commitments.
Radiology Service Review 10.1	des-22	Limited	Work should be undertaken to ensure the training requirements and achievements captured in ESR are accurate: • Management should identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Management should identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • If management feel staff are professionally	High	The Service will undertake a review of the training requirement and achievements captured in ESR to: • Identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • Identify staff are who are professionally qualified above the requirements of any of the ESR modules and liaise with L&D to have this information captured on the ESR records, so that non-completion of the ESR modules does not impact compliance rates.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	mar-23	Now May 2023 Now August 2023		In progress	June 2023 Update. Manual handling training was cancelled by the manual handling team in May 2023. Training has been rescheduled for June 2023. Contact with Safeguarding team around Safeguarding Adults Level 3 competency and relevance to Radiology Staff.	April 2023 Update - The Learning & Development Team have been contacted around core competencies. The matter is ongoing with corporate team.
Radiology Service Review 10.2	des-22	Limited	The Clinical Service Group should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	High	The Service will remind staff that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role and that staff are provided with the opportunity to undertake their mandatory training. Ongoing support at Executive Level will be required to address role requirements.	Chief Operating Officer	Clinical Service Manager Super intendent Radiographers	mar-23	Ongoing		In progress	June 2023 - No update received against this recommendation for the June submission	April 2023 Update - Ongoing work is underway to drive core compliance. Unfortunately there are some classroom based courses which are unavailable. Time is being allotted to staff balancing clinical commitments. A Module of the Month is sent to encourage staff to complete training. Ongoing
Medical Variable Pay 1.1	feb-23	Limited	1.1a A review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be undertaken. From considering the findings from the audit report and reviewing current processes, both documents should be updated to reflect the processes and controls that staff should be adhering to when engaging medical agency staff. 1.1b Updated copies of the updated FCP and SOP should be accessible to all staff and staff should be made aware of their existence. 1.1c Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	High	1.1a The Financial Control Procedure (FCP) and Standard Operating Procedure (SOP) will be reviewed immediately and updated in line with recommendations within this report. They will then go through a ratification process to ensure this is also compliant with the Health Board's scheme of delegation and in place policy and procedures. Both the FCP and SOP were due to be reviewed at the start of this audit, however this was delayed to ensure the recommendations contained in this audit could be incorporated into both documents. The June target date is used as the FCP will have to go through a ratification process. 1.1b Both the FCP and SOP will be hosted on the agency intranet page, also available from the People Directorate on request and issued by Retinue to current users. Every time a new area is added to the system, all staff with access to book agency workers will be issued with the documents, along with training on how to use the system. 1.1c All areas using the agency booking system will be provided with refresher training. A training plan will be developed and provided to all existing users, once the new FCP and SOP are in place. A record will be kept of what areas have had this training and when.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	1.1a and 1.1b June 2023 1.1c August 2023			In progress	June 2023 update - Awaiting FCP changes from finance colleagues	April 2023 Update - FCP draft written and sent to finance colleagues for review.
Medical Variable Pay 3.1	feb-23	Limited	3.1a The process for authorising payments that exceed the WG cap rates should be reviewed, with suitable authorisation taking place to approve higher value payments. 3.1b The FCP and SOP should be updated to reflect the correct process to be followed and should provide greater clarity on the cost elements that need to be included when determining if a rate exceeds guidance rates. There should be consistent use of terminology across the FCP, SOP and Retinue system.	High	3.1a The process for payments exceeding the WG cap rates will be fully reviewed as part of the development of the new FCP and SOP. The recommendations of this audit will be incorporated into the FCP and SOP. 3.1b The new FCP and SOP will fully address and unify the inconsistent terminology used currently, to reduce any confusion going forwards. The documents will also clearly set out the authorisation process required for rates that exceed WG cap rates. The process for requesting above WG cap rates will also be included in the refresher training to all areas using agency workers.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	jun-23			In progress	June 2023 update - Awaiting FCP changes from finance colleagues	April 2023 Update - FCP draft written and sent to finance colleagues for review. Will be reflected in new FCP

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Medical Variable Pay 3.2	feb-23	Limited	Approval of higher rate payments should be retained in a suitable format that allows future reference if needed.	High	All authorisation of higher rates payments will be recorded fully and provided on request. The way this is captured and accessible for audit will be included in the FCP and SOP for future reference.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	jun-23			In progress	June 2023 update - Awaiting FCP changes from finance colleagues	April 2023 Update - FCP draft written and sent to finance colleagues for review. Will be reflected in new FCP
Medical Variable Pay 4.1	feb-23	Limited	It should be ensured that suitable processes are in place and adhered for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum. Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used.	High	The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension. Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	aug-23			In progress	June 2023 update - Direct Engagement report written. Medical Workforce Manager to review and discuss at Medical Workforce Productivity Programme meeting.	April 2023 Update - DE Policy to be written for Care Groups with a clear escalation policy in place
Medical Variable Pay 6.1	feb-23	Limited	6.1a The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate. 6.1b The FCP and SOP should be updated to reflect the correct process to be followed.	High	6.1a A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff. 6.1b The recommendations and subsequent processes developed will be included in the FCP and SOP.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	aug-23			In progress	June 2023 update - As per new FCP. Awaiting FCP changes from finance colleagues	April 2023 - as per new FCP
Reasonable Offer Process 4.1	apr-23	Limited	Training in relation to application of waiting time adjustments should be provided to all booking staff to ensure they are fully aware of and complying with the relevant RTT rules.	High	An audit of the `all users with WPAS compliance' report to take place and training arranged for identified staff	Chief Operating Officer	Director of Operations Planned Care & Head of Clinical Administration Transformation	aug-23			In progress	June 2023 Update - audit very recent, target date remains August 2023.	
Reasonable Offer Process 5.1	apr-23	Limited	A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	High	5.1.1 - Identification of WPAS reports to allow for identification of compliance. 5.1.2 - Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements	Chief Operating Officer	Director of Operations Planned Care & Head of Clinical Administration Transformation	July 2023 August 2023			In progress	June 2023 Update - audit very recent, target date remains August 2023.	
Concerns 1.1	feb-22	Limited+C29:D29	The concerns policy should be reviewed and updated to accurately reflect the structure, roles, responsibilities and active involvement of the corporate function and the ILGs in respect of the management, investigation and reporting arrangements relating to concerns and complaints.	Medium	Changes will be made to the Concerns Policy and management process in line with the Concerns Improvement project. This will be undertaken via a collaborative process between Corporate and the ILGs and in light of any changes to the Operating Model following the current review.	Director of Nursing	Interim Head of Concerns, Redress & Legal	jun-22	Now September 2022 Now January 2023 Now February 2023 Now May 2023 Now July 2023		In progress	June 2023 Update: The overarching Concerns policy has been drafted and following consultation will be presented to the Q&SC (July 2023) for approval.	April 2023 Update - Recommendation: incomplete, open/yellow. The policy has been reviewed and amended. Awaiting discussion on the ratification process.

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Concerns 4.2	feb-22	Limited	4.2a Management should understand why RTE has not been re-categorising early resolution concerns that were not resolved in the timeframe and take appropriate action to resolve and accurately record in Datix. 4.2b To ensure consistency, a Standard Operating Procedure (SOP) should be in place outlining the process for re-categorising concerns, including who is responsible for performing this task. Training should be provided where necessary.	Medium	4.2a As 4.1 above 4.2b Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above.	Director of Nursing	4.2a Complaints Manager 4.2b Interim Head of Concerns, Redress & Legal	apr-22	Now December 2022 Now January 2023 Now February 2023 Now May 2023		Completed	June 2023 Update: Standard Operating Operating procedures are in place. Centralisation of the complaints functionality ensures a consistent approach to the re-opening and classification of complaints.	April 2023 Update - Recommendation: incomplete, open/yellow. 4.2a - A review of RTE practice has been undertaken and changes made to ensure consistency across the Health Board, along with benchmarking with NHS Wales colleagues within the Complaints Network. Complaints are centralised in February 2023. A workshop with complaints handlers has been held to ensure quality and consistency. 4.2b - Policies/SOPs have been reviewed and amended. Awaiting ratification
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	June 2023 - No update received against this recommendation for the June submission	April 2023 Update - work continues within the Fire Team to update the Site Specific Documents where site changes have taken place. Completion should have taken place by the June 2024 deadline.
Fire Safety Management 4.1	feb-22	Limited	Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	Medium	The Health Board will develop a medium term strategy for fire safety across its sites.	Director for People	Head of Health, Safety and Fire Head of Capital and Estates ILG Director of Operations	mar-23	Now June 2023		In progress	June 2023 - No update received against this recommendation for the June submission	April 2023 Update - the update for April is the same position as February 2023.
Patient Pathway Appointment Management Process Follow Up 3.1	jun-22	Limited	Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members	Medium	This will be addressed by the ILG with colleagues from Performance	Chief Operating Officer	ILG Directors of Operations / Head of Information	sep-22	Now February 2023 Now June 2023		In progress	June 2023 update - work continues. Meeting planned with Audit and the Care Group in June 2023.	April 2023 Update. Representative from the Health Board has met colleagues from Internal Audit and agreed approach to resolve this long standing recommendation. Memo has gone to Service Group Managers and Care Groups outlining in detail the action needed. This includes a look at the areas where focus needed and a lengthy list of contacts that need to be reviewed and updated. Meetings have also been held with Performance and also operational managers "on the ground" to express the requirements. Responses have been received and the content will form the basis of further focus meetings (starting with surgery) where Internal Audit colleagues will meet the operational managers. It is hoped that this approach will allow this recommendation to be closed down in the coming months. All sides are aware of the action taken and are in agreement that this is a reasonable approach.
POW Theatres Fire Safety Works 1.2	aug-22	Limited	The Health Board should appropriately define and operate project linkage to the Senior Responsible Officer.	Medium	Agreed - This will be put in place to consider the options appraisal. The executive structure and personnel changed across this time. The project involves Health & Safety, Capital, and Strategy & Planning. The role of Senior Responsible Officer was therefore re-allocated. The project is currently being re-appraised. Subsequent to this, and pending the options appraisal to Welsh Government, governance will be further addressed as appropriate for the approved scheme. The CEO has also been in receipt of regular informal briefings from the Project Director.	Director of Strategy & Transformation	Project Director	aug-22	Now November 2022 Now January 2023 Now March 2023 Now April 2023		Completed	June 2023 Update - The Director of Strategy and Transformation has been confirmed as the SRO and will chair the Project Board	April 2023 Update - The Director of Strategy and Transformation remains the SRO and has been attending ECMG meetings. The SRO will chair the meeting on the 27th March and the revised meeting structure and programme from this meeting will ensure appropriate linkage to the SRO
POW Theatres Fire Safety Works 3.1	aug-22	Limited	The Health Board should ensure timely completion of contacts.	Medium	Agreed – though in this case, due to the bespoke nature of the contract – a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Director of Strategy & Transformation	Project Director	At future contracts	Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - Still in progress pending confirmation of the approved decant way forward as outlined in point 1.1	April 2023 Update - As soon as there is a revised way forward the contract methodology and delivery requirements can be appraised following a meeting with WG. This is a future recommendation and will be fully incorporated when the HB is in a position to enter into contract to deliver the next phase of works

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POW Theatres Fire Safety Works 4.1	aug-22	Limited	The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Medium	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Director of Strategy & Transformation	Project Director	At future contract awards	Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - Once the decant solution has been agreed and approved by WG the SCP can be re-engaged to develop the business case. The contract may require review depending on the preferred solution	April 2023 Update - As with the point above, works are paused with the ongoing review of decant options. For all future awards there will be an emphasis on competition in awarding contracts wherever this is possible. However future contracts will only be awarded after confirmation of an internally agreed way forward which is also endorsed and approved by WG
POW Theatres Fire Safety Works 4.2	aug-22	Limited	The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - Once the decant option is confirmed the arrangements around appointing the cost advisor for the final construction stage can be confirmed to ensure value for money	April 2023 Update - Once the decant phase and internal works phases are agreed then a cost advisor will require appointment and the HB will undertake a competitive process for the appointment of the same
POW Theatres Fire Safety Works 4.3	aug-22	Limited	The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - please see point above that this will be addressed in conjunction with point 4.2	April 2023 Update - As per the point above, once the way forward is known, agreed and approved then attention can be focused on contractor appointment and appropriate processes
POW Theatres Fire Safety Works 6.1	aug-22	Limited	Upon recommencement of the project, management should utilise Key Performance Indicators in accordance with the contract.	Medium	Agreed. These will be applied as required.	Director of Strategy & Transformation	Project Director	Upon re-engagement with the SCP	Now 2023 Now January 2023 Now March 2023 Now September 2023		In progress	June 2023 Update - As agreed as soon as project recommences and the SCP is re-engaged	April 2023 Update - As per points above, once the way forward is known the KPIs under the Designed for Life framework will be brought in to review the work of the contractors appointed. However this is a future recommendation that will not take effect until contractual works re-commence and have been running as KPIs. Will generally take place quarterly at the end of each quarter post works commencement.
POW Theatres Fire Safety Works 8.1	aug-22	Limited	Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: • contacted sums; • cash flow budgeted to date; • expenditure to date; • forecast out-turn; and • associated variance commentary.	Medium	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Director of Strategy & Transformation	Project Director	aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - Agreed, once the decant solution is confirmed and the SCP re-engaged, standard cost reporting and forecasting will commence and templates are developed in readiness for this	April 2023 Update - This will be fully implemented once the go ahead is given on a preferred option and the project team is reinstated to over see this work
POW Theatres Fire Safety Works 9.1	aug-22	Limited	Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Medium	Agreed. This will be undertaken at the future procurement.	Director of Strategy & Transformation	Project Director	At confirmation of the preferred option	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - Agreed, to be reviewed once the decant option is selected	April 2023 Update - As mentioned above pending agreement of the preferred way forward and approval by WG all letting of future contracts and awards will satisfy value for money requirements

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POW Theatres Fire Safety Works 10.1	aug-22	Limited	A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Medium	Agreed	Director of Strategy & Transformation	Project Director	aug-22	Now November 2022 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - This will be developed once the preferred decant solution is agreed with WG. Paper currently under strategic review	April 2023 Update - As raised previously an updated risk register will be developed and kept updated that accords with the agreed and approved way forward for the decant of theatres and delivery of the required works
POW Theatres Fire Safety Works 10.2	aug-22	Limited	Management should actively monitor and report the value of residual risk v remaining contingency.	Medium	Agreed	Director of Strategy & Transformation	Project Director	aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - Actions as above as this cannot be actioned until works recommence.	April 2023 Update - As above this will be undertaken within the governance structure and meeting structure that will be put in place with confirmation of the agreed and approved way forward and WG funding levels
POW Theatres Fire Safety Works 10.3	aug-22	Limited	Risks should be individually assigned to those best placed to control them, with time parameters for action.	Medium	Agreed	Director of Strategy & Transformation	Project Director	aug-22	Now November 2022 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - will be undertaken on re-commencement of the project in conjunction with the review and update of the risk register	April 2023 Update - Please see above comment on the proposed revisions to the risk register to be introduced in line with the confirmation of preferred delivery and way forward for decant theatres
POW Theatres Fire Safety Works 10.4	aug-22	Limited	An exception report should be published of targeted risk mitigations not achieved.	Medium	Agreed	Director of Strategy & Transformation	Project Director	aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - as above in line with the re-commencement of the project and review of the register	April 2023 Update - Please see above comments on the need to integrate this action with confirmation of the agreed and approved way forward
Digital Operating Model 4.1	nov-22	Limited	The balance between the use of DHCW solutions and development of in house solutions within the operating model should be reviewed to ensure that it matches the needs of the organisation. Consideration should be given to increasing the level of in house development resource in order to provide Health Board specific digital solutions at a pace that suits the Health Board	Medium	Accept Development resources will be considered and proposed as part of subsequent structural reviews. Acknowledgement that any development resource proposal will need to be prioritised against other financial decision points for the Health Board.	Director of Digital	Director of Digital	Qtr. 2 2023 / 2024			In progress	June 2023 Update: New Strategic Leadership roles are in process of being recruited to. £2m allocated to digital. This is now being proportioned to cover all critical resource needs. Compliance roles (IG & Cyber) have been prioritised.	April 2023 Update - Discussions have commenced at an Exec level - particularly around the offering for Mental Health and Critical Care services
Radiology Service Review 6.2	des-22	Limited	Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Medium	All superintendents will be advised of the need to maintain accurate documentation of all decision taken including those outside of the Managing Attendance Policy.	Chief Operating Officer	Superintendent Radiographers	31st December 2022	Now February 2023 Now May 2023 Now August 2023		In progress	June 2023 Update - RGH training delivered to five staff, three outstanding. Coordination of dates challenging with clinical responsibilities.	April 2023 Update - All Superintendents have been informed of their responsibilities in terms of sickness management. A training update session is in the process of being arranged with People's Services. PCH & POW staff have attended an update. Awaiting a training date for RGH to attend.

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Radiology Service Review 6.3	des-22	Limited	The roll out of electronic staff files across the service should progress with all electronic files fully populated with documentation scanned from hard copy files. Consideration should be given to replicating the Standard Operating Procedure developed in other CSGs (such as CAMHS) in relation to the set up and use of electronic staff files.	Medium	The service will liaise with other recommended CSGs who have implemented areas of good practice based on previous findings to establish a Standard Operating Procedures for the electronic files.	Chief Operating Officer	Clinical Services Manager	31st January 2023	Now March 2023 Now May 2023 Now August 2023		In progress	June 2023 Update - work has commenced in POW. All new staff have an E Personnel Folder and work is underway scanning legacy information on to the shared drive.	April 2023 Update - An electronic staff Personnel File has already been implemented for new staff at RGH and PCH. There is a hybrid system for established staff and a system to scan in legacy documents. Work is underway at POW but the current sickness absence in admin team has delayed progress.
Radiology Service Review 8.1	des-22	Limited	a) A review on the approach to how TOIL is managed across the service should be undertaken to ensure there is some level of consistency (between accruing hours and being paid overtime) and staff are being treated equally, whilst meeting the needs of the service in each area. b) Consideration should be given to the number of hours staff are able to accrue as TOIL, given that resource constraints can impact the ability for staff to take the hours back	Medium	a) A review of the approach to TOIL will be undertaken across the three localities to ensure a consistency of approach. b) An agreement will be established to the maximum number of hours that can be accrued as TOIL considering the impact of the ability to take back hours and the potential impact of the service.	Chief Operating Officer	Clinical Service Manager Site Superintendent Radiographers	feb-23	Now March 2023 Now May 2023 Now August 2023		In progress	June 2023 Update - Local Radiology Policy to be drafted and ratified.	April 2023 Update - The team have met to review the current HB policy and will implement across Radiology on the 3 sites. Work is underway to streamline across the 3 sites.
Medical Variable Pay 2.1	feb-23	Limited	2.1a The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. 2.1b The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	Medium	2.1a The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. 2.1b Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	jun-23			In progress	June 2023 Update - DE policy written demonstrates a clear escalation policy in place for care groups. For discussion at Medical Workforce Productivity Programme meeting.	April 2023- DE Policy to be written for Care Groups with a clear escalation policy in place
Medical Variable Pay 2.2	feb-23	Limited	The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.	Medium	All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health board, which will allow the organisation to target and reduce DE use.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	jun-23			In progress	June 2023 Update - DE policy written demonstrates a clear escalation policy in place for care groups. For discussion at Medical Workforce Productivity Programme meeting.	April 23- DE Policy to be written for Care Groups with a clear escalation policy in place
Medical Variable Pay 5.1	feb-23	Limited	Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.	Medium	Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	Medical Director	Assistant Director of Finance/ Assistant Medical Director/Head of Workforce Productivity & eSystems	jun-23			In progress	June 2023 - DE policy written demonstrates a clear escalation policy in place for care groups. For discussion at Medical Workforce Productivity Programme meeting.	April 2023 Update - DE Policy to be written for Care Groups with a clear escalation policy in place
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		In progress	June 2023 - audit very recent, target date now August 2023.	

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Reasonable Offer Process 2.1	apr-23	Limited	We recommend that the Health Board review and revise the training arrangements in place for appointment booking staff in the Bridgend booking team and those that are working directly within specialities, to ensure that they have consistent training, with access to the same level of support and training currently being provided to the booking team based in Merthyr/Rhondda.	Medium	A review of the booking process in Bridgend will be carried out and a training compliance plan for Bridgend developed.	Chief Operating Officer	Head of Clinical Administration Transformation	End April 2023	Now August 2023		In progress	June 2023 - audit very recent, target date now August 2023.	
Reasonable Offer Process 2.3	apr-23	Limited	Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	Medium	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Chief Operating Officer	Director of Operations Planned Care/Head of Clinical Administration Transformation	End June 2023	Now August 2023		In progress	June 2023 - audit very recent, target date now August 2023.	
Reasonable Offer Process 3.1	apr-23	Limited	The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Medium	A training needs assessment and compliance sign off will take place post implementation of the agreed SOP. Refresher training to be organised where required for staff identified.	Chief Operating Officer	CSGMs & for all operational/booking team managers/Head of Clinical Administration Transformation	aug-23			In progress	June 2023 - audit very recent, date remains August 2023.	
POW Theatres Fire Safety Works 2.1	aug-22	Limited	The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Low	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Director of Strategy & Transformation	Project Director	At the business case	Now 2023 Now January 2023 Now March 2023 Now September 2023		In progress	June 2023 Update - see above, this will be addressed on scheme re-commencement as part of the business case process.	April 2023 Update - A resource schedule will be drawn up to deliver the agreed way forward for decant and remediation works which will be part of a business case submitted to WG in 23/24 during the business case development process
POW Theatres Fire Safety Works 7.1	aug-22	Limited	The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works	Low	Agreed	Director of Strategy & Transformation	Project Director	aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023		In progress	June 2023 Update - as previously noted this will be undertaken once the options paper is approved at executive level	April 2023 Update - This review will be undertaken once the way forward, contractual mechanism and procurement route is confirmed. The requirement or not and advice will be included in any tender/appointment and business case process
Reasonable Offer Process 2.2	apr-23	Limited	Further consideration be given to the sharing of training materials, checklists and guidance between Merthyr/Rhondda and Bridgend staff.	Low	In line with 2.1, checklist and guidance will be standardised.	Chief Operating Officer	Head of Clinical Administration Transformation	End April 2023	Now August 2023		In progress	June 2023 - audit very recent, target date now August 2023.	

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Nurse Agency Usage 01	apr-20	Reasonable	1. Clarity should be provided as to whether the Staff Bank Policy Induction Checklist (Appendix C) should be completed or the more recently revised 'Ward induction checklist for bank and agency workers'. 2. Ward Managers / the Nurse in Charge should be reminded of the importance to complete the induction checklist to ensure that new agency nurses are appropriately orientated and provided with relevant health and safety overview of the ward they are due to work on.	High	Induction check list to be reviewed and agreed by Heads of Nursing. Ward Managers & Senior Nurses to receive updated check list that must be completed for all new Bank and agency nurses. Updated Bank/Agency Nurse Induction Checklist to be included into the revised Staff Bank policy.	Director for People	Head of Corporate Nursing	March 2020/April 2020/August 2020	February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		Completed	June 2023 Update - The Staff Bank Policy has been ratified by People and Culture Committee and has been uploaded onto SharePoint for use within CTM.	April 2023 - No update received from the Team on this occasion
Nurse Agency Usage 02	apr-20	Reasonable	1. The Bank / Agency Nurse Quality Monitoring Form should be reviewed to ensure it is fit for purpose and provides a suitable means for the routine monitoring of the quality of work provided by agency staff. 2. Ward Managers should be reminded of the need to complete the quality monitoring form and returning it to the Bank office as a means of formally evaluating the performance of agency nurses and aiding and informing any future acceptance or rejection of potential agency nurses in the event of query or concern. 3. The Clinical Incident Reporting for Agency Staff flowchart and the Staff Bank Policy should be reviewed to ensure consistent guidance for managing and monitoring issues relating to the quality of service provided by agency staff. If the flowchart is the Heath Boards preferred approach, all Ward Managers should be made aware that in line with the agreed flowchart, incidents are appropriately and consistently recorded on DATIX to allow effective monitoring. 4. Attempts to cross-reference patient experience data	High	Revised Clinical Incident Reporting flowchart to be placed into the Staff Bank Policy. Bank / Agency Nurse Quality Monitoring Form will be reviewed to ensure it is fit for purpose and amendments made for updated policy in August 2020. The cross-referencing of patient experience and agency use data is something that we will look into. In the first instance we will need to see if data in relation to patient experience can be obtained from colleagues in the Health Board and we will look to see if meaningful reports can be produced. In the mean-time we will continue to review specific concerns that have been raised via our routine processes.	Director for People	Head of Corporate Nursing	aug-20	October 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		Completed	June 2023 Update - The Staff Bank Policy has been ratified by People and Culture Committee and has been uploaded onto SharePoint for use within CTM.	April 2023 - No update received from the Team 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		In progress	June 2023 - position remains unchanged, new Service Group Manager started in post very recently.	April 2023 Update - position remains the same as the last update.
PCH Redevelopment Governance Audit 03	apr-21	Reasonable	Appropriate arrangements will be made to ensure that vacancies identified within the resource schedule are filled as a matter of priority (O).	High	Agreed. All of the appointments for additional resources are progressing and the Senior Responsible Officer has confirmed that all are permanent positions (Noting that the appointments are for a 5.5 year construction programme and employment rights become permanent due to this duration). Responsibility for the appointments rests with departmental heads to progress these positions with assistance from the Major Projects Unit	Director of Finance	Deputy Senior Responsible Officer	mar-21	01/08/2021 Now November 2021 Now May 2022 Now August 2022 Now October 2022 Now March 2023 Now June 2023		Completed	June 2023 Update - Band 7 appointment commenced in post 1/06/23.	April 2023 Update - Band 7 appointment made with commencement in post 1/06/23.
Welsh Language Standards Compliance 04	okt-21	Reasonable	4.1) Management should review and enhance the reporting and monitoring structures which are currently in place and implement a robust system which provides assurance both to senior management but also provides feedback to the departments and ILGS responsible for implementing Standards. In order to implement this management should consider: • Setting up local Welsh Language Standards working groups within the departments and ILGs which are attended by the key leads from those areas and the Welsh Language Manager, thus allowing localised progress to be given on the status of the action plans and relevant support. • These groups could feed into an overall Welsh Language Group, whose membership should consist of relevant staff from Workforce & Organisational Development along with other areas across the Health Board along with representatives from the local working groups and the Welsh Language Manager. Findings and best practice from ward audits should be shared at this group. • Regular updates against the Standards should be provided to Board, via the People and Culture Committee who are responsible for this monitoring compliance.	High	4.1) The Welsh Language Manager will engage with the ILG SMTs, to determine the feasibility and benefits of establishing local ILG Welsh Language Working Groups and how these would be managed and supported by the Welsh Language Manager. Reporting and monitoring of progress will be strengthened by the requirement for regular compliance reporting, from the nominated Senior ILG leads to the Welsh Language Working Group. The reporting will be further enhanced by having a standard agenda item of "sharing examples of good practice" to assist achievement of compliance in other areas. This information will be provided to the nominated senior ILG lead by the network of ward Welsh Language Champions. The People and Culture Committee when developing its cycle of business for 2022 will incorporate Welsh Language Standards Compliance updates, to be presented and report twice yearly, to provide assurance to the Board.	Director for People	Welsh Language Group Manager/Assistant Director of Workforce/ILG Leads	okt-21	Now December 2021 Now March 2022 Now May 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023 Now March 2023		Completed	June 2023 Update - The Welsh Language Steering Group has now been established and has met twice since March 2023 with a planned programme of meetings for 2023/24. A standing agenda item is Care Groups showcasing best practice initiatives in their areas and sharing the learning wider.	April 2023 - No update received from the Team on this occasion
Overtime & Additional Hours 5.0	mai-22	Reasonable	The functionality available in Health Roster to monitor compliance with the various Working Time Regulations requirements should be used to ensure staff are not in breach of regulations. For those areas not using Health Roster, managers should routinely monitor the hours and working patterns of staff to ensure they are not in breach of WTRs. To do this effectively, they should be aware which staff have opted out of the WTRs and therefore know the upper limit of hours to be worked in a week.	High	The UHB will turn on the Health Roster functionality to block book bank / agency workers to work any non-WTR compliant shifts. The revised Overtime Policy will set out the line manager's responsibility to routinely monitor the hours and working patterns of their staff, to ensure compliance with WTRs, when Health Roster is not used. The Policy will also require the manager to check whether their staff who regularly work overtime have completed a WTR Opt-Out Form. The Overtime Policy will be cross referenced with the WTR Policy	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023 Now August 2023		In progress	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.	April 2023 - No update received from the Team on this occasion

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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		In progress	June 2023 update - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened, Completion by Sept 2023. FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of local monthly P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). Further lunch and learn sessions being scheduled from June 2023 as part of Procurement Engagement plan to target Non compliant areas.	April 2023 update - As part of the Finance Delivery Unit AW P2P group, the No PO policy approach within HBs is being developed as best practice within the HB, and internal communication to Directorates is being strengthened, Completion by Sept 2023. FCPs are being reviewed as part of the new delivery model and update of the SoD. Therefore the FCP will be updated once the new SoD has been approved. CTM systems ensuring training undertaken prior to giving Oracle access to new users, and refresher training being developed. As part of local P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). Further lunch and learn sessions being scheduled from April 2023 as part of Procurement Engagement plan to target Non compliant areas.
Radiology Service Review 3.1	des-22	Reasonable	a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.	High	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via SharePoint underway.	Chief Operating Officer	Senior Superintendents Clinical Leads Superintendent Radiographers Clinical Leads Health & Safety Leads	June 30th 2023	Now August 2023		In progress	June 2023 - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including the governance role has been submitted to the executive board for approval.	April 2023 Update - a) A review of all policies and procedures is an ongoing programme of work. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been ratified.
Radiology Service Review 12.1	des-22	Reasonable	A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.	High	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Chief Operating Officer	Care Group Service Director Care Group Medical Director	30th November 2022	Now August 2023		In progress	June 2023 - Second Phase of planning ongoing and will not be operational until August 2023.	April 2023 Update - Work has been developed within the IMTP framework to address this. IMTP submitted February 2023. A more detailed workforce review is required but is delayed due to the second phase of the wider organisational planning.
Bridgend Transfer of Informatics Services Follow Up 1.1	apr-23	Reasonable	Consideration should be given to requesting that services fully quantify the impact of the lack of integration on the delivery of services and service change, with monitoring with reporting at an appropriate committee.	High	Bridgend disaggregation is reported to every Digital & Data Committee. This reporting will be reviewed to ensure it covers integration, service delivery and service change. The programme is currently developing a template which will assess the impact of any of the repatriation. The template is planned to be completed by June 2023.	Director of Digital	Director of Digital / Assistant Director of ICT	Qtr. 2 2023/2024			In progress	June 2023 Update: Issue raised at Joint Management Group and escalated to Joint Executive Group. Action Ongoing.	
Medical Equipment and Devices Follow Up 03	feb-20	Reasonable	While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Medium	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Chief Operating Officer	Assistant Director of Facilities	apr-20	September 2020 April 2021 July 2021 Now March 2022 Now September 2022 Now January 2023 Now July 2023		Part Completed	June 2023 Update – the current RF-ID tracking system migration is currently in progress by Clinical Engineering, Kinsetsu and UHB ICT, this work is continuing with various information being sanitised and updated for new server which has been installed. ICT infrastructure issues are still restricting/expanding use of system in POW, until the specified SBUHB de-segregation work is completed and fully tested, this will remain an issue (for a number of cross UHB medical device linked projects). Phase 1 of ICT de-segregation is completed with phase 2 and 3 to be completed in next couple of months. Pharmacy are on board with expanding use of system as soon as migration and infrastructure work is completed as there are financial benefits in ability to track CD size cylinders due to the rental costs and lost cylinder charges applicable. Deputy Head Of Clinical Engineering has formulated a bid to expand use of the passive system to support Pharmacy and also by use of new active tag technology exploring costs and infrastructure requirements for active tags which reduce the quantity of passive aerials required for medical equipment tracking as they can in part use existing Wi-Fi infrastructure in place with reduced modification costs where needed. Costs will have to be funded via capital, however we are working with CTM innovation/R & D department to investigate possible technology funding sources. Due capital constraints and how funds are prioritised, any further development will be on hold until funding can be secured. Due to the above a target date remains 31/07/23 .	April 2023 Update - The current RF-ID tracking system Ktrack 1 to Ktrack 2 (new) migration is currently in progress by Clinical Engineering, Kinsetsu and UHB ICT. ICT infrastructure issues are still restricting/expanding use of system in POW, until the specified Swansea Bay desegregation work is completed and fully tested, this will remain an issue (for a number of cross UHB medical device linked projects). Pharmacy are on board with expanding use of system as soon as migration and infrastructure work is completed as there are financial benefits in ability to track CD size cylinders due to the rental costs and lost cylinder charges applicable. Deputy Head Of Clinical Engineering has formulated a bid to expand use of the passive system to support Pharmacy and also by use of new active tag technology exploring costs and infrastructure requirements for active tags which reduce the quantity of passive aerials required for medical equipment tracking as they can in part use existing Wi-Fi infrastructure in place with reduced modification costs where needed. Costs will have to be funded via capital, however we are working with CTM innovation/R & D department to investigate possible technology funding sources. Due to the above a target date remains 31/07/23.

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Nurse Agency Usage 03	apr-20	Reasonable	1. The Staff Bank Policy should be reviewed and updated as necessary to reflect current practice, process and systems in place within the Health Board. The policy should more explicitly reference the engagement and management of agency nurses as opposed to just focussing on Bank staff. 2. Where other relevant policies exist, such as the Rostering Policy, these should be cross-referenced within the Staff Bank Policy. 3. Where procedures are developed to supplement existing policies, reference should be made to the overarching policy and if necessary, the policy should be updated to reflect the existence of the procedure. 4. Senior Nurse Management across the Health Board should ensure the dissemination and awareness of the recently developed procedure for booking bank and agency nurses for use by Ward Managers and the Thornbury authorisation and approval pro forma.	Medium	The Staff Bank Policy will require updating to include the Collaborative Bank project which is due to commence in April 2020. The updated version will include appropriate references to the UH Rostering Policy. The updated policy will include: ▪ The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' ▪ The new Request for Thornbury Nurses proforma. ▪ The updated e-datix reporting algorithm The following documents will be recirculated to Heads of Nursing. ▪ The updated The updated 'Booking Bank & Agency Nurses -Procedures for Ward Managers' ▪ The new Request for Thornbury Nurses proforma. ▪ The updated e-datix reporting algorithm Heads of Nursing to ensure all the documents listed above are circulated to Ward Managers and Senior Nurses.	Director for People		March 2020/April 2020/August 2020	October 2020 February 2021 June 2021 Now September 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		Completed	June 2023 Update - The Staff Bank Policy has been ratified by People and Culture Committee and has been uploaded onto SharePoint for use within CTM.	April 2023 - No update received from the Team on this occasion
Nurse Agency Usage 04	apr-20	Reasonable	1. A review of the Temporary Nursing & Midwifery Staffing Decision Checklist (Appendix 5) contained within the Roster Policy should take place to ensure all aspects remain relevant. Consideration should be given if the checklist needs to be completed for every shift filled by an agency employee or if one checklist could be completed covering all agency shifts needed on a week's rota. 2. The importance of completing the checklist should be reiterated to the Nurse in Charge as means of supporting and substantiating the decision to use agency nursing.	Medium	Appendix 5 in the Roster Policy will be replaced with the updated 'Booking Bank & Agency Nurses -Procedures for Ward. Heads of Nursing to ensure the checklist is re-circulated to Ward Managers and Senior Nurses emphasising the importance of the completion of the check list for all new bank and agency nurses to the ward areas/department.	Director for People	Head of Corporate Nursing	April 2020/May 2020	August 2020 February 2021 June 2021 Now September 2021 Now December 2021 Now April 2022 Now July 2022 Now August 2022 Now October 2022 Now December 2022 Now March 2023		Completed	June 2023 Update - The Staff Bank Policy has been ratified by People and Culture Committee and has been uploaded onto SharePoint for use within CTM.	April 2023 - No update received from the Team on this occasion
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	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Chief Operating Officer	ILG Directors/ General Manager	September 2020/December 2020	01/04/2021 Now April 2022 Now December 2022 Now February 2023 Now June 2023		Part Completed	June 2023 - position remains unchanged, new Service Group Manager started in post very recently.	April 2023 - position remains unchanged.
Risk Management 2021 03	feb-21	Reasonable	Whilst we acknowledge that compiling a Training Needs Analysis is a new task that has been included on the Risk Management Improvement Plan, Management need to ensure that all departments and staff are provided with training on the new Risk Management Strategy, and the use Datix to record risks, as soon as possible. This will help ensure consistency of approach across the organisation.	Medium	A training needs analysis will be undertaken early in 2021. In the interim monthly risk training sessions via Microsoft Teams has been scheduled with an open invite for staff across ILG's to attend.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	apr-21	01/07/2021 Now October 2021 Now December 2021 31.12.2021 - Module 1 Training. Module 2, 3 and TNA - 31.3.2022 Now April 2022 Now October 2022 Now 31 December 2022 Now 31 October 2023		In progress	June 2023 Update - This recommendation is paused as the Health Board continues to wait the implementation of the new OFW Risk Module on Datix to ensure that the Training Needs Analysis aligns with the new system and process. The implementation date continues to be undetermined. The OFW Team Senior Management and Datix Senior Management are meeting w/e 19th May to discuss options with a further meeting of the All Wales OFW Task and Finish Group meeting after that to consider the next steps. A more detailed update should be available at the next meeting.	April 2023 Update - This recommendation remains linked to the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A further meeting with the Task and Finish Group of the OFW Implementation is scheduled for late March 2023. A further update will be reported at the next meeting of the Audit & Risk Committee. The revised implementation is approximate whilst a further programme update is awaited from the Implementation Team of OFW Risk Module. In the meantime monthly risk training is scheduled throughout 2023 which is open to all staff. These sessions are publicised on SharePoint and been included in the Staff Newsletter.
Financial Systems 03	apr-21	Reasonable	1. As part of the ongoing review of the Charitable Funds FCP the inconsistencies between the FCP and Scheme of Delegation should be resolved, and updates made where processes and appendices have been amended. 2. Consideration should be given to introducing tolerance levels, below which finance can approve variations in payment values, as opposed to requiring fund holder authorisation. 3. Relevant staff should be made aware of the revised FCP and old copies of forms removed from circulation.	Medium	Agreed, FCP needs to be reviewed in line with the Scheme of Delegation and updated.	Director of Finance	Head of Corporate Finance	jun-21	01/08/2021 Now November 2021 Now December 2021 Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now January 2023 Now April 2023		In progress	June 2023 Update - no further update to provide in relation to this recommendation	April 2023 Update - No further update, we are still awaiting ICT advice on setting up electronic forms online.
Sunnyside Health & Wellbeing Centre 01	aug-21	Reasonable	Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	Medium	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Director of Finance	Head of Capital	sep-21	Now January 2022 Now 31 March 2022 Now May 2022 Now August 2022 Now December 2022 Now March 2023 Now July 2023		In progress	June 2023 Update - The tender process remains ongoing and therefore the PEP can not be continued until a contractor appointment is confirmed and funded. This will not be known until Late July early August 2023 once returns have been submitted and analysed. Once this occurs an application will be made to WG for funding. Once the funding is confirmed as approved a PEP can be presented to Project Board	April 2023 Update - To date, the PQQ (pre qualification questionnaire) period has closed and only 2 submissions were made. They have been scored and only 1 party taken forward to tender. The tender process will close on 5th June and post this time it should be known if there is a viable tender. If there is then a PEP and revised business case will be drafted with the business case submitted for WG approval and funding. The PEP will be taken to Project Board and approved via the capital structure
Sunnyside Health & Wellbeing Centre 04	aug-21	Reasonable	Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	Medium	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Director of Finance	Senior Project Manager	mar-22	Now July 2022 Now December 2022 Now March 2023 Now July 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Once it has been clarified that there is a competitive tender returned and WG have approved the revised funding level then the contractor can be appointed and at that point all revised cost schedules can be drafted in line with the revised template that has already been created. Once this is in place then this will be updated and reported to the project Board on an ongoing basis but this can not be developed if there is no viable tender return and WG approval in the summer

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Sunnyside Health & Wellbeing Centre 05	aug-21	Reasonable	Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	Medium	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Director of Finance	Senior Project Manager	jan-22	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Once the tender process has completed and WG have approved a revised works cost then the requirement for WG dashboard reporting will recommence, at that stage CTM will ensure that all dashboards are properly and fully completed. Until tenders are returned in June however the existence of a viable tender and likely timeframe can not be confirmed.
Sunnyside Health & Wellbeing Centre 07	aug-21	Reasonable	Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	Medium	These are available and will be supplied by the developer.	Director of Finance	Senior Project Manager	sep-21	Now November 2021 Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Review July 2023 but could be later depending on timings of approvals		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Following the outcome of the current tender process and WG approval of the revised tender sum and works cost, a whole new contract will need to be awarded to the new contractor and the Health Board will ensure that as soon as these are executed that they are made available as copies for the project file.
Sunnyside Health & Wellbeing Centre 10	aug-21	Reasonable	Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	Medium	This will be provided when the project restarts and all design works are completed.	Director of Finance	Senior Project Manager	No Date Identified	01/03/2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Once there is a contractor as per the points outlined above then the contract can be put in place. Variations will be recorded through the project reporting structure
Sunnyside Health & Wellbeing Centre 11	aug-21	Reasonable	The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	Medium	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Director of Finance	Senior Project Manager	mar-22	Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - As mentioned previously, these communications will be put in place and reported in line with requirements. The newly appointed contractor will be made aware of their requirements to report accurately and in a timely manner
Sunnyside Health & Wellbeing Centre 12	aug-21	Reasonable	A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	Medium	A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	Director of Finance	Head of Capital	nov-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - A risk register is currently in place but will have to be updated in line with a new contractor and WG approval sum. Once this takes place the risk register will be kept under regular review and updates through the project reporting structure
Sunnyside Health & Wellbeing Centre 13	aug-21	Reasonable	Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	Medium	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Director of Finance	Head of Capital	sep-21	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - As mentioned above, once there is a contractor and an approved WG funding sum then the contingency can be confirmed and risks can be measured against this.
Sunnyside Health & Wellbeing Centre 15	aug-21	Reasonable	The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	Medium	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Director of Finance	Project Leader	sep-21	Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - This will take place once the new contractor is appointed and updates on the process and timeframe have been provided above
Sunnyside Health & Wellbeing Centre 18	aug-21	Reasonable	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Medium	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Director of Finance	Primary Care Estates and Development Manager	jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now October 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Once there is a contractor in place and the revised cost and programme is known then lease arrangements can be developed
Sunnyside Health & Wellbeing Centre 19	aug-21	Reasonable	Management should confirm an agreed service model with measurable outcomes for front line and support services.	Medium	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Director of Finance	Bridgend ILG Community Lead	mar-22	Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Once the revised programme is confirmed then regular meetings will recommence and the service planning will need to restart to deliver within the revised works programme

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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		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - These will be updated and revised with the resubmitted business case being provided to WG once it is known if the tender process has been successful
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		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - These will be updated and revised with the resubmitted business case being provided to WG once it is known if the tender process has been successful
Welsh Language Standards Compliance 06	okt-21	Reasonable	6.1) The importance of compliance with the Welsh Language Standards should be reiterated to all staff, and the implications of non-compliance should be considered for inclusion on departmental and ILG risk registers and subsequent monitoring. 6.2) The risk register should be reviewed to ensure the controls listed as being in place and the action marked as completed are an accurate reflection of the findings made during the audit review.	Medium	6.1) The Welsh Language Manager will develop regular communications to remind all staff of their responsibilities and the importance and benefits of complying with the Welsh Language Standards. These communications will be distributed to staff via a range of communications media, including social media. 6.2) The nominated senior ILG leads on the Welsh Language Working Group should discuss with department managers, the inclusion of non-compliance with the Standards on their departmental registers, to assist with the monitoring of progress and completion of outstanding actions. 6.3) The Welsh Language Manager will review the actions on the current Workforce and OD and Health Board Risk Registers to ensure that they are up to date and include the risks identified in this audit report. 6.4) The nominated ILG senior members of the Welsh Language Working Group will have responsibility for adding relevant and appropriate non-compliance issue to the ILG risk registers, which are monitored by the respective SMTs.	Director for People	Welsh Language Manager/ILG Leads/Head of Policy, Compliance and Agenda for Change	January 2022/October 2021	Now March 2022 Now June 2022 Now August 2022 Now October 2022 Now December 2022 Now January 2023 Now March 2023		Completed	June 2023 Update - The Welsh Language Steering Group has now been established and has met twice since March 2023 with a planned programme of meetings for 2023/24. A standing agenda item will be Risks to consider departmental non-compliance with the Welsh Language Standards and the inclusion of risks on local risk registers for monitoring.	April 2023 - No update received from the Team on this occasion
CHC and FNC 1.2	feb-22	Reasonable	1.2 A terms of reference for the Clinical Service Group Panels and Integrated Locality Groups panels should be put in place to set out the roles of each panel, their decision-making responsibilities and membership and quoracy arrangements. When developing the ILG panels terms of reference, consideration should be given to decision making powers of the panel when they are making funding decisions on behalf of another ILG for cases where the individual does not reside in their ILG area.	Medium	1.2 • Clinical Service Group Terms of Reference are in draft and are to be finalised by March 31st 2022, to include decision-making responsibilities, membership and quoracy arrangements. • Integrated Locality Group Unit Panel Group Terms of Reference will be reviewed and updated in line with the CSG ToR above and will be approved by March 31st 2022.	Chief Operating Officer	Lead Nurse for CHC and NHS Funded Care	mar-22	Now July 2022 Now October 2022 Now December 2022 Now March 2023 Now June 2023		Completed	June 2023 Terms of Reference were completed. However we have had to redraft them in line with the New Operating Model. Now complete.	April 2023 Update - ToR still in draft will be finalised by June 2023.
CHC and FNC 1.3	feb-22	Reasonable	1.3 The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board.	Medium	1.3 The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed.	Chief Operating Officer	Finance Manager CHC/Finance Manager Commissioning and Contracting	mai-22	Now August 2022 Now October 2022 Now December 2022 Now April 2023 Now June 2023		In progress	June 2023 Update - Finance element not completed, will be chased for the next update.	April 2023 Update - CHC Finance Team are currently drafting Financial Control Procedure and will liaise with us to confirm when completed.
Overtime & Additional Hours 1.1b	mai-22	Reasonable	Given the time and events that have passed, a reminder should be issued to all senior managers in relation to the Overtime and Additional Hours Policy, including the authorisation process to follow if payments outside of AfC are necessary.	Medium	The Workforce Policy Review Group will ensure that this is included in the policy and that the current and future versions of the Overtime Policy are shared with the managers within the UHB. The current policy is available via the intranet. Further communications will be sent out in the Staff Bulletin and via the ILG Heads of Workforce briefing, with the senior management Team and cascaded to managers on their email distribution lists.	Director for People	Head of Workforce Productivity and E-Systems / Assistant Director of Policy, Governance and Compliance	jun-22	Now November 2022 Now January 2023 Now March 2023 Now August 2023		In progress	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.	April 2023 - No update received from the Team on this occasion
Overtime & Additional Hours 1.2	mai-22	Reasonable	Procedure documents in relation to overtime should be developed and made available to those areas that do not currently use Heath Roster. The procedure should cover key points such as how overtime is captured and any prior authorisation required, and the checking and authorisation process that managers should follow. A standardised claim form should form part of the procedure.	Medium	There currently is guidance contained in the Overtime Policy directing managers on overtime use and application. The WPRG will undertake to review this policy to ensure that it is fit for purpose and reflects the requirement of the audit recommendation.	Director for People	Assistant Director of Policy, Governance and Compliance	nov-22	Now January 2023 Now March 2023 Now August 2023		In progress	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.	April 2023 - No update received from the Team on this occasion

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Overtime & Additional Hours 2.1	mai-22	Reasonable	The value and practicality of using the overtime authorisation checklist should be reviewed. Consideration should be given to alternative approaches for capturing the justification and authorisation of overtime in advance of it being worked. For example, in some instances, it may be more efficient to have one justification checklist completed and approved per department but reviewed periodically.	Medium	The Overtime Policy review will be undertaken by the Workforce Policy Review Group (WPRG), in partnership with local trade union colleagues and key stakeholders. The revised Overtime Policy will set out the new, more practical approach for capturing the justification and authorisation of overtime in advance of it being worked in accordance with the Audit recommendation. Provision will be made within the revised Overtime Policy to address both circumstances i.e. consistent use of overtime and occasional use, ensuring that clear guidance is provided on how to manage both in Health Roster and outside of Health Roster.	Director for People	Assistant Director of Policy, Governance and Compliance	nov-22	Now January 2023 Now March 2023 Now August 2023		In progress	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.	April 2023 - No update received from the Team on this occasion
Overtime & Additional Hours 2.2	mai-22	Reasonable	If the approach to using the overtime authorisation and justification checklist is to be consistently used in the future, then the information being captured should be reviewed and scrutinised in order to understand the underlying reasons for use of overtime and to aid the development of plans to address those issues.	Medium	The revised Overtime Policy will outline the responsibility of the Workforce Efficiency Team to regularly review and analyse the overtime authorisation and justification checklist data to provide the UHB with intelligence on the reasons for overtime, which will assist the organisation to review and development the Workforce Plan to address the identified issues. The Workforce Efficiency Team will explore alternative more practical approaches for capturing the justification and authorisation of overtime in advance of it being worked in accordance with the Audit recommendation. This work will be undertaken in parallel with the review of the Overtime Policy, to ensure this process is reflected within. The new process will form the basis of a clear and auditable overtime justification and authorisation process.	Director for People	Assistant Director of Policy, Governance and Compliance /Head of Workforce Productivity and E-Systems	nov-22	Now January 2023 Now March 2023 Now August 2023		In progress	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.	April 2023 - No update received from the Team on this occasion
Overtime & Additional Hours 3.0	mai-22	Reasonable	A standardised claim form for capturing overtime and additional hours should be in place, that incorporates the requirement for individuals to confirm the hours they have worked, and for management to authorise the claim ahead of input on pay return. Claim forms also need to be clear about the need to capture time net of breaks.	Medium	A single standardised claim form, for the use in all non-health roster areas will be developed by the WPRG and contained within the Overtime Policy, for all areas of the UHB to access and use. The form will be based on the standardised NWSSP Payroll form for overtime and additional hours claims, which will contain information on the shift worked, the date, time, rate of pay and who has approved and authorised the payment. Once the Overtime Policy is reviewed and ratified all former UHB overtime forms in circulation and use will be withdrawn (removed from SharePoint etc.) and Payroll instructed to only accept and process the new standard form for payment.	Director for People	Head of Workforce Productivity and E-Systems	nov-22	Now January 2023 Now March 2023 Now August 2023		In progress	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.	April 2023 - No update received from the Team on this occasion
Overtime & Additional Hours 4.0	mai-22	Reasonable	Now that all Covid related agreements for payment of higher overtime rates have concluded, a review of payroll data should be carried out to identify departments that are continuing to pay staff outside of the AfC terms and conditions. Payroll codes set up specifically for such payments should be closed to prevent usage. Where it identified that payments outside AfC remain, discussions should be held with the departments to ascertain the reasons why. If necessary, the appropriate procedure should be followed to obtain authorisation in line with the scheme of delegation to continue with such payments.	Medium	Review of Payroll Overtime enhancement codes undertaken by Head of Workforce Productivity and e Systems with an NWSSP Payroll manager to ensure all non AfC payroll codes are closed immediately. The revised overtime policy will set out that all overtime and enhanced payments will be paid only in accordance with AfC. Should a department wish to deviate from these arrangements a discussion must take place with Executive Director for People.	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023 Now August 2023		In progress	June 2023 Update - The Overtime Policy has been consulted on and comments and amendments noted, actioned as appropriate. The revised version will follow the ratification process and be presented to the People and Culture Committee in August 2023 for approval.	April 2023 - No update received from the Team on this occasion
Consultant Job Planning Follow Up 5.1	mai-22	Reasonable	Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	Medium	A paper discussing the principles on which a rate card will be developed has been submitted to Director of People. Agreement of these principles will then result in the engagement of interested parties to develop the rate card.	Director for People	Director for People	des-22	Now April 2023 Now August 2023		In progress	June 2023 Update - Although not formally confirmed yet, it seems that there will not be an all Wales rate card issued in the near future. Therefore, a proposal for a CTM rate card will be presented to Executive team in June 2023 with a proposed summer launch date.	April 2023 - There is work currently taking place looking at a regional rate card in collaboration with all other Welsh NHS Organisations. This work is being led by NWSSP. • Whilst this work is ongoing we are discussing with finance colleagues about a possible in house rate card for non-Consultant CTM staff. This is in its infancy of discussion. A consultant rate card requires further work and analysis. • Of note there has been a recent rate card released by the BMA in Wales and England for junior Doctors, SAS and Consultants. These rates are not sustainable or affordable by CTM. As a result engagement events have been held by the AMD for Medical Workforce to all junior doctor messes and with the wider Medical Workforce.
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		In progress	July 2023 Update: The overarching Concerns policy has been drafted and following consultation will be presented to the Q&S Committee in July 2023 for approval. LFER Improvement plan is ongoing, with a trajectory to reduce deferred LFERS. Dashboards to be implemented to allow live monitoring of LFERs The SOPs in respect of LFERs (including new escalation process) have been drafted and are to be agreed before presenting to the Q&S Committee for approval.	April 2023 Update, recommendation, incomplete, open/red. 1.1aLegal Services SOPs have been reviewed and updated. 1.1b LFERs are regularly monitored via reports/trackers and dashboards. Datix Cymru has been updated to enable better tracking of red/amber deferred cases. These are regularly monitored via weekly data review meetings and Executive Patient Safety meetings. 1.1c Spot check audits undertaken by the Legal Services Manager Regular engagement with Welsh Risk Pool. LFER improvement plan devised, prioritising as appropriate, between legacy cases and new cases, as well as high value claims. LFERs have been given as a key responsibility for PSIM within the new operating model.

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Welsh Risk Pool Claims 2.1	jun-22	Reasonable	Procedures should be in place that provide staff with clear guidance on how to process claims, especially the dates that are to be used in relation to the 'Decision to Settle' and 'Final Payment', and the circumstances of when these dates should be updated in Datix. Guidance should also cover the other issues we identified including the correct process for capturing financial transactions in Datix and the process that should be followed if a claim is dismissed when taken to court.	Medium	2.1 Legal Services SOPs to be reviewed and updated and staff to be retrained where appropriate. 2.2 SOP to be devised to assist staff through the financial process if a claim is dismissed.	Director of Nursing	Legal Services Manager	des-22	Now January 2023 Now February 2023 Now May 2023 Now July 2023		In progress	June 2023 Update: The Legal services SOP for managing Claims and Redress has been drafted and following consultation will be presented to the Q&S Committee (July 2023) for approval. This includes the operating procedures in relation to financial limits.	April 2023 Update 2.1 Legal Services SOPs have been reviewed, meeting with Cally Hamblyn to discuss ratification 2.2 Financial SOP to be developed
Financial Systems 8.2	jun-22	Reasonable	In cases where it is appropriate, management should explore the use of alternative mechanisms for raising orders and paying invoices, for example the use of 'call off' orders.	Medium	As above, we will identify the areas where retrospective orders are raised and review alternative mechanisms for order or payment.	Director of Finance	Head of Procurement	mar-23	01/09/2023 (aligned to AW T&F exemption list review)		In progress	June 2023 update - Alternative methods of payments will be reviewed as part of AW PO exemption list T&F group by Sept 2023. AW T&F group being led by Head of Corporate finance and Head of Procurement.	April 2023 update - Alternative methods of payments will be reviewed as part of AW PO exemption list T&F group by Sept 2023. AW T&F group being led by Head of Corporate finance and Head of Procurement.
Financial Systems 8.3	jun-22	Reasonable	Where a retrospective order is deemed appropriate, staff should be encouraged to complete the notes section of Oracle explaining the reason for use of a retrospective order, including details of who requested the goods or service to be procured.	Medium	Where retrospective orders are deemed acceptable, further training will be given to end users to ensure notes are completed within Oracle	Director of Finance	Head of Procurement	mar-23	Now September 2023		In progress	June 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly	April 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly
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		In progress	June 2023 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by June 2023. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB.	April 2023 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by May 2023. Year end demands and stretched resource had delayed development of CTM share point and NWSSP Buyers toolkit
CSG & ILG Quality Assurance 3.0	aug-22	Reasonable	All ILG Quality and Safety Groups and their constituent CSGs should establish annual quality assurance work plans that will allow focus, monitoring and reporting on their relevant quality issues and objectives in a targeted manner.	Medium	Response as in 1.1; The health board is in transition period of adopting a new operating model. The current framework (Nov 2020) describes quality governance arrangements within the current model of Integrated Locality Groups (ILGs), including a template for Quality, Safety & Patient Experience (QSPE) meetings, terms of reference, frequency, agenda and more recently common quality measures. It is recognised that this clear direction was not extended to the Clinical Service Group (CSG) structure, which was very much in its early stages of development in 2020. This assurance audit was requested to explore the governance interface in relation to CSG, ILG and Health Board assurance, escalation and risk. This has been a very helpful activity in reaffirming the need to apply a standardised framework to CSG's for good governance and assurance from service point to Board line of sight. This granular governance will be articulated through the revised Quality & Patient Safety Framework and embedded within the new Care Group operating model. In addition, the requirement of annual work plans for Clinical Service Groups will be re-established and monitored through the new Care Group model governance system. Progress against CSG annual plans will be upwardly reported by Care Groups to Quality and Safety Committee on a yearly basis.	Director of Nursing	Assistant Director Quality & Safety Care Group Nurse Directors	des-22	Now January 2023 Now May 2023 Now September 2023		In progress	June 2023 Update: Care Group Q&SC are embedding within the new operating model and following phase 2 of the OCP the newly developed CSG will replicate the care group Q&SC structure	April 2023 Update - Recommendation: incomplete, to remain open. Whilst appropriate governance reporting structures exist across the health board and are feeding into the Quality and Safety Committee, a program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.

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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		In progress	June 2023 Update - For discussion at LNC meeting scheduled to take place on 13th June 2023 for noting and implementation.	April 2023 Update - The policy has been updated and amended as recommended. The policy is now being processed through Policy Review Group. The policy will then be taken to the next Local Negotiating Committee for noting and implementation.
CAMHS Workforce Follow Up Review 2.1	aug-22	Reasonable	a) The SOP in relation to the set up and use of electronic staff files should be finalised. b) All current electronic files should be fully populated with documentation scanned from hard copy files. c) The roll out of electronic staff files to all other areas of the CSG should commence.	Medium	a) A SOP is being drafted by the Swansea Bay CAMHS locality Senior Nurses on the set up and use of electronic staff files and will be taken to the Quality, Patient Safety and Experience meeting for review and discussion prior to sign off. b) Swansea Bay CAMHS locality Senior Nurses will ensure all current electronic files will be fully populated with the documentation from the hard copy files c) CTM CAMHS locality will commence the roll out of electronic files following sign off of the SOP to approach and any learning from the Swansea Bay CAMHS team	Chief Operating Officer	a) Senior Nurses for Swansea Bay CAMHS locality b) Senior Nurses for Swansea Bay CAMHS locality c) Head of Nursing and Senior Nurses for each locality	a) End of October 2022 b) End of September 2022 c) End of November 2022	Should all be complete by November 2022 Now January 2023 Now March 2023 Now October 2023		In progress	June 2023 Update - SOP has been shared at CAMHS Quality, Safety and Patient Experience meeting and no comments received. It has been shared with HR colleagues and the SOP will be formally signed off at next CAMHS meeting at the end of June. Teams have been asked to develop an implementation plan for moving to the electronic records and this will be done in a phased approach. In the interim there is an agreed process around where staff files are held and how they can be accessed if staff members are not in work, which addresses the initial concern from the audit.	April 2023 Update - SOP will be reviewed for sign off in the CAMHS Quality, Safety and Patient Experience meeting at the end of March. In the interim there is an agreed process around where staff files are held and how they can be accessed if staff members are not in work, which addresses the initial concern from the audit.
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	June 2023 Update: Proposals being developed. New standardised procedure for booking patients moving across Health Board has been developed. Further work required for a comprehensive suite of procedures.	April 2023 Update - In progress - discussions ongoing regarding a phased approach to standardisation of process - commencing with booking processes and alignment of functions
Radiology Service Review 1.1	des-22	Reasonable	The Terms of Reference for all groups and committees should be reviewed to ensure they are up to date and relevant, including information such as purpose and remit of the group, attendees and quoracy arrangements, frequency of meetings and arrangements for rescheduling.	Medium	Due to the HB restructure, the previous Radiology Performance Meeting Forum has been stood down and replaced with a weekly Care Group Radiology Performance Review. ToR to be sourced from the Executive Office to reflect attendees, quoracy and frequency of the meetings while the care group structure beds in. A Radiology Quality, Improvement & Governance Structure Meeting has been arranged to update the governance meeting arrangements, reporting structure and review of ToR on 9/11/2022.	Chief Operating Officer	Executive Office Clinical Service Manager Senior Superintendents Clinical Lead for Quality and Governance Health and Safety Leads	31 December 2022 9 November 2022	Now March 2023 Now April 2023 Now August 2023		In progress	June 2023 - Radiology Team actions complete. ToR for monthly Radiology Performance meeting to be provided by executive team.	April 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. Executive lead for Performance Review to provide ToR. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR for QI&G and the first new meeting took place on 25/01/23, with vice chair appointed.
Radiology Service Review 2.1	des-22	Reasonable	a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	Medium	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancelation the members will review the agenda to assess whether there are any urgent matters that require action and re arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	Chief Operating Officer	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads	30-nov-22	Now March 2023 Now April 2023 Now August 2023		In progress	June 2023 - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager. A management structure including the governance role has been submitted to the executive board for approval. Changes to current monthly Radiology Performance meetings discussed and new structure. Executive team to update.	April 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups. Executive department to provide ToR for Performance Review Meetings. The Radiology Quality, Improvement and Governance Chair and management have met to finalise the ToR and the first new meeting took place on 25/01/23. A Vice Chair has been appointed to oversee meetings in absence of Chair. Radiology ToR for QIG completed action.

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Radiology Service Review 2.2	des-22	Reasonable	Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	Medium	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	Chief Operating Officer	Clinical Service Manager	des-22	Now March 2023 Now May 2023 Now August 2023		In progress	June 2023 - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including the governance role has been submitted to the executive board for approval.	April 2023 Update - A standardised ToR is in the process of being implemented for all meeting groups.
Radiology Service Review 4.1	des-22	Reasonable	a) Acknowledging that for 2022/23 the Standards of Behaviour Policy has been amended, and less categories of staff will be required to make a return, relevant staff within Radiology should be reminded of the relevance of the policy and the requirement to comply with it and complete an annual return. Where individuals fail to make a return, managers should continue to prompt staff to do so. b) Management should work with the Committee team to identify any gaps in the declaration of interest reporting.	Medium	a) The register of the declaration of interest information is maintained by the Corporate Service Department and submissions are registered and updated through this Department. A request for any outstanding declaration of interest will be made to the Corporate Services Department to identify those individual where these are outstanding and the relevant staff will be prompted to complete. b) A system of review will be agreed with the Corporate Services Department.	Chief Operating Officer	Corporate Services Manager/Clinical Service Manager	31st December 2022			In progress	June 2023 - No update received against this recommendation for the June submission	April 2023 Update - DOI data/info to be provided by Corporate Team.
Radiology Service Review 13.1	des-22	Reasonable	To allow more effective monitoring, improvements should be made to the data and reporting format of information taken to the Performance Review meetings, including: • Having a level of consistency in the data so that management can differentiate between the data of the constituent services within the CSG. Similarly, where necessary the breakdown of data across localities should be in place. • Performance data on areas such as workforce and quality should be presented at every meeting. • Where performance targets are included, it should be clear if the target is an internal CSG one. Any Health Board and Welsh Government targets should also be included and reported against to allow comparisons to other CSGs. • IMTP priority updates and actions should be better articulated to determine what is actually	Medium	A new system of Performance Review across the Care Group has now been established with weekly meetings with the Chief Operating Officer and monthly Business Meetings. The exact format of the Business Meetings has yet to be finalised but it is anticipated that they will: • Have a level of consistency and accuracy in the data so that management can differentiate between the data of the constituent services within the CSG and plan to address gaps. • Report Performance data on areas such as workforce and quality and risks at every meeting. • Include any Health Board and Welsh Government targets and trajectories towards achieving them. • Include any IMTP priorities and actions in the wider health board IMTP.	Chief Operating Officer	Care Group Director	31st December 2022	Now March 2023 Now April 2023 Now August 2023		In progress	June 2023 - ToR to be sought from executive team	April 2023 Update - There is no formal agenda for the monthly performance meeting. Following receipt of the ToR, this will enable the department to follow an agenda or inform expectations for reporting consistently. Ongoing.
Board Awareness of Digital	apr-23	Reasonable	Training sessions that have already been delivered at Board Development sessions should be revisited as part of the 2023 Board members training and development schedule. Board members are encouraged to proactively familiarise themselves with training topics to aid their ability to lead the digital agenda and enable digital transformation.	Medium	In partnership with the Corporate Governance team, we will ensure regular board development sessions to include topics such as Cyber, Data Visualisation and awareness of the latest digital developments.	Director of Digital	Director of Digital	des-23			In progress	June 2023 Update: Board development sessions being planned. eWhiteboards has been added to the list alongside Digital Patient Contact. Planned for later in the year	
Board Awareness of Digital 2.1	apr-23	Reasonable	We encourage the Board to reflect on the above feedback and consider the need for more digital experts and champions across all areas of the Health Board to help engage staff with digital transformation and increase their digital literacy.	Medium	In partnership with the Chief Operating Officer, there is now Digital & Data representation at the new Care Group Operating Management Board and Improving Care Board	Director of Digital	Director of Digital	mar-23			Completed	June 2023 update: Visible leadership from Care Group Leads on the adoption of digital ways of working. Governance still being developed to support this further. Ongoing action. Propose to close	

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Bridgend Transfer of Informatics Services Follow Up 2.1	apr-23	Medium	Consideration should be given to expanding the risk description on the organisational risk register to bring in the wider financial, organisational and reputational impacts.	Medium	The relevant risk on the risk register will be reviewed to ensure it fully incorporates all aspects of financial, organisational and reputational risk impact	Director of Digital	Director of Digital	Qtr. 1 2023/2024			Completed	June 2023 Update: Risk has been reviewed and reported to Digital & Data Committee. Proposed to close.	
Health & Safety Management 06	aug-20	Reasonable	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Director for People	Head of Health, Safety & Fire	01/01/2021 Now 31 May 2022	01/07/2021 Trial Audit on Social Distancing completed August 2021. New completion date for audit package to be suitable for H&S Audits 31/01/2022 Now May 2022 Now September 2022 Now February 2023 Now June 2023		Part Completed	June 2023 - No update received against this recommendation for the June submission	April 2023 Update - Findings from the recent Health and Safety Audit were provided to the Heath, Safety and Fire Sub Committee in February 2023. Problems are still present with the use of AMaT to present the data captured and following discussions with the Clinical Audit Team, the Health and Safety Team are having to explore the use of alternative audit packages.
Financial Systems 06	apr-21	Reasonable	Management may want to consider creating a procedure, as it will help strengthen efficiencies, deliver best practice and more importantly it will provide added support should the department have new staff working in that area.	Low	Agreed. A manual for the fixed asset register will be created.	Director of Finance	Finance Manager	sep-21	Now September 2022 Now November 2022 Now December 2022		Completed	June 2023 Update - This was completed for the financial year end. A manual is now in place for the fixed asset system - 31st March 2023	April 2023 - No update received from the Team on this occasion
Sunnyside Health & Wellbeing Centre 09	aug-21	Reasonable	Performance of relevant parties should be monitored appropriately	Low	As above although there will be a delay with the appointment of a new contractor.	Director of Finance	Senior Project Manager	sep-21	Now January 2022 for Contractor only Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Once a contractor is in place then agreed KPIs will be used to monitor ongoing performance
Sunnyside Health & Wellbeing Centre 17	aug-21	Reasonable	Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	Low	The Health Board already has in places processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Director of Finance	Senior Project Manager	nov-21	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023		In progress	June 2023 Update - The actions remain as for the previous meeting as the tender window has still not closed	April 2023 Update - Once the contractor is appointed the agreed mechanism for sign off of variations can be put in place
CSG & ILG Quality Assurance 2.0	aug-22	Reasonable	Quality governance training should be provided to all relevant staff in the ILGs and their constituent CSGs to ensure a sound understanding of quality assurance principles and practices	Low	The Health Board launched a new Patient Safety Incident Management Framework and Toolkit in June 2022. This describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. In July 2022, the Health Board also launched a rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience. The training also introduces the important concepts of psychological safety, human factor errors and safety thinking. Attendance is recorded on the Health Board's Electronic Record System, which ensures that those undertaking incident investigations are appropriately, and consistently trained to improve standards and performance. Bespoke Datix training has been rolled out by the Datix Management Team following the adoption of the Once for Wales incident module, and is ongoing. The corporate team have initiated good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. Training sessions are supported by the Health Board's Communication channels, Intranet SharePoint system where further information and assistance for colleagues is signposted by the Patient Care and Safety site. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework.	Director of Nursing	Assistant Director Quality & Safety	The nature of this action is ongoing; however, the new structure will provide an opportunity to target CSGs. Quality & Patient Safety Framework December 2022	Now January 2023 Now June 2023		In progress	June 2023 Update: phase one is in progress with phase two as outlined in last month's update to then take place within the care groups. The objective is still on target for June 2023 completion.	April 2023 Update - Recommendation: incomplete, open/yellow. The leadership teams are to have understanding and all staff have RCA training for moderate & above moderate reviews as set out within the DofC-hofQlty and clinical care group. A request via Heads of Quality to respective care groups and the corporate team to: 1. establish an assessment as to the number of current RCA and governance trained senior staff, 2. establish a list of core senior team members to be trained. This will ensure each service group is represented by a core group of trained individuals to fulfil governance and learning requirements as an initial baseline. The initial assessment is to be completed by end of April 2023, and phase 2 is to be completed by end of June 2023. This action can then be considered complete and closed.
CSG & ILG Quality Assurance 5.0	aug-22	Reasonable	For clarity, each CSG should consider mapping out its quality assurance reporting and oversight arrangements from the CSG up to the ILG Quality and Safety Group.	Low	This will be actioned through the new Quality and Patient Safety Framework as detailed in earlier agreed management actions.	Director of Nursing	Assistant Director Quality & Safety	des-22	Now January 2023 Now May 2023 Now June 2023		In progress	June 2023 Update: phase one is in progress with phase two as outlined in last month's update to then take place within the care groups. The objective is still on target for June 2023 completion.	April 2023 Update - Recommendation: incomplete, open/yellow. A program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.
iCTM – Quality Improvement Team 3.2	des-22	Reasonable	The updated faculty framework document should be formally approved with the date of approval and issue recorded on the document.	Low	As part of its response to this audit we are producing an overarching set of procedures and guidance for the iCTM Improvement Team which will incorporate this recommendation.	Director of Nursing	Assistant Director Improvement Culture, Capability & Delivery	mar-23	Now April 2023 Now June 2023		In progress	June 2023 Update: Faculty post only recently recruited to so framework will be updated June 2023	April 2023 Update - The Faculty framework has been reviewed but not yet formally approved. This will be done shortly via the Executive Nurse Director with an expectation that the faculty framework will be formally approved by 28th April 2023.
Wellbeing 5.1	feb-23	Substantial	The 'Inspiring People' Group should provide a return to a formal and regular oversight and monitoring of the Wellbeing Priorities Work plan and the work of the Employee Wellbeing Services as whole. However, arrangements under the new operating model structure for locality based wellbeing groups should be made to ensure localised communication is not lost.	Medium	The Inspiring People Group will provide a mechanism for overseeing and reporting on Health and Wellbeing activity and through its representation provide an opportunity to test new ideas and share learning. The need to maintain good communication to wellbeing groups within the service is recognised	Director for People	Assistant Director of OD & Wellbeing	31.1.2023 (inaugural meeting)	Now April 2023		Completed	June 2023 Update - The Wellbeing work programme will be shared for regular oversight at the People directorate Business & Transformation meeting. For strategic direction & monitoring of the priorities against the CTM People Plan, this will be delivered through the Inspiring People Board.	April 2023 Update - Inspiring People Programme Board has been set up, an initial meeting has taken place with the Executive and Deputy Sponsor. Our first formal meeting is due to take place 17 April 2023.

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Board Assurance Framework 2.1	apr-23	Substantial	The Risk Management Strategy & Board Assurance Framework should be reviewed to provide greater clarity in relation to 'action plans', making it clear that the action plans form part of the BAF. Guidance should be incorporated in relation to the expected information to be captured for the 'gaps in controls and assurances' and 'mitigating action', so a consistent approach across the strategic risks and a clear link between gaps and actions can be applied. Timeframes for actions should be included to allow ongoing monitoring.	Medium	The review of the Risk Management Strategy and Board Assurance Framework will include explicit reference that the action plans for the strategic risks forms part of the Board Assurance Report and what is expected in terms of that section of the report.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	31.5.2023			Completed	June 2023 Update - Completed This action has been completed and is captured in the Draft Risk Management Strategy seeking approval by the Board at the end of May 2023.	
Board Assurance Framework 2.2	apr-23	Substantial	Management should review the 'gaps in controls and assurances' and 'mitigating actions' section of the BAF to ensure points clearly articulate what the gap is and what mitigating action is being taken to address the gap. There should be a clear link between gaps and mitigating actions.	Medium	The Assistant Director of Governance & Risk in conjunction with the Strategic Risk Owner will review all gaps in control to ensure there is a robust mitigating action aligned.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk and Strategic Risk Owners	31.5.2023			Completed	June 2023 Update - Completed This action has been completed and gaps and mitigating actions are aligned in the BAF for May 2023. Further refinement will be a continuing action to ensure this recommendation is sustained.	
Wellbeing 2.1	feb-23	Substantial	For the proactive elements of the Wellbeing service provided we would encourage the use of the forward looking work plan, while acknowledging that it should remain flexible to accommodate the reactive nature of more immediate priorities.	Low	A Wellbeing Service is predominately reactive in nature and responsive to the changing needs of the staff population. To be effective, the service has to react to these changing needs in a flexible and timely manner. To support the proactive element of the service a Wellbeing Priorities Work plan is developed; however, the plan can and will be impacted by reactive priorities that arise which can result in the plan not necessarily recognising the current and accurate position of the work being undertaken. The work plan will continue to evolve and will be developed based on anticipated activity in the following 6-month period. In response to this specific action, the team will revisit the Work plan in December 2022.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	des-22			Completed	June 2023 Update - A wellbeing work priorities plan has been developed to identify strategic goals up to 2030 with associated actions. This will be reviewed the People priorities as detailed above.	April 2023 Update - The wellbeing team are developing a detailed action plan informed from the detail gathered from our surveys. The strategic aim and actions of the service are captured and monitored through the 10 Priorities of the People Directorate
Wellbeing 3.1	feb-23	Substantial	For future staff surveys, analysis work should be undertaken in relation to where respondents were located and the return rates by Clinical Services Groups / departments, so as to aid identification of those areas where more targeting and awareness work is needed to encourage completion of future surveys.	Low	At the time of running the current 2022 survey the new care group model had only just launched, work to reflect this in organisational hierarchies is still ongoing to include every staff member within the Health Board, the highest context marker in conducting the Wellbeing survey is to make the survey feel as assessable to as many staff as possible. In order to support small departments where staff may feel they could be identifiable, the Team are exploring how it could introduce a free text entry where staff would not need to indicate the area where they work.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	Next survey 31/05/2023			Completed	June 2023 Update - The 2023 wellbeing survey was launched on 15th May and will run to 25th June. Staff are asked to identify which care group they work for and at which location. This was designed in collaboration with the Heads of People to ensure that the data generated will be meaningful to the care group management. This also allows us to target areas where there has been a low response rate.	April 2023 Update - Revised Wellbeing Survey to be live in May/June 2023
Wellbeing 3.2	feb-23	Substantial	To help analysis of the data, where relevant, future Wellbeing surveys should incorporate 'drop down' menus for responders to choose pre-set answers as opposed to 'free text' fields.	Low	To further support the action in 3.1, the Team will also explore the introduction of 'Drop Down' menus where location identification at a department level does not present a risk in terms of staff becoming identifiable.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	mai-23			Completed	June 2023 Update - To help analyse the data, where relevant, the Wellbeing survey 2023 now incorporates 'drop down' menus for responders to choose pre-set answers as opposed to 'free text' fields.	April 2023 Update - Revised Wellbeing Survey to be live in May/June 2023
Wellbeing 4.1	feb-23	Substantial	To maximise potential uptake of Wellbeing Activists in the former Merthyr & Cynon ILG locality, awareness and engagement work should be undertaken to build relationships, confidence and trust with staff.	Low	Work is already underway to increase the number of Wellbeing Activists in underrepresented areas, by promoting the work of those already providing this role locally and by informing staff within services of similar work going on in the same service on another site. Activity is also underway to identify the number of activists in the new Care Group Model to be able to reflect this position moving forward.	Director for People	Strategic Lead for Employee Experience, Inclusion and Wellbeing	mar-23			Completed	June 2023 update - We have recently undertaken wellbeing roadshows across 16 sites and have used the opportunity to raise awareness and engage with staff to build relationships, confidence and trust and promote the role of the activist.	April 2023 Update - work is ongoing with care groups to promote and attract further activists across all our geographical locations
Board Assurance Framework 1.1	apr-23	Substantial	Consideration should be given to ensuring the BAF captures the key statements that the Health Board has set out for each strategic goal within the IMTP, and the link to the associated control/s and assurance report/s or the gap in control and mitigating action.	Low	The Assistant Director of Governance & Risk in conjunction with the Strategic Risk owner will review the narrative in the BAF to align to the Health Board's key statements as set out in the IMTP.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk & Strategic Risk Owners	31.07.2023			In progress	June 2023 Update - In Progress The Interim Head of Corporate Governance & Assurance is reviewing the BAF in conjunction with planning leads.	
Board Assurance Framework 3.1	apr-23	Substantial	To allow Board committees greater oversight of the strategic risks that they are assigned responsibility for, each committee should receive a relevant extract of the BAF, thus allowing sight of all listed controls, identified gaps in controls and assurance and mitigating actions, to allow more detailed information to be requested if needed.	Low	In the current review of the Risk Management Strategy, this statement has been removed as the BAF is reserved for the Board review, scrutiny and approval. However, the assigned risks are now considered at Committee Agenda planning sessions to support agenda planning.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	31.5.2023			Completed	June 2023 Update - Completed As indicated in the Management Action column the Risk Management Strategy has been updated to remove this specific narrative and Board Committees are now sighted on their Principal Risks via the Organisational Risk Register.	
Board Assurance Framework 3.2	apr-23	Substantial	Consideration should be given to updating the Risk Management Strategy & Board Assurance Framework to give greater clarity on how regularly the Audit & Risk Committee is expected to review the adequacy of the BAF, with future reviews falling in line with that timeframe.	Low	The revised Risk Management Strategy will include the frequency of review for the BAF by the Audit & Risk Committee.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	31.5.2023			Completed	June 2023 Update - Completed This action has been completed and is captured in the Draft Risk Management Strategy seeking approval by the Board at the end of May 2023.	

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R2 Follow Up Outpatients Not Booked	okt-17	Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.	CTM Focussed Review	The original review reported that the Health Board was undertaking unnecessary retrospective validation activities and this was an additional pressure on capacity which could be avoided. Unfortunately retrospective validation is still being undertaken by the Health Board. The latest figures reported in April 2017 show that the current volumes of patients without a target date was 1,129, however this is a significant improvement from the same time last year where the volume was 3,509. It remains an area of focus for the Health Board. Work continues to improve in this area. As part of the outpatient improvement theme new software has been introduced for clinicians to enable them to record the outcomes of their consultations in real time. Although only rolled out to a small selection of specialities the system has potential to improve recording of patient outcomes which will support the quality of patient data in respect of follow-ups. Performance data is also captured though the Qlik Sense system. This data analytics tool enables directorates and clinicians to interrogate a vast array of data to support day to day management and continuous improvement.	Chief Operating Officer			February 2021 Ongoing August 2021 Now December 2021 Now March 2022 Now June 2022 Now September 2022 Now February 2023		Completed	Response from Audit Wales 18 May 2023 - This report was published in October 2017. Since then, the landscape has changed significantly due to the impact of COVID 19. We are aware of significant work in this area which includes validation of waiting lists as part of the Health Boards recovery programmes. The Health Board has a planned care recovery programme, delivery of which is reported to the Planning, Performance and Finance committee. We originally raised this recommendation because we were concerned that the processes in place were not robust however due to its focus, we are content that the Health Board are taking action to address the issues we previously raised. We will be undertaking an all Wales Planned Care review in late 2023/24. We therefore are content to close this recommendation.	April 2023 - nothing further to report this month. Will receive focus for the next meeting. Work is underway across the UHB on FUNB and other patient waiting times.
Clinical Coding Follow Up Review 01	okt-19	Raising the importance of good quality medical records throughout the Health Board;	CTM Focussed Review	In 2014, we found that the quality of medical records across the Health Board was not of a good standard, with key information required for accurate clinical coding often missing or inappropriately filed. Our work has found that there continues to be issues with the quality of medical records within the Heath Board. In 2018, NWIS produced a report into clinical coding documentation. This review was undertaken as part of ongoing service improvement work to improve the quality of clinical coding data. The primary aim of this review was to assess the quality of the clinical documentation held within case notes. Overall administrative documentation was of good quality, but there were issues with loose paperwork and records being filed out of order. There were also issues with deceased notes and unplanned admissions. The quality of information for coders in the notes was poor. Only half of the clinical entries contained a diagnosis and of these, a third would be unable to be used for coding purposes. This report highlights that there are issues that need to be addressed by the Health Board. In our 2014 report, we noted the re-establishment of the Health Records Committee. The aim of this was to give the necessary focus to the quality of medical records to enable coders to code accurately. However, this Committee was disbanded in August 2017 and we are unaware of any new arrangements in place to [illegible]	Director of Digital		Not specified by the Health Board	October 2020 April 2021 Now March 2022 Now June 2022 Now October 2022 Now October 2023		Completed	June 2023 Update: Regular audits are undertaken on the quality of records. These are reported to the Information Governance Group and Digital & Data Committee. In November 2022, an external peer review was undertaken by representatives of the Institute of Health Records Management. Data Quality Issues remain with the paper record. This will now be part of a formal programme of improvement work with the support of the Medical Director (Caldicott Guardian) and Exec Director of Nursing. Propose to close	February 2023 Update - Action plan now in place for Medical Records - Action Plan in place until October 2023. Propose to close.
Clinical Coding Follow Up Review 03	okt-19	Developing a programme of routine audits of medical records to provide assurance that the quality of medical records is improving;	CTM Focussed Review	The quality of the patient record has a direct impact on the coders ability to undertake their role. As highlighted previously, work by NWIS into the quality of documentation highlighted concerns with loose paperwork, and the filing of deceased patient records. As part of the annual clinical audit and effectiveness plan, there is currently a Health Board wide audit of the quality of case notes. This audit is looking at documentation in case notes and is aligned to the health records committee, however this committee has been disbanded so we are unsure where the results of this audit are reviewed. The current audit plan shows that this audit was also undertaken last year but there is no record of the report. The results of the current audit are due for publication in March 2019.	Director of Digital		Not specified by the Health Board	October 2020 November 2021 Now June 2022 Now October 2022		Completed	June 2023 Update: Audits of Records now standardised as above. Propose to close.	February 2023 Update - Regular audits and reporting of the quality of the medical record are now in place - propose to close.
Audit of Accounts Addendum 2020/2021 02	aug-21	The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	CTM Focussed Review	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	Director for People		Immediate	Now August 2022 Now October 2022 Now December 2022 Now March 2023 Now August 2023		In Progress	June 2023 Update - In partnership with Trade Union colleagues, a new "NHS Pension Scheme Benefit Flexibilities Policy" has been drafted. This new policy will go to the Local Partnership Forum in June 2023, to be endorsed to be approved by the People and Culture Committee in August 2023. The Policy will apply to all employee's requesting to take their pension benefits, who wish to request to retire and return (including Executive Directors). The process will require the employee's manager to meet with them to discuss their request and provide in writing the decision along with the objective business reasons for either approving or declining the application.	April 2023 - No update received from the Team on this occasion
Audit Wales/HIW Quality Governance Follow Up Review R2.3	aug-21	The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically; a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board c- The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework	CTM Focussed Review	The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows: • Strengthened focus on quality on strategic planning; • Individuals' voices are better heard; • Shared learning and continuous quality improvement; • Risk better articulated, shared and mitigated; • Strengthened two-way 'point of service delivery' to Board sight; and • Extensive review and improvement of the management of concerns and serious incidents. Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's . The revised framework will provide improved granular detail in respect of ILG governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSG/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded.	Director of Nursing	des-21	01/03/2022 Now June 2022 Now December 2022 Now May 2023 Now June 2023		Part Completed	June 2023 Update: Quality & Safety agenda shared amongst the clinical care group directors, the heads of nursing role is currently under review as part of phase 2 of operating model - Partial Complete	April 2023 Update - Recommendation: incomplete, open/yellow. A program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.
Audit Wales/HIW Quality Governance Follow Up Review R6.1	aug-21	There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	CTM Focussed Review	Health Board purchased CIVICA (captures population feedback using a patient insight software platform)	Director of Nursing		jul-21	Now December 2021 Now July 2022 Now March 2023 Now December 2023		In Progress	June 2023 Update- Governance and the performance paper submitted. Awaiting response from finance on Civica funding and to move funding to Value Based Healthcare (VBHC). Patient Experience feedback for 2022/23 via CIVICA system has been developed and will be presented at a future Quality & Safety Committee. Care Groups actively use feedback to enhance clinical care.	April 2023 Update - the team continue to engage with specialties to look at bespoke surveys and to promote training with staff to embed across the HB. Work is ongoing to look at how we can implement SMS messaging for the ED departments. SMS messaging is constricted at present due to IT infrastructure and the capacity to implement across the Health Board. Volunteer patient feedback team continue to support gaining of feedback within POW and volunteer team are working to increase teams available to develop this across to RGH and PCH. VBHC Admin support is also helping to support the input of paper copies of "Have Your Say" into the system and the creation of surveys. VBHC has just recruited a B6 PM who can also provide support for communication and engagement e.g. webpage, leaflets, events etc. Still awaiting the finance issue of Civica to be resolved to enable VBHC team to take over that aspects moving forward.

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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		des-21	01/03/2022 Now June 2022 Now December 2022 Now January 2023 Now May 2023 Now June 2023		Part Completed	June 2023 Update - Quality & Safety agenda shared amongst the clinical care group directors, the heads of nursing role is currently under review as part of phase 2 of operating model - Partial Complete	April 2023 Update - Recommendation: incomplete, open/yellow. A program of work is yet to be completed on the care group consultation and implementation of the Quality and Safety Framework. The engagement process will commence in the second week of April with a view to closing and aligning during May 2023. The framework has been noted by the Quality and Safety Committee and was approved by Board in January 2023.
Audit Wales/HIW Quality Governance Follow Up Review R10.1	aug-21	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	CTM Focussed Review	Risk Training: including the development of a Training Needs Analysis (TNA) in line with All Wales developments, dissemination of the TNA across the Health Board, new risk training programmes which are aligned to the new TNA.	Director of Corporate Governance	Assistant Director of Governance & Risk	okt-21	Now December 2021 Now April 2022 Now October 2022 Now 31 December 2022 Now 31 March 2023 Now 31st October 2023		In Progress	June 2023 Update - This recommendation is paused as the Health Board continues to wait the implementation of the new OFW Risk Module on Datix to ensure that the Training Needs Analysis aligns with the new system and process. The implementation date continues to be undetermined. The OFW Team Senior Management and Datix Senior Management are meeting w/e 19th May to discuss options with a further meeting of the All Wales OFW Task and Finish Group meeting after that to consider the next steps. A more detailed update should be available at the next meeting.	April 2023 Update - This recommendation remains linked to the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A further meeting with the Task and Finish Group of the OFW Implementation is scheduled for late March 2023. A further update will be reported at the next meeting of the Audit & Risk Committee. The revised implementation is approximate whilst a further programme update is awaited from the Implementation Team of OFW Risk Module. In the meantime monthly risk training is scheduled throughout 2023 which is open to all staff. These sessions are publicised on SharePoint and been included in the Staff Newsletter.
Audit Wales/HIW Quality Governance Follow Up Review R10.4	aug-21	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy.	CTM Focussed Review	An efficient risk management process which is seen as efficient and not cumbersome – linked to the new Once For Wales Risk Management System.	Director of Corporate Governance	Assistant Director of Governance & Risk	apr-22	Now October 2022 Now 31 December 2022 Now 31 March 2023 Now 31 October 2023		In Progress	June 2023 Update - The implementation date of the OFW Risk Module continues to be undetermined. The OFW Team Senior Management and Datix Senior Management are meeting w/e 19th May to discuss options with a further meeting of the All Wales OFW Task and Finish Group meeting after that to consider the next steps. A more detailed update should be available at the next meeting.	April 2023 Update - This recommendation remains linked to the implementation of the OFW Risk Module as the intention is that the training will include how to undertake a risk assessment utilising the risk module on Datix. The pace of implementation on the new module has slowed and therefore the work in this activity has not been progressed. A further meeting with the Task and Finish Group of the OFW Implementation is scheduled for late March 2023. A further update will be reported at the next meeting of the Audit & Risk Committee. The revised implementation is approximate whilst a further programme update is awaited from the Implementation Team of OFW Risk Module. In the meantime monthly risk training is scheduled throughout 2023 which is open to all staff. These sessions are publicised on SharePoint and been included in the Staff Newsletter.
Audit Wales/HIW Quality Governance Follow Up ReviewR11.6	aug-21	The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.	CTM Focussed Review	Review all backlog incidents to eliminate duplicates and ensure correctly identified/categorised.	Director of Nursing		okt-21	Now 31 August 2022 Now December 2022 Now January 2023 Now May 2023 Now July 2023		In Progress	June 2023 Update: The Business Intelligence Manager will be commencing on the 12.06.23. A key priority following this will be to implement the validation and audit programme. In addition a 12 month programme of work has commenced to develop dashboards that provide real time information at all levels of the organisation.	April 2023 Update - recommendation: incomplete, open/yellow. The exercise to close down all outstanding incidents within the Health Board's Datix Legacy System remains ongoing. All incidents have had an initial review and the investigation being is concluded for the remaining incidents which relate to delays and admission. In relation to Datix Cymru a data validation and audit programme has been drafted, which will be presented to the Datix Management Group for ratification on the 24.04.23. An update report will be presented to Quality & Safety Committee on the 24.05.23 in relation to incident reporting and management within Datix Cymru.
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		Part Completed	June 2023 Update- CIVICA-Governance and the performance paper submitted. Awaiting response from finance on CIVICA funding and to move funding to VBHC	April 2023 Update-Listening and learning framework developed. The first listening and learning event held in September 2022. The next Listening and Learning event is planned for May 2023. The learning repository is in its infancy, set up and being further developed. The showcasing of the repository will continue as part of the care group engagement program on the quality and safety framework during April 2023. PREMS & CIVICA April 2023-Update the team continue to engage with specialties to look at bespoke surveys and to promote training with staff to embed across the HB. Work is ongoing to look at how we can implement SMS messaging for the ED departments. SMS messaging is constricted at present due to IT infrastructure and the capacity to implement across the Health Board. Volunteer patient feedback team continue to support gaining of feedback within POW and volunteer team are working to increase teams available to develop this across to RGH and PCH. VBHC Admin support is also helping to support the input of paper copies of "Have Your Say" into the system and the creation of surveys. VBHC has just recruited a B6 PM who can also provide support for communication and engagement e.g. webpage, leaflets, events etc. Still awaiting the finance issue of Civica to be resolved to enable VBHC team to take over that aspects moving forward.
Audit Wales/HIW Quality Governance Follow Up Review R7.7h		There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	CTM Focussed Review	Undertake audit of compliance against Royal College of Anaesthesia (RCOA) Standards (ACSA process) identify and develop standards to meet with RCOA recommended GPICS (set standards by RCOA for Anaesthetic services) baseline and inform continuous improvement programmes and improve compliance against the standards.	Medical Director		jul-24			In progress	June 2023 Update - The ACSA process is more in depth and time consuming than was originally understood. Like all good accreditation processes if they were easy they would not be worth the doing, and this one involves looking at all aspects of clinical care. However due to clinical pressures the ACSA processes on the 3 sites have not progressed at the pace we would have wished. The teams will continue to work on them but completion in 2024 is not realistic. The Planned Care Group will continue to monitor the process.	April 2023 - No update received from the Team on this occasion
Audit of Account Addendum 2021/22 R2	aug-22	The Health Board should ensure that its related-party process is fully and properly applied to support the preparation of the 2022-23 financial statements.	CTM Focussed Review	This was largely due to a transposition error between the reviewed working paper and the final document. We will ensure checks are made in future accounts.	Director of Finance		apr-23			Completed	June 2023 Update - This has been actioned in the annual accounts for 2022/23	April 2023 Update - Will be updated as part of year end accounts

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Audit of Accounts Addendum 2021/22 R5	aug-22	The Health Board should ensure that working papers provided at the start of the audit are as described in the deliverables document and have clear cross-referencing to the relevant figures in the financial statements. Also, where spreadsheets are the underlying form of evidence, the Health Board should ensure that all cell values have an appropriate audit trail and that they are never manually input.	CTM Focussed Review	A change in process for the completion of audit working papers caused a delay and a member of the finance team who left at the end of the financial year also caused some issues with submitting working papers. We will ensure that audit deliverables are clearly communicated and deadlines for submission kept.	Director of Finance		apr-23			Completed	June 2023 Update - Audit Deliverables were placed on a new system for the 2022/23 accounts and delivered in a timely manner	April 2023 Update - Will be updated as part of year end accounts
Audit of Accounts Addendum 2021/22 R6	aug-22	The Health Board should ensure that all financial returns are made available by the Welsh Government deadlines and that the figures in the financial statements agree to those returns.	CTM Focussed Review	This was an oversight on the return. We will ensure checks are made that all returns are fully completed.	Director of Finance		apr-23			Completed	June 2023 Update - Returns for 2022/23 were completed within timescales	April 2023 Update - Will be updated as part of year end accounts
Audit of Accounts Addendum 2021/22 R10	aug-22	Wherever possible, the Health Board should ensure that all Excel-based working papers include formulae and cell references which will provide a clearer audit trail.	CTM Focussed Review	We encourage where possible to link working papers to source documentation and not hard code. We will reinforce this for the accounts in 2022/23.	Director of Finance		apr-23			Completed	June 2023 Update - Where possible working papers are linked to source document.	April 2023 Update - Will be updated as part of year end accounts
Audit of Accounts Addendum 2021/22 R11	aug-22	The Health Board should update its Medical Pay Financial Control Procedure to reflect the current process	CTM Focussed Review	This is being updated in line with other FCPs, it will go to Audit & Risk Committee for approval.	Director of Finance		okt-22	Now December 2022 Now April 2023		Completed	June 2023 Update - Within the June Audit Committee papers.	April 2023 Update - The Medical Variable Pay has been updated and circulated for comment. We are awaiting confirmation of the agreed rate card to include before finalising and submission to Audit & Risk Committee for approval.
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		In Progress	June 2023 Update - Our new Head of Organisational Development and Inclusion has started in post and needs to review the new digital form and comment on the proposed process. Meeting arranged for w/c 29.05.23. A new digital form has been developed and IT are adding in 'behind the scene' controls to ensure that it does what it needs to do. Learning and Development have completed the video to go alongside this and the guidance document needs to be finalised. Subject to testing, the new process will go live July 2023.	April 2023 Update - A draft EQIA form has been shared with IT to build into a digital tool. Once the screening tool is ready, need to test with the key stakeholder group (subject to IT ideally April/May2023). Currently developing a video explaining revised form and supplementary guidance docs.
Transformational Leadership Programme Board – Baseline Governance Review R1	des-22	Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: a) taking a longer-term approach to its planning beyond five years, b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.	CTM Focussed Review	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners	Director of Strategy & Transformation	Head of Regional Collaborative Unit	31 March 2023			In Progress	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R2	des-22	Performance Management The outcomes and performance framework was still being finalised at the time of our review. The TLPB needs to finalise and implement the framework, ensuring it contains quantitative and qualitative measures that will enable the RPB to demonstrate outcomes and impact.	CTM Focussed Review	Agreed. Work is ongoing in relation to the performance framework in support of the new delivery plan and this will also need to reflect changes arising from the population needs assessment	Director of Strategy & Transformation	Head of RCU	30 September 2022			In Progress	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R3	des-22	Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated	CTM Focussed Review	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R4	des-22	Regional Commissioning Unit Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team.	CTM Focussed Review	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Director of Strategy & Transformation	Head of RCU	31 December 2022			In Progress	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R5	des-22	Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core	CTM Focussed Review	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion
Transformational Leadership Programme Board – Baseline Governance Review R6	des-22	Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities	CTM Focussed Review	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health	Director of Strategy & Transformation	Chair TLPB	31 March 2023			In Progress	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion

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CTMSB SLA Review R1	feb-23	We observed good scrutiny by the commissioning and contracting group. However, there was a significant agenda which was challenging to cover in the allotted meeting time and there was a lack of operational and clinical representation. The health boards should: • Review the time allotted to meetings, or review the content of the agenda to ensure that agenda items can receive sufficient discussions; and • Ensure appropriate membership at the group so that issues from operational and clinical staff are raised.	CTM Focussed Review	At the time the review was undertaken there was a significant amount of disaggregation's being worked through as well as operational/ contractual issues. The frequency of the meetings was increased from monthly to three weekly in order to accommodate the large agenda. This appears to have stabilised meaning that the agenda is more manageable and at the meeting on 11/10/22 the group considered reverting back to monthly meetings or keep to three weekly but reduce the meeting to 1 hour. Services are invited to attend the C&C meetings to discuss cessations or operational issues. At least 30 minutes of the meeting is dedicated to the service discussion. The last service to attend a C&C meeting was Pathology in August 2022. C&C members also attend the service to service meetings and report back to C&C on the outcomes of the meetings. Due to the significant amount of SLAs in place which covers numerous services, it would be extremely challenging to gain operational/ clinical representation at every C&C meeting and attending the meetings is not a good use of colleague's clinical time. All service to service meetings include both operational and clinical staff and this arrangement appears to be working.	Director of Strategy & Transformation	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)	nov-22			Completed	June 2023 Update - Management actions relating to the service changes with Swansea Bay UHB have been implemented. The Contracting and Commissioning meeting now meets monthly and there is a regular cycle of Joint Management Group and Joint Executive Group meetings. The process for agreeing service cessations has been reviewed and revised to commence with benefit appraisal, followed by impact assessment, prior to agreeing cessation dates. The risk register is regularly reviewed and this includes the risks relating to capacity to undertake service changes related to service agreement cessations. The work programme for 2023-24 has been developed to spread the work programme throughout the year and is subject to regular review of its deliverability.	April 2023 - No update received from the Team on this occasion
CTMSB SLA Review R2	feb-23	Up until recently, there has been no plan for the disaggregation of services and oversight and scrutiny at Board and Committee level has been lacking. A plan for 2022-23 is now in place but oversight still needs to be improved. The health boards should: • Develop a programme with clear timescales for the future disaggregation of services, where appropriate, that goes beyond 2022-23. The programme needs to be informed by the respective health board clinical service plans and communicated within the health boards, including clinical staff. • Use the plan to facilitate monitoring of delivery and increase the level of oversight of the disaggregation programme through the relevant Board and Committee structures within both health boards.	CTM Focussed Review	The disaggregation plan for 2022-23 incorporates a plan into the next financial year as it is recognised that most cessations are still in the planning stage and that cessation dates are still to be agreed once the due diligence has been completed. • Exercise to be undertaken with all services to categories SLAs into the following categories as this will inform work plan over the next few years: • Short term disaggregation before end of March 2024 • Plan to medium term disaggregation between 2 and maximum of 5 years • Long term service and contractual relationships to be maintained between the two Health Boards on a partnership basis with no intent of disaggregating • Revised disaggregation plan to be signed off by Joint Management Group which includes a 5 year work programme. Progress against the work plan to be reported through SBU's Performance & Finance Committee and through CTMUHB's Planning Performance and Finance Committee and Board. This is in place –the PPF committee received a full progress update on 25th October 2022 and will continue to receive reports at 6 monthly intervals	Director of Strategy & Transformation	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)/ Assistant Director of Strategy (SB) & Assistant Director of Transformation	January 2023/March 2023			Completed	June 2023 Update - The work programme has been developed, as per the management action. This may be subject to some further changes but any changes will be agreed through the joint governance processes. The work programme is reviewed at both the Joint Management Group and Joint Executive Group.	April 2023 - No update received from the Team on this occasion
CTMSB SLA Review R3	feb-23	Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.	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	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion
CTMSB SLA Review R4	feb-23	Our work identified that there was no clear link between the risk registers managed by the commissioning and contracting group to the health board risk registers. The health boards should review the risk management process associated with the transition so that risks are linked and reflected in individual health board corporate risk registers.	CTM Focussed Review	Clinical risk matrix has been developed and is completed as part of the disaggregation process. The risk score is highlighted to Joint Management Group and Joint Executive Group through the slide deck. However, the risk register for the programme needs to be reviewed and there needs to be a stronger link between the risk register for the programme and the corporate risk registers. Process to be developed outlining how service risks are linked with the CTMU and SBU risk registers.	Director of Strategy & Transformation	Head of Strategic Commissioning (SB) & Assistant Director of Transformation (CTMUHB)	mar-23			In Progress	June 2023 Update - No update received on this occasion	April 2023 - No update received from the Team on this occasion
Structured Assessment 2022 R1	apr-23	Improving administrative governance arrangements We found opportunities for the Health Board to improve its administrative governance arrangements to enhance public transparency and support Board and committee effectiveness. The Health Board, therefore, should: a) publish the agendas of private Board and committee meetings; b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner; c) update report cover sheets to enable authors to better link their reports to the requirements of the Well-being of Future Generations (Wales) Act 2015; and d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.	CTM Focussed Review	a) In the exceptional circumstances where the Health Board is required to hold a Private Board meeting or Board Committee it will endeavour to highlight the agenda items covered on the Public Agenda for transparency. b) Due to capacity constraints within the Corporate Governance Function it is accepted that the timely publishing of papers maybe impacted. Discussions are underway with the Web Development Team to consider if they can provide interim support over the next 3-6 months. c) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act. d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues.	Director of Corporate Governance	Assistant Director of Governance & Risk	a) 30th April 2023 b) 31st August 2023 c) 30th June 2023 d) 30th June 2023			In Progress	June 2023 Update - a) Complete Board and Board Committee agendas will now include a section capturing the occasions where a Private meeting was held and the topics covered. b) The Interim Head of Corporate Governance & Assurance is undertaking a review of the website to identify where there are gaps. Agenda Bundles are being uploaded as an interim measure. The Web Development Team have kindly agreed to support the team. c) Cover reports under review in respect of this recommendation and the requirements under the new Duty of Quality. d) Presentations Templates under review in light of the changes also identified in 'c' above as well as ensuring key risks and issues are captured.	
Structured Assessment 2022 R2	apr-23	**Using the Board Assurance Framework (BAF) to shape Board business** 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.	CTM Focussed Review	The Health Board will continue to include the BAF Report in its agenda setting meetings and align the Board and Committee Cycles of Business to ensure that the business of the meetings are shaped by the principal risks facing the organisation. The BAF will also help shape Board and Committee Cycles of Business at the beginning of each financial year. Each Committee will receive the principal risk assigned to it as the 'assuring Committee' within the cover paper of the Organisational Risk Register, which is received at all regular Committee meetings as appropriate.	Director of Corporate Governance	Assistant Director of Governance & Risk	31st August 2023			Completed	June 2023 Update - Propose to Complete. The Board Assurance Framework is received at agenda planning sessions for the Board and Board Committees. Each Committee will now receive the principal risk assigned to it as part of the cover paper for the Organisational Risk Register. This has commenced with the May 23 Quality & Safety Committee.	
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.	Executive Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)		30th September 2023 The workshop with Board Members is scheduled for Quarter 1 – 2023-2024.			In Progress	June 2023 Update - No update received on this occasion	
Structured Assessment 2022 R4	apr-23	**Establishing measurable outcomes for strategic priorities** Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.	CTM Focussed Review	We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter". In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible.	Executive Director of Strategy & Transformation		30th June 2023 Now September 2023			In Progress	June 2023 Update - Work has been completed in regards to aligning the population health goals and the strategy groups. This is now being used to support the development of measures and outcomes for each group which is developing well. To note, this may not be completed by the end of June but will be completed summer 2023.	
Structured Assessment 2022 R5	apr-23	**Enhancing arrangements for monitoring delivery of corporate plans and strategies and reporting progress to the Board** We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring: a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	CTM Focussed Review	a) All plans and strategies will contain an executive summary setting out this information. As set out above, work is ongoing around outcome measures. b) Executive Directors are clear on their responsibilities for delivery so we will ensure this is more visible. c) Reports will be reviewed to ensure they provide the Board with sufficient information to assess the impact of implementation of key actions and deliverables on the Health Board's Performance.	Executive Director of Strategy & Transformation		30th June 2023			In Progress	June 2023 Update - a) this message has been disseminated and will be put into place moving forward with the development of plans b) this is clear on all board papers and portfolios have been agreed by execs c) there is still further work to be done in line with this as we set out our performance monitoring approach	

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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
Structured Assessment 2022 R6	apr-23	**Strengthening financial management arrangements** We identified the need for the Health Board to improve its arrangements for containing expenditure and delivering savings. The Health Board, therefore, should review its arrangements to ensure there is sufficient grip and challenge at all levels of organisation on expenditure and savings delivery.	CTM Focussed Review	Finance review meetings are held with all of the Care Groups on a monthly basis and with other functions on a bi-monthly basis. These meetings cover savings delivery, expenditure variances plus action plans to improve the overall control environment. These processes will be reviewed to ensure that they are sufficiently robust in terms of containing Health Board expenditure and delivering planned savings. Within the draft, Internal Audit Plan for 2023-2024 it is proposed that Internal Audit will undertake a review of budgetary control at a localised level.	Executive Director of Finance		30th September 2023			In Progress	June 2023 Update - Strengthened accountability agreements cascaded from CEO to Directors and Care Groups. Finance review meetings scheduled with all of the Care Groups on a monthly basis and with other functions on a bi-monthly basis. These meetings cover savings delivery, expenditure variances plus action plans to improve the overall control environment. These processes will be subject to review after Q1 to ensure that they are sufficiently robust in terms of containing Health Board expenditure and delivering planned savings. Within the Internal Audit Plan for 2023-2024 it is proposed that Internal Audit will undertake a review of budgetary control at a localised level.	
Structured Assessment 2022 R7	apr-23	**Strengthening financial controls** Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions.	CTM Focussed Review	a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance. b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is Chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas. c) A review of all the outdated Financial Control Procedures is underway.	Executive Director of Finance		a) 30th September 2023 b) 30th June 2023 c) 31st December 2023 (Qtr. 3)			In Progress	June 2023 Update - a) Reviewed So &SFIs and confirmed upper limit for contracts is consistent with model Sos and SFIs. Contract in excess of £1m require WG Ministerial approval CLOSED b) Quarterly Capital reports included on PPF agenda c) FCP review ongoing	
Structured Assessment 2022 R8	apr-23	**Enhancing financial reports to the Board** 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.	CTM Focussed Review	The monthly finance reports to the Board and the Planning, Performance and Finance (PPF) Committee summarise the key risk and opportunities facing the Health Board. These reports will be reviewed to ensure they provide assurance to the Board that mitigating actions and plans are in place and that the PPF Committee has confidence the risks are being appropriately managed. These reports will capture financial performance of the new Care Group Model.	Executive Director of Finance		31st July 2023			Completed	June 2023 Update - 1. Board Report reviewed and updated for 2023-24 2. Care Group level reporting continues into PPF. Any issues of concern will be escalated to Board through committee reports	
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	June 2023 Update: During the months of May and June 2023 - recruuitment is taking place for two new Assistant Directors within the Digital & Data Directorate. From here the structural design of the Digital & Data Directorate will evolve further.	
Structured Assessment 2022 R10	apr-23	**Strengthening Board-level oversight of estates issues and risks** There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should: a) ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee; b) update the committee's Terms of Reference to reflect these responsibilities; and c) establish a clear process for ensuring appropriate cross-referral of issues with the Quality and Safety Committee, which oversees health and safety matters.	CTM Focussed Review	On publication of Welsh Government's annual Estates, Facilities Performance Management System data, the findings are reported to the Planning, Performance and Finance (PPF) Committee. The report includes the Health Board's performance measured against the national estates key performance indicators which are Physical Condition, Statutory and Safety compliance, fire safety, functional suitability and space utilisation. In addition the report includes the estates operational planned and reactive performance data for statutory and mandatory jobs and also captures helpdesk request data, the reported data is compared against previous years so that trends can be analysed. The report also includes the organisations energy performance and Carbon Dioxide (CO2) emissions which is measured and reported against the Welsh Government performance targets. At all of the Health Board's Health, Safety and Fire Sub Committees there is a standard agenda item for an Estates Safety and Compliance report and a fire safety report. These reports cover the critical infrastructure systems such as high and low voltage electricity, medical gases, ventilation and water. The Estates and Capital Directorate has its own risk register which is reported quarterly to the Estates / Capital Governance Board, the risks identified with a score above 15 are subsequently reported to Corporate Governance for inclusion on the Health Board's Organisational Risk register. The Health Board is also considering its approach to developing an Estates Strategy within the Health Board and how this will align with other key strategic documents and plans. The Planning, Performance & Finance Committee Terms of Reference will be reviewed to reflect the responsibility to receive Board level oversight of estates issues. The Health Board has a defined Committee Referral process which will be used if there are matters considered at either the PPF Committee or HS&F Sub Committee that require consideration at the Quality & Safety Committee. The HS&F Committee will also ensure any estates issues will be notified to the Q&S Committee through the Committee Highlight Report.	Executive Director of Finance		In accordance with the Committee Cycle of Business for the PPF Committee and Health, Safety and Fire Sub Committee – Circa April / May 2023.	Now October 2023		In Progress	June 2023 Update - Revised date to reflect expected publication of Estates and Facilities Performance Management System data.	

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

Date issued: June 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.

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Contents

Audit and Risk Committee Update

About this document

1 This document provides the Audit and Risk Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board. We presented our Outline Audit Plan to the committee on 19 April 2023; and will present our detailed Audit Plan at the next meeting on 21 June 2023.

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Planned date for consideration
2022-23 Performance Report, Accountability Report and Financial Statements	Executive Director of Finance and Director of Corporate Governance	The statutory audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements, which are prepared and audited in accordance with the Welsh Government's 2022-23 'Manual for Accounts' guidance.	We are currently undertaking this audit.	To be considered by the Audit and Risk Committee on 26 July 2023 and by the Board on 27 July 2023; with the Auditor General scheduled to certify on 28 July 2023.

2022-23 Charity Account.	Executive Director of Finance	The statutory audit of the Health Board's Charitable Funds Accounts.	Audit work not yet started	December 2023 / January 2024

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Review of the commissioning and contracting arrangements post Bridgend boundary change	Executive Director of Strategy and Transformation	This work examined the robustness of the arrangements for overseeing and managing the contractual agreements established following the Bridgend service transition in 2019. The work also considered the programme for service disaggregation (for relevant services), and whether the arrangements support future regional service models currently being explored by the organisations.	Completed	Considered December 2022

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Cwm Taf Morgannwg Health and Social Care Partnership - Transformation Leadership Programme Board	Executive Director of Strategy and Transformation	The review examined how the Transformation Leadership Programme Board arrangements are supporting the four bodies (Cwm Taf Morgannwg University Health Board, Rhondda Cynon Taf County Borough Council, Merthyr Tydfil County Borough Council and Bridgend County Borough Council) to develop effective and sustainable approaches to regional working.	Completed	Considered December 2022
Review of the temporary closure of the Ysbty Cwm Cynon Minor Injuries Unit (Local work 2022)	Executive Director of Nursing, Midwifery, and Patient Care	The high-level review examined the issues surrounding the temporary closure of the Minor Injuries Unity at Ysbyty Cwm Cynon.	Completed	Considered February 2023
Structured Assessment 2022	Executive Director of Corporate Governance	The review assessed the corporate arrangements in place at the Health Board in relation to: • Governance and leadership;	Completed	Considered April 2023

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		• Financial management; • Strategic planning; and • Managing the workforce, digital, resources, estates, and other physical assets.		
Orthopaedic services – follow up	Chief Operating Officer	This review examined the progress made in response to our 2015 recommendations. The findings from this work inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings have been summarised into a single national report with supplementary outputs setting out the local position for each health board.	Completed	To be considered in June 2023
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the	Drafting	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.		
Joint Review Follow up (Local work 2022)	Chief Executive	This work will examine the Health Board's progress in implementing the recommendations made in the Joint Review Report from 2019.	Drafting	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
All-Wales thematic on workforce planning arrangements	Executive Director of People	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Fieldwork	To be confirmed
Primary Care Services - Follow-up Review (Local Work 2023)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made several recommendations to the Health Board. This work will follow-up progress against these recommendations.	Fieldwork	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
Digital Inclusion in Wales and Key questions for public bodies	March 2023
Orthopaedics Services in Wales – Tacking the Waiting list backlog	March 2023
Betsi Cadwaladr University Health Board – Review of Board Effectiveness	February 2023
Together we can – Community resilience and self-reliance	January 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
Audit Wales Annual Plan 2023-24	April 2023
Fee Scheme 2023-24	January 2023

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

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Our work programme for 2023-2026

Our work programme for 2023-2026

About our work programme

1 Our Audit Wales strategy for 2022-2027 includes a focus on the development and delivery of a 'strategic, dynamic and high-quality audit programme', as well as a 'targeted and impactful approach to communications and influencing'.

2 In spring 2022, we consulted on our work programme. Informed by responses to that consultation, and our 2021 Picture of Public Services analysis, we have been shaping an indicative medium-term programme of performance audit work that sits alongside our annual audit of accounts at over 800 public bodies in Wales. By identifying a clearer medium-term horizon and drawing together different parts of our overall work programme, we aim to enhance our overall research and development, and the timeliness and impact of our audit work.

3 Our audit programme for 2023-2026 will be focused on four themes:

Tackling inequality

Responding to the climate and nature emergency

Service resilience and access

Well-managed public services

About this paper

4 We have prepared this paper in advance of work to develop our website and the information it holds about our work programme to improve our engagement with the public and other stakeholders about our work.

5 The paper focuses on our national value for money examinations and studies. This programme of work includes value for money examinations, local government studies, and the preparation of summary reports of the findings from local audit work across multiple NHS, central government and/or local government bodies. It also includes examinations undertaken in response to issues of public concern identified through our audit work or raised with the Auditor General through correspondence. Our work will include consideration of how the sustainable development principle and its 'five ways of working' are being applied.

6 The topics identified below as work in progress at 1 April 2023, or to start during 2023-24, mirror Appendix 2 of our Annual Plan 2023-24. Plans for other outputs may emerge as our work programme evolves at both a national and local level, including follow up work and local audit work already planned as part of previous years' programmes.

7 In addition, our local audit plans will include other new work at individual bodies to be progressed during 2023-24:

- For principal councils: local reviews include coverage waste and recycling, planning services, the Welsh Housing Quality Standard, performance management and reporting, counter fraud and whistleblowing, transformation programmes, roads and transport, arrangements to support application of the sustainable development principle, corporate governance, scrutiny, and safeguarding.

- For NHS bodies: as an extension to our annual structured assessment work across all bodies we will undertake a deeper dive into digital developments. While planning arrangements for local bespoke projects are still ongoing, emerging areas of focus at individual bodies include follow up of previous audit recommendations in areas such as primary care, quality governance, clinical coding and outpatient services, use of strategic assistance funding in escalated organisations, and the robustness of operational governance arrangements.

- For Fire and Rescue Authorities: our local audit programme will include consideration of approaches to targeting fire prevention work.

- For National Park Authorities: our local audit programme will include consideration of arrangements for ensuring under-represented groups are encouraged and supported to visit.

8 We have also listed below indicative topics that we have identified for possible national work to start during 2024-25 and 2025-26, some of which we would expect to then flow into 2026-27. These indicative plans will be revisited as part of our annual planning cycle and taking accounts of any emerging areas of interest / concern and ongoing risk assessment.

National value for money examinations and studies 2023-2026

Work in progress at 1 April 2023

NHS quality governance	A summary of how NHS bodies' quality governance arrangements are supporting good quality and safe care, building on local audit work.
Corporate Joint Committees (CJCs)	Whether CJCs are making good progress in developing their arrangements to meet their statutory obligations and the Welsh Government's aim of strengthening regional collaboration.
Managing assets and workforce in local government	How councils' strategic approaches to workforce and asset management are supporting their ability to transform, adapt, and maintain service delivery in the short and longer term.
Maximising EU funding	Progress in maximising drawdown of EU funds under the Structural Funds Programme and Rural Development Programme by the end of December 2023.
Net zero (pan-UK overview)	An overview of policy and delivery arrangements across different parts of the UK, and in partnership with other UK audit bodies.
Unscheduled care	A whole system review, undertaken in phases, that will examine the effectiveness of hospital discharge arrangements, management of unscheduled care demand and the effectiveness of national leadership arrangements.

Covering teacher's absence	Developments since our November 2020 report on this topic, and a March 2021 report by the Senedd Petitions Committee.
NHS workforce	NHS bodies' approaches to workforce planning and drawing together key data.
Planning for sustainable development – brownfield regeneration	Action local councils are taking to support and encourage vacant non-domestic properties and vacant brownfield sites being repurposed into homes or for other uses.
Building safety	How responsible public bodies are discharging their statutory responsibilities to ensure buildings in Wales are safe, against the backdrop of the UK Building Safety Act 2022.
Ukrainian refugee services	How the Welsh Government, working with its partners, has responded to support Ukrainian refugees in Wales.
Governance/oversight of National Park Authorities	Whether authorities have effective governance arrangements that support good outcomes for citizens.
Digital strategy in local government	Councils' strategic approach to digital, including application of the sustainable development principle and arrangements for securing value-for-money.

Use of performance information in local government	Whether councils' use of performance data enables senior leaders to understand the service-user perspective and the outcomes of their activities to effectively manage performance.
Cancer services	Examining different stages of the patient pathway and building on local audit work at Public Health Wales around the recovery of screening services.
Affordable housing	Arrangements to deliver the Welsh Government's target and realise wider benefits, progress to date and risks to delivery, and application of the sustainable development principle.
Active travel	Delivery of Welsh Government objectives and how associated funding is being managed and deployed.

Other work that we intend to start during 2023-24

Capital planning and programme management	A programme of work, covering the Welsh Government's overall approach to capital and infrastructure, local audit work on capital planning and work on specific capital programmes, including possible further work on the Welsh Government's investment programme for schools and colleges following on from our report in 2017.
Challenges for the cultural sector	Covering Amgueddfa Cymru (Museum Wales), the National Library of Wales, Sport Wales, and the Arts Council of Wales to examine how they are applying the sustainable development principle when taking steps to meet their well-being objectives.
Homelessness	Examining how services are working together to progress the response to homelessness, informed in part by our previous work on people sleeping rough, and in the context of the Welsh Government's 2021-2026 homelessness action plan.
Addressing biodiversity decline	A high-level look at how audited bodies are responding to the biodiversity and resilience of ecosystems duty under the Environment (Wales) Act 2016. Also, a more focused review to examine action that Natural Resources Wales is taking around terrestrial, freshwater and/or marine protected sites.

Rebalancing care and support	A programme of work looking at different aspects of the Welsh Government's Rebalancing Care and Support agenda and associated funding streams, including the Health and Social Care Regional Integration Fund and the Health and Social Care Integration and Rebalancing Capital Fund.
Tackling NHS waiting lists	Local audit work across health boards following on from our national overview report on the planned care backlog in May 2022.
Access to education for children with Additional Learning Needs.	Considering costs associated with the Welsh Government's transformation programme and challenges around its implementation.
Further and higher education funding and oversight – Commission for Tertiary Education and Research	Early work to look at the application of the sustainable development principle by the newly created Commission as it becomes fully operational from 1 April 2024. This could include reflecting more broadly on financial and other challenges for the sectors, picking up from our October 2021 Picture of Higher and Further Education report.
Governance of Fire and Rescue Authorities	Considering whether authorities have effective governance arrangements that support good outcomes for citizens (applying a similar approach to our current work at National Park Authorities – see above).

The senior public service	Building on other work that we have been undertaking on public service workforce issues, this review would focus on issues around senior leadership, potentially encompassing issues including pay and secondments, performance management, departures, succession planning, and leadership development.
Financial sustainability in local government	Local audit work across the 22 principal councils to revisit local government finances and approaches to financial sustainability, also considering application of the sustainable development principle. This work would build on themes in our national summary report in September 2021.
Commissioning and contract management in local government	Local audit work to consider how principal councils' arrangements for commissioning, and subsequent contract management where a client-contractor model is chosen, apply value-for-money considerations and the sustainable development principle.

Indicative topics for work to start in 2024-25 or 2025-26

Narrowing educational attainment gaps	Picking up from issues summarised in our October 2021 Picture of Schools report, this work could examine variation across Wales and good practice, as well as the impact of funding associated with deprivation.
Public health challenges	Examining key public health challenges of our time, with a possible focus on tackling obesity or planning for future health pandemics.
Post Brexit economic developments	Exploring potentially the Welsh Government's support – financial and other – for sectors most impacted by Brexit, such as ports and export-led companies.
The socio-economic duty	Building on our September 2022 report on Equality Impact Assessment, to consider how public bodies are integrating the socio-economic duty under the Equality Act 2010 into their decision-making processes since it came into force in March 2021.
Health inequalities	Linked to work on public health challenges, considering the issues which effect equality of access to services and the wider impact on individuals, communities and our health and social care systems.
Foundational economy	Examining the impact of Welsh Government policy and support around the foundational economy and its provision of basic goods and services that society relies upon.

Net zero follow up	Following up on issues relevant to our July 2022 report on public sector readiness for net zero carbon by 2030. This work is likely to focus in more detail on specific areas of concern, such as the robustness of public bodies' net zero reporting arrangements.
National Transport Delivery Plan	Building on our current work on Active Travel to look at other key areas of delivery for Llwybr Newydd: the Wales transport strategy 2021.
Decarbonising housing	Examining progress in decarbonising housing across different tenures and the delivery and impact of related Welsh Government funding.
Adult mental health services	Considering issues of demand for and access to mental health services, including potentially community mental health support.
Primary care – dentistry	Looking at progress with the national strategic approach and various initiatives to improve access, as well as the dental contract and its impact on NHS dental provision in Wales.
The National Fraud Initiative (NFI) 2022-23	Reporting in autumn 2024 on the results of the latest NFI exercise 2022-23.

Partnership governance	Building potentially on evidence from other work and/or following up on our October 2019 review of Public Services Boards, this review could reflect on the partnership working landscape in Wales, with a possible good practice focus.
Applying the sustainable development principle	Reporting by May 2025 on findings from our examinations of how public bodies prescribed under the Well-being of Future Generations (Wales) Act 2015 are applying the sustainable development principle.
Delivering the Digital Strategy for Wales	Following on from other work, including our March 2023 report on digital inclusion, work that we have undertaken on cyber resilience, and other local audit work, this review would examine issues relevant to the six 'missions' that the Welsh Government has set out in the Digital Strategy for Wales.
Public sector workforce challenges	Drawing together findings from other relevant work supported, potentially, by some additional data analysis to consider challenges around workforce planning and management across Welsh public services.
Public procurement	A pan-public sector review examining developments in the public procurement landscape including, potentially, early consideration of the implementation of new duties proposed by the Welsh Government in its Social Partnership and Public Procurement (Wales) Bill.
Picture of public services	An update to our 2021 Picture of Public Services analysis and ahead of the end of the current Auditor General's term of office in summer 2026.

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Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Report of the Auditor General for Wales

March 2023

This report has been prepared for presentation to the Senedd under the Government of Wales Acts 1998 and 2006.

The Auditor General is independent of the National Assembly and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the National Assembly on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the umbrella brand of the Auditor General for Wales and the Wales Audit Office, which are each separate legal entities with their own legal functions. Audit Wales is not itself a legal entity. While the Auditor General has the auditing and reporting functions described above, the Wales Audit Office's main functions are to providing staff and other resources for the exercise of the Auditor General's functions, and to monitoring and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/ or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Summary report

Context

1 Orthopaedics is the branch of surgery that relates to musculoskeletal conditions. Common surgical procedures include hip and knee joint replacement, and diagnostic intervention such as arthroscopy. Orthopaedic surgeons tend to sub-specialise focussing on areas such as major joints, or foot and ankle, shoulder, or wrist.

2 NHS Wales orthopaedic spend had grown year on year to 2019-20 peaking at nearly £396 million. The pandemic saw reduction in activity and spend the following year. But even with the increases in spend pre-pandemic, the size of orthopaedic waiting lists was one of the biggest challenges facing the NHS in Wales. This challenging pre-pandemic position has further deteriorated because of the impact of COVID-19 on planned care activity. In November 2022, of the 748,271 people on the NHS waiting list in Wales, 101,014 were waiting for orthopaedic services.

3 At the time the UK went into lockdown in March 2020, we were concluding our work to follow up progress against our 2015 reports on waiting times for elective care and orthopaedic services. Across both reviews we had found the same story: many patients still face long waiting times. Some progress has been made in specific areas, but we had not seen the sorts of whole system change that is needed to make the planned care system sustainable.

4 In September 2020, we published a report setting out Ten Opportunities for Resetting and Restarting the NHS Planned Care System. We then prepared a broader commentary on Tackling the Planned Care Backlog in May 2022.

5 This report provides a commentary on orthopaedic services. It describes the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the recent nationally coordinated work to modernise services. The report also sets out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services. In some instances, we use long term trends to help illustrate change over time.

Key messages

A note on patients and pathways

Throughout this report we talk about patients waiting for treatment. Our figures are based on NHS Wales's 'open' referral to treatment measure. The measure counts the number of pathways which have started but not yet completed treatment, rather than people. Each pathway represents a patient waiting but patients may have more than one health condition and therefore be on the waiting list more than once. As a result, the total number of people waiting for treatment will be lower than the total number of pathways.

6 Meeting demand for planned orthopaedic services has been a significant challenge for the NHS in Wales over the last 20 years. The impact of COVID-19 has elongated what was already a lengthy waiting list, such that patients are now facing exceptionally long waits to be seen and treated. For many people this means living in pain and discomfort, with a life-limiting condition.

7 Proportionately, there are more than twice as many people waiting in Wales for orthopaedic services as there are in England. In fact, proportionately, there are more people waiting over 36 weeks in Wales than are waiting in England in total[1]. Month on month, the orthopaedic waiting list has been increasing, peaking with 102,699 patients on the waiting list in September 2022. Referral rates dropped during the pandemic, and we estimate that there are around 135,000 potentially 'missing' referrals that could come back into the system, putting further pressure on the waiting list.

1 Statement by the British Orthopaedic Association, on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022. Direct comparisons are not available with Northern Ireland and Scotland due to differences in the way in which waiting lists are reported.

8 Services have been slow to restart as the immediate impact of the pandemic has lessened, operating on average at around 60% of pre-pandemic activity levels. There is unexplained variation of orthopaedic waits across Wales depending on where you live and the type of procedure you are having. Necessary infection control regimes will continue to have an impact on patient throughput in settings such as operating theatres, but there is scope for current capacity to be used more efficiently by making appropriate use of day case procedures and looking to safely reduce lengths of stay.

9 In the past, the Welsh Government has allocated temporary additional monies to health boards to try and fill the gap between capacity and demand. Whilst this resulted in short term improvements, it did not achieve the sustainable changes to services that were necessary and referral to treatment time waiting list targets[2] for orthopaedics have never been met since the targets were first established in 2009. There needs to be a realistic assessment of capacity. Funding for orthopaedic services has not reflected growing demand and with a predicted 27% growth in over 75s between now and 2030, services need to be sustainably designed to meet that need.

10 We have repeated the wider modelling exercise presented in our Tackling the Planned Care Backlog report in May 2022 for orthopaedic services in order to estimate how long it will take to recover these services. Our optimistic scenario modelling suggests that it could take three years to return orthopaedic waits to pre-pandemic levels. This is based on both a significant drive on community-based prevention, which has shown to have a positive impact on demand, and a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels, noting that current activity is below pre-pandemic levels. Our more realistic scenario indicates that it could be nearer to five years, and our pessimistic scenario indicates that services may never return to pre-pandemic waiting list levels. The scenarios highlight the scale of the challenge facing orthopaedic services in respect of managing demand and building additional capacity.

11 There is some hope, however. NHS Wales has commissioned an in-depth review of orthopaedic services with the Getting It Right First Time team[3] outlining numerous service efficiency, effectiveness, and productivity improvements for acute orthopaedic services. They set out a comprehensive suite of recommendations in their national report and have also provided reports and recommendations to each of the health boards in Wales. Their work sets out the immediacy and urgency needed.

2 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks.

3 Getting It Right First Time is a national programme designed to improve the treatment and care of patients through review and benchmarking.

12 Aligned to this, the Welsh Government commissioned the Welsh National Orthopaedic Society to prepare a National Clinical Strategy for Orthopaedics. This thorough and honest appraisal of the current position and service options for the future sets out in the strongest terms the perilous state of services and gives a clear clinical voice on what needs to be done. It will require brave and bold leadership at a ministerial level all the way through to operational and clinical leaders in hospitals to deliver it.

13 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.

14 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively, including primary, community and diagnostic services. New technology and improved estate need to be prioritised and health boards must work together to develop regional solutions to help tackle the backlog. In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.

Securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with COVID-19 making this significantly worse. It is positive to see that there is a clear commitment to improve orthopaedic services, but urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

Adrian Crompton
Auditor General for Wales

Key facts[4]

37% of people waiting **over 12 months** for orthopaedic treatment[5]

101,014 Total number of people on an orthopaedic waiting list

60% of people waiting **over 26 weeks** for orthopaedic treatment

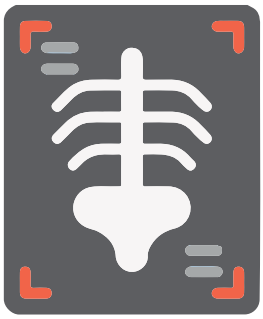
The number of people waiting for orthopaedics accounts for 1/7th of the total NHS waiting list

£395.8m Annual musculoskeletal spend at its peak in 2019-20[6]

£37.2m Annual primary and community musculoskeletal spend in 2020-21[7]

14,639 Number of people waiting more than **two years** (105 weeks) or more for orthopaedic treatment

12,500 Average number of referrals for orthopaedics during 2021-22



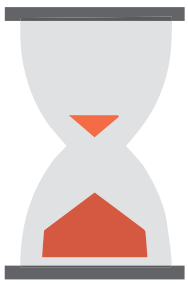
10% of people waiting **two years or more** in the Cardiff and Vale area

compared to

23% of people waiting **two years or more** in the Swansea Bay area

13% variation in the percentage of people waiting **two years or more** across health board areas

29-fold increase in the number of people waiting **over 14 weeks** for physiotherapy between March 2020 to November 2022



56% increase in total numbers waiting for orthopaedics from March 2020 to November 2022

4 Data as of November 2022 unless otherwise stated. Data is all-Wales.

5 Welsh Government data used is over 53-week data. The true 12-month position will be marginally higher.

6 The following year (2020-21) spend decreased to £308.2 million. The reduction in expenditure is a direct consequence of reduction in orthopaedic activity during the pandemic. Source: Stats Wales NHS Programme Budget for Musculoskeletal system problems (excluding Trauma)

7 Primary and community musculoskeletal spend forms part of the total annual musculoskeletal spend.

Recommendations

15 The box below sets out recommendations that we think are needed to strengthen the delivery of orthopaedic services. These recommendations are meant to complement those already made in the Getting It Right First Time reports and the new National Clinical Orthopaedics Strategy.

Recommendations

For the Welsh Government

R1 Actions previously taken to tackle orthopaedic performance have had a short-term focus, not delivered sustainable services, and lacked 'buy-in' from local clinical teams. The new national clinical strategy for orthopaedics sets out clinical solutions to deliver sustainable services. We recommend that the Welsh Government now needs to:

a prepare a clear national delivery plan which sets out the priority actions to be taken over the next three to five years to achieve the clinical strategy. The plan needs to include key deliverables and milestones, and clearly defined roles and responsibilities at a local and national level.

b ensure that the national delivery plan includes a clear direction for regional models to recognise the opportunities that exist to maximise available capacity and provide centres of excellence that deliver better outcomes.

c ensure that the national delivery plan encompasses the wider service input needed to deliver effective orthopaedic services. This should include but not be limited to primary and community care capacity, diagnostic capacity, capital and estates, and digital services.

d ensure that the national delivery plan is reflected in NHS planning guidance and health boards are held to account for implementation through routine performance management arrangements.

Recommendations

R2 The Getting It Right First Time reports at a national and health board level set out clearly a range of recommendations which will help drive improvements in the hospital element of the orthopaedic pathway across Wales, but many of the areas of focus are not new. We recommend that the Welsh Government needs to:

- a ensure mechanisms are in place to obtain assurance from health boards that the Getting It Right First Time recommendations are being implemented.
- b place a significant and constant focus on improving efficiencies and productivity in orthopaedics through its challenge and scrutiny of health boards. This needs to be supported by regular benchmark reporting, and an agreed set of orthopaedic procedures that have been shown to have limited clinical value.

For Health Boards

R3 The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to:

- a ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and
- b ensure that clear action plans are in place to address the things that get in the way of improvement.

Recommendations

R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to:

- a ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and
- b ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.

R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to:

- a ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level;
- b ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and
- c put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.

What is the scale of the challenge?

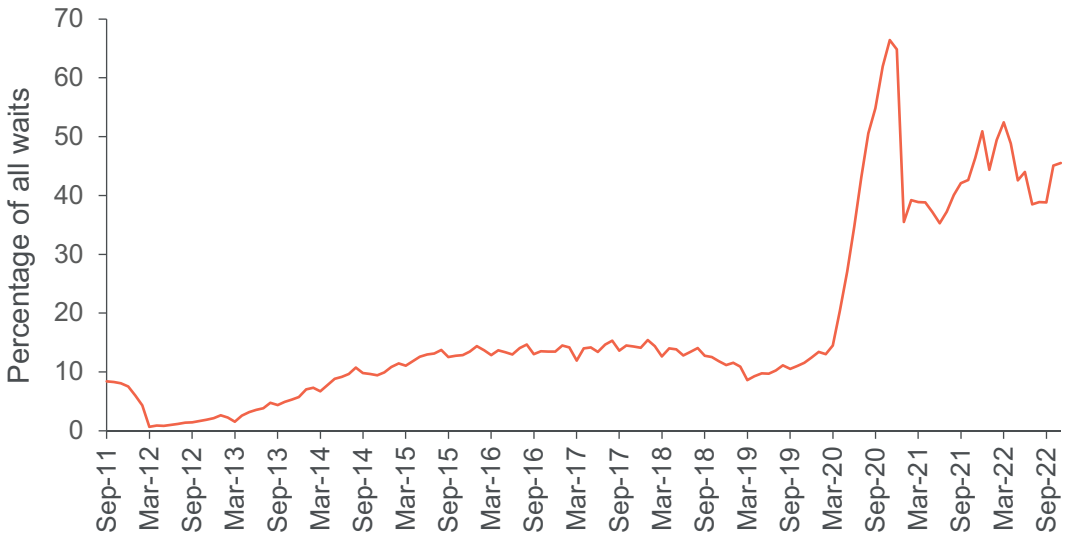
01

Orthopaedic waits have dramatically deteriorated from an already poor position prior to the pandemic

16 Orthopaedic services have not been in a position where they have been able to see and treat people within target timescales since well before the onset of the pandemic. National data show a long-term trend in deteriorating performance against waiting time targets. Since 2011, the national targets of 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks have never been met. At its best, in 2012, 88% of orthopaedic patients were waiting no more than 26 weeks, and 11% waiting over 36 weeks across Wales[8].

17 Immediately before the pandemic, in March 2020, 14% of patients were waiting over 36 weeks. But the pandemic has made a bad position worse. The latest (November 2022) data shows that for those waiting to receive orthopaedic treatment, 46% were waiting over 36 weeks (**Exhibit 2**). This position peaked at 66% in November 2020.

Exhibit 2: Percentage of patients waiting over 36 weeks for orthopaedic treatment by month across Wales, September 2011 – November 2022

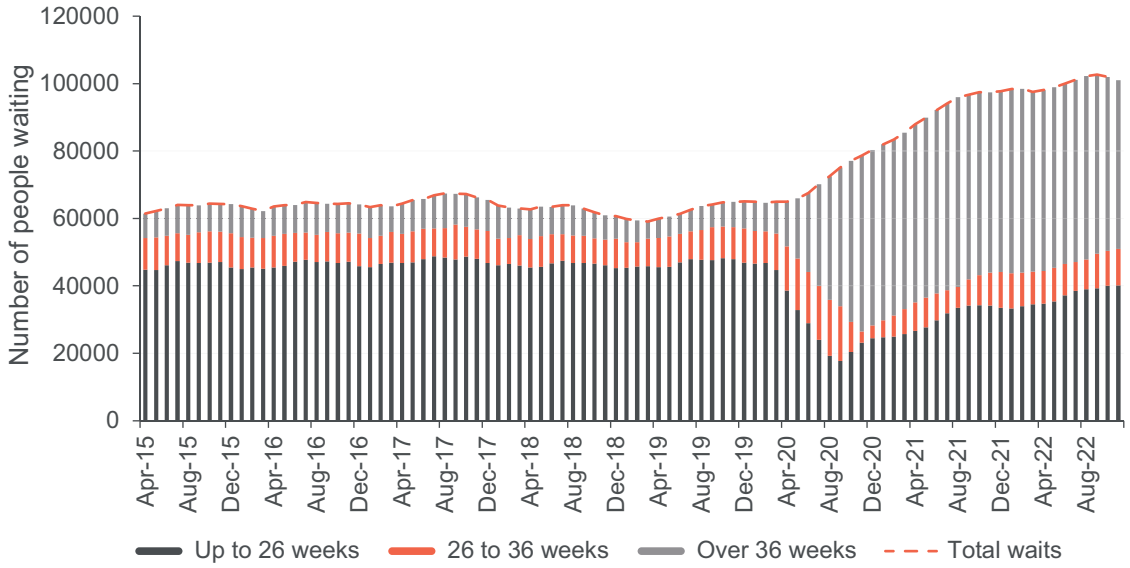


Source: Audit Wales analysis of StatsWales data

8 Data source: Stats Wales, Referral to treatment open pathway data for Trauma and Orthopaedics

18 In March 2020, there were 64,942 people on the orthopaedic waiting list. By September 2022, this had increased to 102,699 people (**Exhibit 3**). This position had slightly improved to 101,014 patients in November 2022. Of those, 50,024 (45.5%) have been waiting more than 36 weeks. More concerning is that of those waiting more than 36 weeks, 37,396 have been waiting over 12 months, and 14,639 have been waiting two years or more.

Exhibit 3: Number of patients waiting for orthopaedic treatment across Wales, April 2015 – November 2022



Source: Audit Wales analysis of StatsWales data

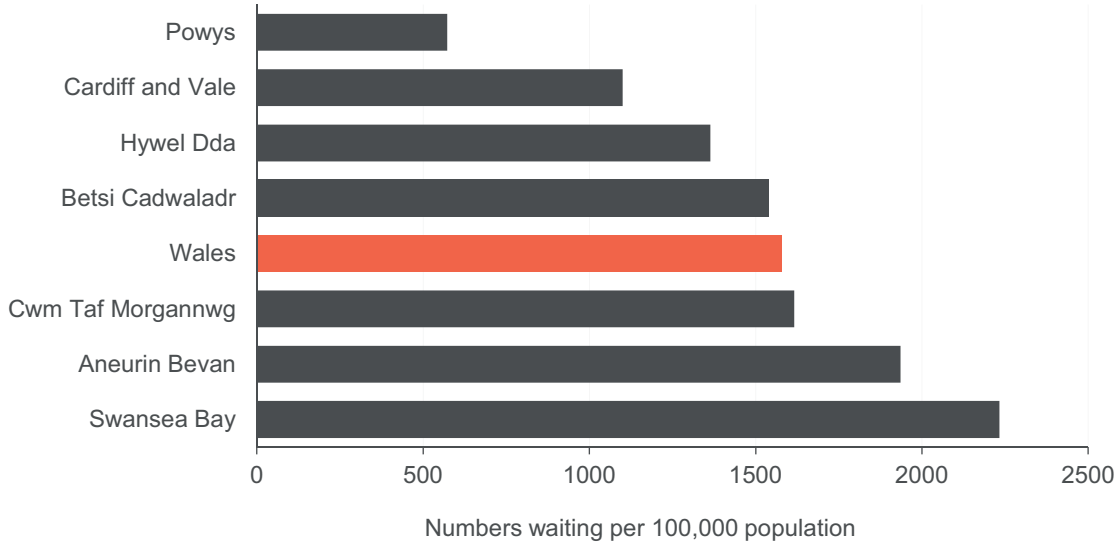
19 To give a broader perspective of the extent of the challenge, in March 2022, 1.3% of the population in England were on an orthopaedic waiting list. In Wales, 3% of the population were on an orthopaedic waiting list[9]. In November 2022 proportionately, there were more people waiting for orthopaedic treatment in Wales over 36 weeks (1.6% of the population) than there were waiting in total in England. These figures do however not take account for the health and age of the respective populations, with the Welsh population generally older and sicker than those in England.

9 Statement by the British Orthopaedic Association, on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022

The extent of the orthopaedic waiting list shows significant geographical variation across Wales

20 A comparison across health board areas of the total numbers of patients waiting over 36 weeks per 100,000 population shows some stark geographical variations (**Exhibit 4**).

Exhibit 4: Number of patients waiting over 36 weeks for orthopaedic treatment per 100,000 population, by Health Board of residence (November 2022)



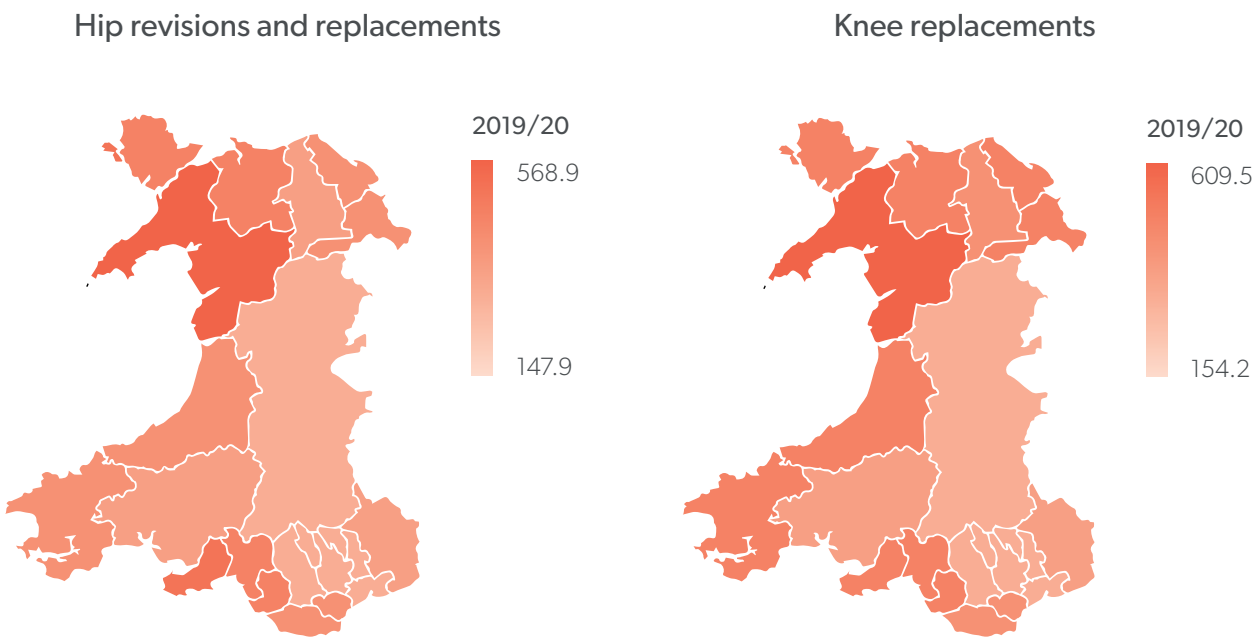
Source: Audit Wales analysis of StatsWales data

21 This geographical variation is equally as noticeable when considering specific orthopaedic procedures such as hip or knee replacement surgery. **Exhibit 5** shows average waits in Wales for hip replacement in 2019-20[10] varied from around 148 days for Powys residents[11] to almost 567 days for Gwynedd residents. A similar, though slightly worse position is observed for patients receiving knee replacement procedures with waits varying from 154 days for Powys residents to almost 610 days for Isle of Anglesey residents in 2019-20.

10 2020-21 procedure level wait data is currently incomplete. We have therefore used the most recent pre-pandemic dataset.

11 Note that some Powys residents will receive treatment from English providers where waiting times are shorter than in Wales.

Exhibit 5: Mean waiting times in days for hip revisions and replacements, and knee replacements for 2019-20, by local authority area



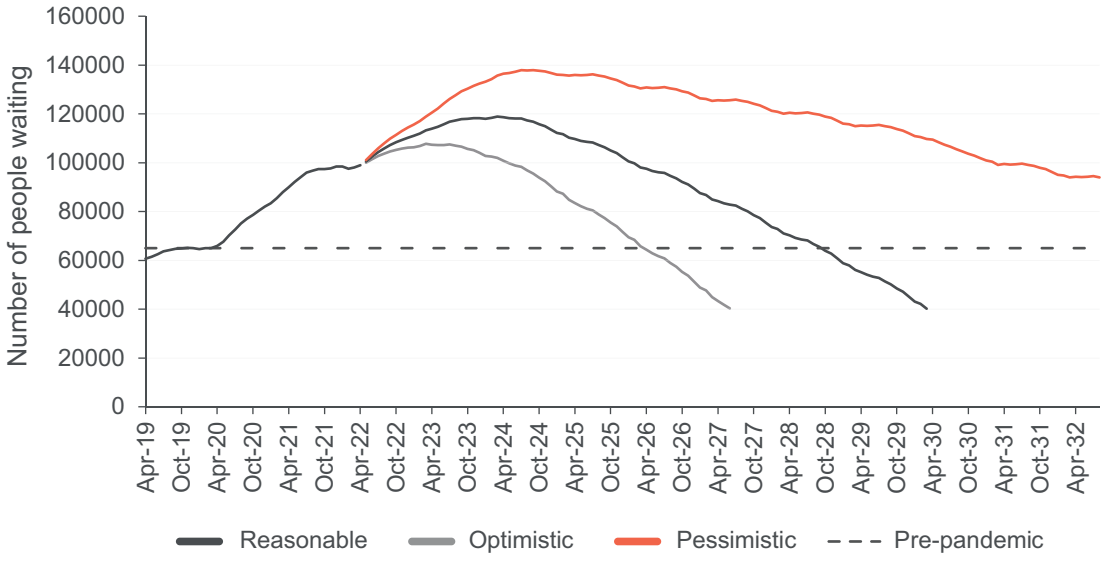
Source: Health Maps Wales, Common Procedure dataset

22 Health Boards are using all possible means to try to reduce the waiting lists. This includes outsourcing, where Health Boards are seeking third-party organisations to provide services on their behalf, such as private healthcare providers or NHS Trusts in England. Outsourcing provides a short-term solution, but this potentially could further widen inequalities of access to care. People living in deprived communities may not be able to travel further to receive their care and those with complex comorbidities may require their procedure in a hospital with intensive care facilities. This may mean those groups of patients face potentially longer waits for their treatment.

Without significant intervention, orthopaedic waits may never return to pre-pandemic levels

23 We have used national data to work out how long it could take NHS Wales to get orthopaedic waiting lists back to March 2020 levels[12]. We developed three illustrative scenarios: **reasonable**, **pessimistic**, and **optimistic**. The modelling (**Exhibit 6**) for our optimistic scenario suggests that the orthopaedic waiting list could peak in 2023 but return to pre-pandemic levels by 2026. The reasonable model would see waiting lists return to pre-pandemic levels by 2028, noting that pre-pandemic performance was itself not meeting Welsh Government targets. The pessimistic scenario may never see a return to pre-pandemic waiting list levels.

Exhibit 6: Illustrative scenarios of waiting list numbers for orthopaedic services across Wales



Source: Audit Wales analysis of StatsWales data

12 **Appendix 1** sets out how we modelled the scenarios.

24 The key variables in our modelling cover the rate at which patients are added to the orthopaedic waiting list over time, the rate at which patients are removed from the list, the potential growth in demand, and the extent to which potentially 'missing' referrals or latent demand returns (discussed later in this report). Our optimistic modelling is also based on assumptions around increasing current activity through increased capacity by 25% by 2025 and reducing the referral demand through prevention and early treatment (such as increased use of CMATS). Our modelling does not consider possible new or more complex demand because of changes in population health.

Long waits for treatment are affecting many people's physical and mental health

25 While orthopaedic and musculoskeletal problems are not, in themselves, life threatening, they can be debilitating and can significantly affect people's quality of life. Many patients waiting for treatment will be experiencing discomfort and pain daily which can lead to a loss in mobility and independence, which in turn can cause wider deterioration in physical and mental health. For some patients this can impact on their ability to work and for many patients there will be an increased need for ongoing support from GPs to help manage their condition. Prolonged waits for joint related problems can also result in further deterioration which could make the required surgery more problematic and potentially less effective.

26 In its submission to the Senedd's Health and Social Care Committee inquiry into the impact of the waiting list backlogs on people in Wales, the Board of Community Health Council's (CHCs)[13] highlighted that orthopaedic services were one of the most common services that the local CHCs were hearing about. In a report by the Swansea Bay Community Health Council on the lived experiences of people waiting for elective orthopaedic surgery, 92% of patients reported a deterioration in their condition. Nearly three-quarters agreed the length of time they had been waiting for surgery had affected their mental health and wellbeing.

13 Inquiry into the impact of the waiting times backlog on people who are waiting for diagnosis or treatment in Wales: Board of Community Health Councils

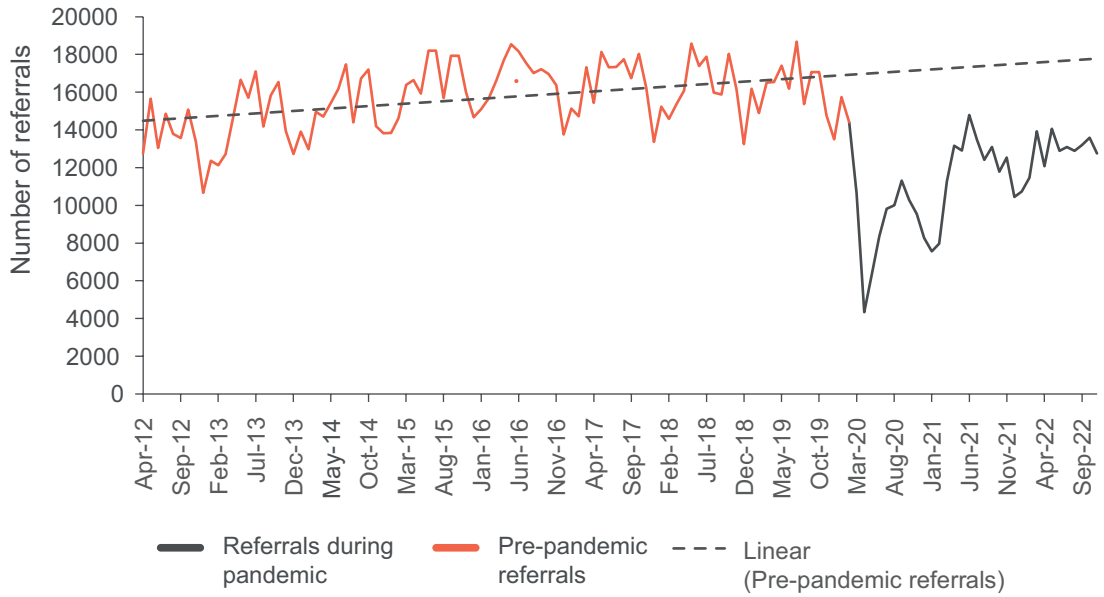
What is impacting the recovery of orthopaedic services?

02

Referral rates are not yet back to pre-pandemic levels

27 The change in the pattern of orthopaedic referrals during the pandemic is like that experienced across planned care services more generally, with a sharp decline in referrals at the onset of the pandemic[14] (**Exhibit 7**). Referrals have not yet returned to pre-pandemic levels. When comparing the level of referrals between March 2020 and March 2022, against 2019-20 referral levels, around 135,000 referrals are 'potentially missing'.

Exhibit 7: Number of orthopaedic referrals across Wales, April 2012 – November 2022



Source: Audit Wales analysis of StatsWales data

28 NHS Wales is currently benefitting from rates of orthopaedic referrals continuing to be lower than pre-pandemic levels. The waiting list position would otherwise be substantially worse. Some of the missing referrals or latent demand may never appear due to, for example, people choosing to seek private treatment, but it is expected that a proportion of the unmet demand will appear and further exacerbate the challenges being faced by orthopaedic services.

14 Note that referral patterns vary significantly by Health Board.

Although radiology and physiotherapy services are recovering, increased demand is adding to delays in orthopaedic pathways

29 Timeliness of orthopaedic treatment is dependent on the timeliness of each stage of the orthopaedic pathway[15] which will include other services such as radiology services and physiotherapy. Since the beginning of the pandemic, the total number of patients across Wales waiting for a consultant referred radiology test increased from 23,979 in March 2020 to 33,121 in November 2022. The total number of people across Wales waiting for a GP referred radiology test increased from 18,703 in March 2020 to 30,175 in November 2022.

30 Of particular interest to orthopaedic services are waits for diagnostic magnetic resonance imaging (MRI) and ultrasound scans. While the number of people waiting has increased, positively the number of people waiting less than the target wait of eight weeks is now at, or marginally better, than levels experienced pre-pandemic, suggesting good progress had been made to recover services. The number and proportion of people waiting over 14 weeks however has grown substantially across both diagnostic tests due to the increased demand (**Exhibit 8**).

15 A pathway is an agreed common approach for a course of care. For orthopaedic patients, this would typically include some or all the following: GP referral, first outpatient appointment, diagnostic test and/or therapy intervention, preoperative assessment, MRSA and COVID-19 screening, consenting, surgery and follow-up outpatient appointment.

Exhibit 8: Number and proportion of patients waiting over 14 weeks for diagnostic tests across Wales in March 2020 and November 2022

	March 2020		November 2022	
	Number	%	Number	%
MRI – Consultant referred	34	3.6%	1,344	10.4%
MRI – GP referred	1	0.04%	478	14.6%
Ultrasound Scan – Consultant referred	55	0.7%	2,361	19.5%
Ultrasound Scan – GP referred	18	0.1%	6,611	26.7%

Source: Audit Wales analysis of StatsWales data

31 Access to physiotherapy presents a similar but more concerning picture. The number of adults waiting for physiotherapy increased from 16,253 in March 2020 to over 32,269 in November 2022. Although more patients are now being seen by a physiotherapist within eight weeks compared to pre-pandemic levels, the number of patients waiting over 14 weeks for physiotherapy has increased 29-fold from 148 in March 2020 to 4,202 in November 2022. Numbers waiting however are gradually reducing. Long therapy waits will not only have an impact on the timeliness of orthopaedic pathways but can also undermine preventative efforts to reduce people's need for surgery.

Capacity and efficiency were already problematic prior to the pandemic, and a slow restart of orthopaedic services has exacerbated the backlog

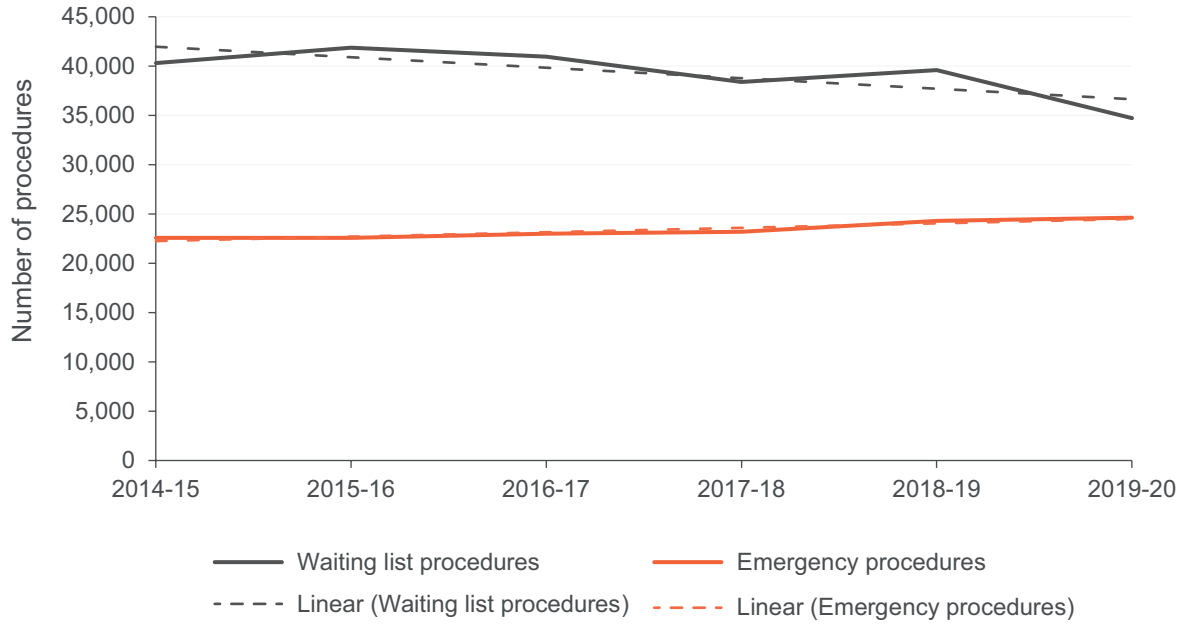
32 For several years there has been insufficient NHS orthopaedic capacity to meet demand. Prior to the pandemic, NHS Wales typically commissioned around 45,000 procedures for the Welsh population, with around 40,000 procedures provided though 'core' activity and waiting list initiatives[16]. The remainder was commissioned from other non-NHS Wales providers[17]. Outsourcing and waiting list initiatives have been short-term measures to improve waiting lists and provide capacity but had done nothing to ensure the sustainability of orthopaedic services.

16 Waiting list initiatives are used by NHS bodies to tackle waiting lists and meet national targets. They involve a short-term increase in capacity such as extra clinics at nights and at weekends, and the use of private healthcare provision.

17 Audit Wales analysis of Patient Episode Data Wales orthopaedic waiting list procedure data, NHS Wales provider versus total commissioned.

33 Over the six years leading up to the onset of the pandemic, the deployment of trauma and orthopaedic capacity changed. National data shows a 10% increase in emergency trauma activity between 2014-15 and 2019-20 which has placed pressure on capacity for planned care. For the same period, there was a 14% decrease in orthopaedic waiting list activity[18] (**Exhibit 9**). The shift between orthopaedic waiting list activity to trauma may not have been readily noticed over such a long period of time but will have had an impact on the capacity to tackle the already existing waiting list backlog. Changes to pension rules for NHS consultants have also impacted on waiting list activity due to a reduction in the willingness of consultants to take on waiting list initiatives.

Exhibit 9: Trend in emergency trauma and orthopaedic waiting list activity, based on the number of procedures, 2014-15 and 2019-20



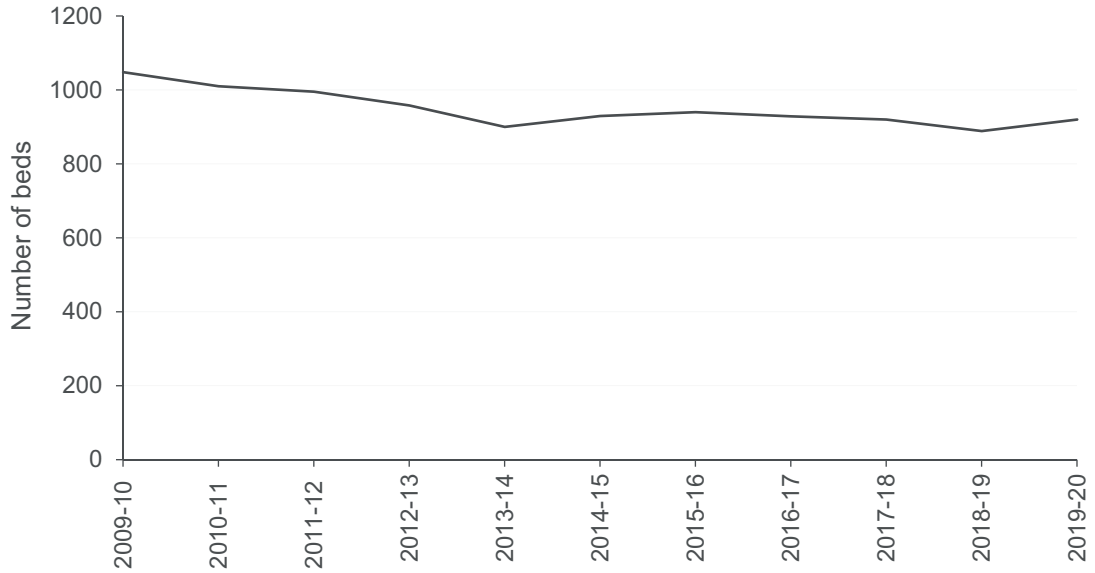
Source: Audit Wales analysis of Patient Episode Database for Wales

34 Capacity constraints also occurred because of a reduction of beds and wider urgent and emergency care pressures resulting in cancellations of orthopaedic activity. **Exhibit 10** shows the total number of orthopaedic beds declined by 12% from 1,048 in 2009-10 to 920 in 2019-20[19].

18 The numbers of waiting list procedures reduced disproportionately in 2019-20. We have assumed this is because of the onset of the pandemic.

19 2020-21 Bed data cannot be compared to previous years because it is based on a different source, definitions, and hospital types.

Exhibit 10: Trend in number of trauma and orthopaedic beds, 2009-10 to 2019-20



Source: Audit Wales analysis of StatsWales data

35 Bed capacity has also further reduced over the last two years with the continual need for health boards to respond to COVID-19 cases and retain infection control measures.

36 Orthopaedic services can operate models with fewer beds if the surgical element of the pathway is well planned, patients are prepared and educated, and processes enable effective and timely discharge. Enhanced recovery approaches also help to reduce length of stay. However, our data analysis indicates lengths of stay have not reduced for many years. Average combined trauma and orthopaedic lengths of stay have stayed at around seven days between 2014-15 and 2019-20[20], with substantial variability in lengths of stay by health board. Our data analysis also indicates around a 25% reduction in day case activity between 2014-15 and 2019-20.

20 Audit Wales analysis of Patient Episode Database for Wales

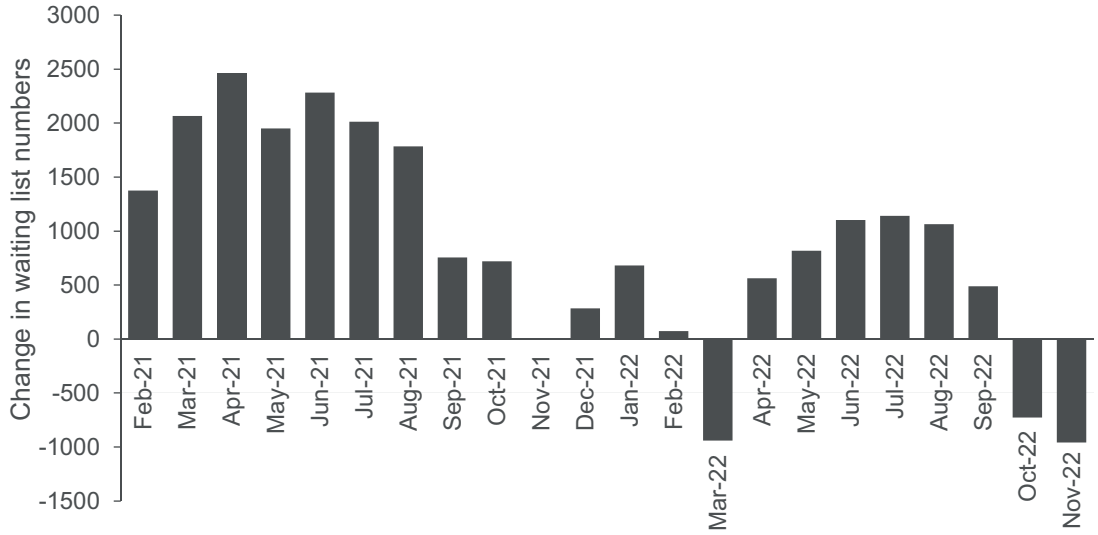
37 Orthopaedic services have been slow to restart since the lessening in the impact of the pandemic in 2021 and since the last major (omicron) COVID-19 wave in early 2022. Services are currently still far off the levels of activity seen prior to the pandemic. Current inpatient and day case orthopaedic activity across Wales is around 60% of pre-pandemic levels[21]. Most health boards are also only achieving around 20% to 30% of their orthopaedic procedures as day cases. NHS Wales is targeting around 60% in future. Day case (and very short stay) provides a significant opportunity for utilising existing capacity better.

38 Based on changes to waiting lists on a month-by-month basis, orthopaedic capacity is currently not meeting demand, resulting in monthly increases in the number of patients waiting (**Exhibit 11**). In 2021-22, the Welsh Government provided extra funding to health boards to buy additional short and medium-term capacity to support the recovery of planned care services, including orthopaedics. Historically NHS Wales would have looked to NHS England for additional capacity, but they too are struggling to recover their own waiting lists. Consequently, requests for additional capacity through private providers have been greater than the supply available and the ability of health boards to secure the additional capacity needed has been limited. This is particularly the case for orthopaedics. Some medium-term additional capacity has been secured using temporary expansions to health boards' existing clinical estate, such as using demountable units to create operating theatres.

39 Funding has also supported administrative and clinical validation of waiting lists to ensure that only those who need treatment are waiting. However, these have tended to be undertaken as one-off exercises to cleanse waiting lists at year end, resulting in a temporary reduction in waiting lists in March. Funding to support the ongoing recovery of planned care has continued and will be available to health bodies for a further three years.

21 Audit Wales analysis of Welsh Government, unvalidated orthopaedic statistics

Exhibit 11: Month-by-month change in waiting lists numbers across Wales, February 2021 – November 2022



Source: Audit Wales analysis of StatsWales data

Orthopaedic services have not kept up with demand and previous national funding initiatives have failed to secure sustainable service improvements

40 Basic analysis of trend data indicates that demand for orthopaedic services is growing. Furthermore, forecasts by the Office of National Statistics indicate a 27% growth of over 75-year-olds (from around 307,000 to 390,000) living in Wales between 2020 and 2032. While positive, this will likely drive further growth in demand for orthopaedic services as more people will be living with age-related orthopaedic and musculoskeletal conditions. This additional demand needs to be planned for and funded.

41 Given that orthopaedic waiting lists pre-COVID-19 were deteriorating, it is unrealistic to think that without significant changes, current capacity will ever result in sustainable service recovery. Indeed our 'optimistic' scenario modelling (**Exhibit 6**) is based on a gradual increase of commissioned orthopaedic capacity (whether provided by NHS Wales or externally commissioned) and/or productivity levels to 5% above pre-pandemic levels noting that services are currently only running at about 80% of pre-pandemic levels. Our model also assumes that services can curtail any growing demand.

42 There has been a history of short-term funded national initiatives for orthopaedic services in Wales. In June 2001, the then Minister for Health and Social Services announced a £12 million package to reduce orthopaedic waits to 36 weeks. Much of this was non-recurrent and consequently had limited ongoing impact. In 2005, the Welsh Government launched its orthopaedic plan for Wales. This initially brought down waits but again did not result in sustainable service improvements. In 2011, the national orthopaedic programme began its aim to eliminate over-36-week waits. At the same time, the then Minister for Health and Social Services announced £65 million over three years to make orthopaedics best in class. Our 2015 report[22] considered the £65 million investment. We reported that orthopaedic services have become more efficient in the past decade, but NHS Wales was not well placed to meet future demand. Whilst there had been a focus on securing immediate reductions in waiting times, less attention had been paid to developing more sustainable, long-term solutions to meet demand. Since then, NHS Wales has struggled to meet its orthopaedic waiting list targets.

43 Planning for elective orthopaedic services needs to have a clear focus on the short, medium, and longer term, and be supported by realistic assessments of capacity and demand. The short-term focus must be on speeding up recovery of services and addressing existing inefficiencies in the system, the medium-term on building sustainable service models which will start to tackle the backlog; whilst the longer- term view needs to take account of population demographics in forecasting future demand on services, and what is needed to meet that demand.

44 While NHS Wales needs to focus on getting services back up and running to meet the demands being placed on them, there is also a duty on health boards to be maintaining a focus on keeping people safe while they are waiting for treatment. Lack of communication from health boards whilst waiting was identified as an issue in the CHC reports. Very few health boards have put arrangements in place to monitor patients on waiting lists and provide the contact needed to reassure patients and provide advice and support as necessary.

22 Audit Wales Review of Orthopaedic Services, 2015

What action is being taken?

03

Community-based prevention and treatment are having a positive impact on reducing demand, but capacity is an issue

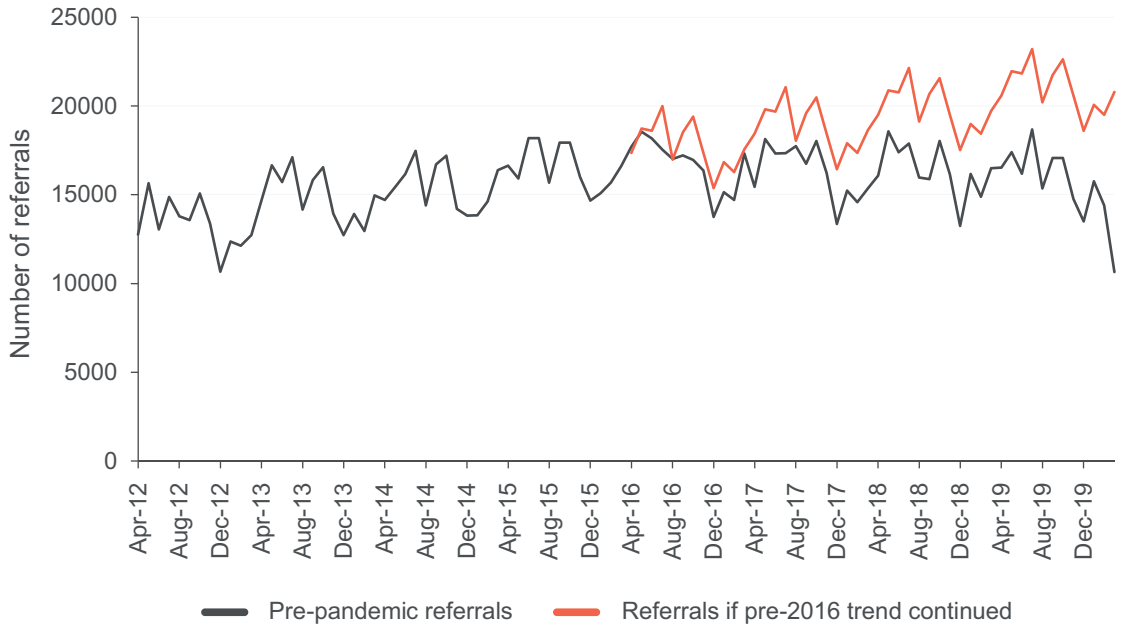
45 For several years, the Welsh Orthopaedic Board has helped to influence developments in orthopaedic services. The Board has overseen the rolling out of preventative approaches such as Community Musculoskeletal Assessment and Treatment Services (CMATS)[23], and more recently First Contact Practitioners (FCPs)[24]. While community-based musculoskeletal services began far earlier in some health boards, for most they started to be rolled out more comprehensively from 2016.

46 While it is difficult to attribute cause and effect directly to the achievements of the community-based prevention, national data suggests that efforts between 2016 and 2020 helped stem the growth in referrals. **Exhibit 12** shows referral trends, and a change in the referral trajectory had community-based prevention not been in place. We have applied a forecast trendline to highlight how the referrals may have increased if the pattern of demand seen between 2012-2016 continued into 2016-2020. With an aging population over this time, we would have expected to see a continued growth in referrals. But this has not been the case.

23 CMATS were developed to provide a community-based service for the assessment and treatment of musculoskeletal-related pain and conditions.

24 First contact practitioner is a new model evolving across the UK which involves placing physiotherapists directly into GP practices to see and treat patients who come into the practice with musculoskeletal problems.

Exhibit 12: Actual orthopaedic referrals compared with predicted referrals from 2016 onwards had community-based schemes not been in place, April 2012- December 2019



Source: Audit Wales analysis of StatsWales data

47 But capacity for CMATS has been an issue. Although waits for CMATS are not included as part of the standard waiting times, our recent work on orthopaedic services identified that CMATS waits could be up to four months. All referrals for orthopaedic services are made via CMATS, and only at the point in which is it considered that CMATS intervention is not appropriate, are referrals passed on to orthopaedic services. For many patients, this will be at the point the referral is triaged by the CMATS which can typically take up to a week. But for some, onward referral to orthopaedic services may not happen until they have waited and been seen by the CMATS.

48 Our recent work also identified inconsistencies in the CMATS model across Wales, with differences in the range of multidisciplinary professionals that make up the team, and differences in the ability for CMATS to refer directly for diagnostic tests. We also found potential duplication of effort between CMATS which include physiotherapists and FCPs and a risk that overall waits for treatment are elongated because of the need to access both FCPs and CMATS before onward referral to orthopaedic services.

49 One scheme to support people is the National Exercise Referral Scheme (NERS). Funded by the Welsh Government and run by the 22 local authorities, the scheme provides opportunities for people with long term conditions to make and maintain healthier lifestyle choices. This is provided through physical activity and behaviour change with the aim to improve health and wellbeing. One intervention is focused on low back pain[25], with another focused on weight management. Although numbers are small, the shift to virtual working in response to the pandemic has provided an opportunity to increase capacity and support people on waiting lists. In its latest report[26], over 25,000 participants attended one of the virtual, outdoor, or indoor activities put in place to support the wider NERS programme. However, due to the pandemic, the NERS was unable to take new referrals. This has now been changed, but services are heavily reliant on the short-term funding available from the Welsh Government and the support of local authority facilities such as leisure centres to run activities.

There is a clear commitment to improve and transform orthopaedic services nationally, although this may take time to achieve

50 Service efficiency, clinical productivity and effectiveness of hospital based orthopaedic services has been an aim in Wales for a long time. NHS Wales has developed clinical pathways based on best practice. But in the past, these clinical pathways have not always been well implemented and there continues to be variation in approaches across health boards.

25 NERS Low Back Pain Intervention
26 All Wales NERS Infographic Quarter Two, 2021-22

51 More recently NHS Wales has commissioned the Getting It Right First Time (GIRFT) team to review acute orthopaedic services. The reviews started in early 2022 and covered all seven health boards and 21 hospital sites that provide orthopaedic services in Wales, comparing clinical practice with England. Recommendations to health boards focussed on:

- strengthening leadership, through health board specific orthopaedic steering groups;
- reducing unwarranted and inappropriate variation in clinical practice, performance, and efficiency;
- engaging staff in change and improvements to orthopaedics and understanding the drivers that are affecting morale;
- implementing waiting list recovery at pace;
- better arrangements to support patients prior to admission, and better discharge planning;
- improving the consistency of collection and use of patient reported outcome measures;
- improving surgical site infection data recording and reducing deep infection rates to 0.5% or lower;
- creating short, medium, and long-term multi-disciplinary workforce plans; and
- building elective orthopaedic recovery plans, including capacity and demand planning on a health board and broader regional footing, multi-disciplinary workforce planning, ring-fencing elective capacity and boosting short-term theatre capacity.

52 The GIRFT team's national report to the Welsh Government includes 28 recommendations spanning but not limited to leadership, safety, workforce, efficiency and clinical practice. The recommendations from both the national and local reports need implementing swiftly and effectively.

53 At the same time as the GIRFT work, the Welsh Government, through the Welsh Orthopaedic Board, commissioned the Welsh Orthopaedic Society to prepare a clinical strategy for Wales. This strategy provides a thorough and honest appraisal of the current position of orthopaedic services. It sets out the need for new leadership through a Welsh Orthopaedic Network and a requirement for the development of orthopaedic hub sites to better protect waiting list activity from unscheduled care pressures, and to enable efficient high volume low complexity centres of excellence.

54 Regional treatment centre hubs offer a good solution to provide protected orthopaedic capacity and deliver best in class levels of efficiency in the medium and longer term. But these will take time, investment, and cooperation across health boards to implement. As an immediate action, some health boards are creating additional operating theatre capacity in the short term, as mentioned in **paragraph 38**.

What else needs to be done?

04

Several challenges need to be addressed if services are not just going to tackle the orthopaedic backlog, but be sustainable for the future

55 This report sets out the huge scale of challenge that is faced in Wales. The extent of the numbers of patients waiting, limited capacity available and potential for further growth in demand provide a concerning landscape not just in the short term but also the medium term. All that can be done must be done within the current operating environment, but there remain several risks to longer-term improvement.

56 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.

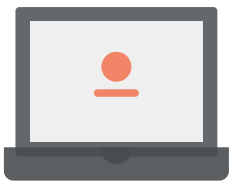
57 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively. New technology and improved estate need to be prioritised and regional solutions need to be much more at the core of delivery plans.

58 In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.

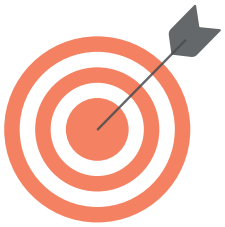
59 These key actions are explored further in the exhibit below.

Exhibit 13: Key actions for NHS Wales to tackle the challenges in orthopaedic services

Lessons must be learnt from previous initiatives which have failed to secure service transformation 	Together the new clinical strategy and the GIRFT reports provide the most comprehensive assessment on the position of orthopaedic services in Wales. It is positive that the Welsh Government and NHS Wales are recognising the scale of the challenge. But the response to these cannot be the same as we have seen in response to previous orthopaedics plans; fundamental embedded change is needed.
National plans must be accompanied by buy-in from local clinical teams 	Our recent work in orthopaedics, whilst recognising good intent from the Welsh Orthopaedics Board to improve and transform services, highlighted the variability in which that intent translated into practice across health boards. Where national directives to implement service changes have been set in the past, implementation has often been slow, inconsistent, and without the 'buy-in' of local clinical teams. The strategy needs to be underpinned by clear and defined programmes of activity and bold leadership will be needed at all levels to ensure that the new clinical strategy delivers a consistent service across Wales.

A renewed focus on efficiencies is needed 	The GIRFT reports have a clear focus on improving efficiency and productivity in orthopaedics, and ultimately delivering better outcomes for the people of Wales. But this focus is not new. NHS Wales has been focusing on reducing length of stay, improving theatre productivity, reducing follow-up rates, and minimising cancellations for some time, but inefficiencies still exist. There needs to be a significant and constant focus in this area. Regular benchmarking reporting needs to be in place to enable challenge and scrutiny to happen locally and nationally, supported by clear action plans to address the things that get in the way of improvement.
A whole system and wider patient pathway focus is needed 	The GIRFT reports and clinical strategy quite rightly focus on orthopaedic services, but effective delivery is reliant on wider services across the NHS. Capacity of enabling clinical services such as diagnostics and therapies to support timely diagnosis, prevention and treatment in the community and effective discharge needs to be available.
Investment in new technologies and improved estate needs to be prioritised 	Digital solutions offer further opportunities for efficiencies but need to be effectively piloted and evaluated to ensure wider investment delivers value. Capital and revenue investment needs to be carefully prioritised to get most impact, considering where opportunities exist to make better use of digital initiatives and estate development.

Regional solutions to meet current and future demand need to be pursued with much more rigour



Developing regional service models has been notoriously difficult in the past but regional working provides opportunity to maximise available capacity and provide centres of excellence that deliver better outcomes. Some health boards are starting to work together to look at regional solutions, but these are limited and often as a reactive response to short-term capacity issues. Regional models need to be at the core of orthopaedic delivery plans, and not around the margins with small scale low impact initiatives, which has been the case previously.

Information on patient experience and outcomes must be used extensively to shape clinical decisions and advice to patients

A greater focus needs to be given to patient experience and outcomes. The roll out of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) for orthopaedic services is still variable across Wales. These have been an ambition for a long time but are not well used to inform future investment and more importantly dis-investment and value-based decisions. At a patient level, outcomes should inform choice and 'what matters' discussions. More also needs to be done to support consistent clinical decision making. For example, establishing a common list of procedures not normally undertaken and setting criteria such as BMI thresholds, if surgery for some patient groups would not result in positive outcomes. Our earlier audit work found health boards were working to different lists of procedures considered ineffective.

Appendices

1 Our approach

Our approach

The evidence base for our work comes from reviews of documents on orthopaedic and musculoskeletal services, data analysis, observation of the Welsh Orthopaedic Board and more recently the Orthopaedic Summit in August 2022, and interviews with Welsh Government and NHS officials. We also build on evidence captured prior to the pandemic from health boards.

Our data analysis is based on Welsh Government data on StatsWales, Health Maps Wales, Patient Episode Dataset Wales, and bespoke data requests to NHS officials.

Our scenario modelling in **Exhibit 6** draws on some initial modelling work carried out by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit, was:

- removals are calculated by taking the number of patients waiting over four weeks (ie they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- additions are the people reported in the monthly figures who have been waiting less than four weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their 'clock' reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 6**). We accounted for the possible pent-up demand (see **paragraph 26**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario, with the optimistic scenario assuming that no pent-up demand returns. **Exhibit 14** sets out our modelling assumptions.

Exhibit 14: Waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90.0%	85.0%
Annual increase in additions 2025 onwards	-0.1%	0.0%	-0.2%
Latent 'missing' referral demand presenting	5.0%	10.0%	0.0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80.0%	80.0%	80.0%
2023-24	90.0%	85.0%	95.0%
2024-25	100.0%	95.0%	105.0%
2025 onwards	102.5%	100.0%	105.0%

Source: Audit Wales

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.

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Orthopaedic Services in Wales – Tackling the Waiting List Backlog

A comparative picture for Cwm Taf Morgannwg University Health Board

Audit year: 2018

Date issued: February 2023

Document reference: 3292A2022

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

Contents

Summary

Introduction

1 This report supplements our national report on orthopaedics services and provides additional analysis of the orthopaedic waiting list position at Cwm Taf Morgannwg University Health Board (the Health Board). The report presents a range of data to inform discussion and oversight of the current challenges associated with the recovery of orthopaedic services at the Health Board. It includes several prompts and questions for board members to inform debate and obtain assurance that improvement actions are having the desired effect.

2 **A note on the data**: In some instances, the most up to date data available is prior to the pandemic. In others, the data available since the onset of the pandemic is not comparable because of service changes over this period. Therefore, we have:

- selected data and indicators to help stimulate board member and senior manager discussion and scrutiny on specific aspects of orthopaedic service delivery.
- used long-term trends and calculations to help present a perspective on orthopaedic services both in relation to the current position and taking a more strategic longer-term outlook.

3 In May 2022, the Getting It Right First-Time (GIRFT) team[1] issued its national report on orthopaedic services in Wales and provided additional local feedback to each health board. The local report for the Health Board was finalised in April 2022. The findings presented here seek to complement rather than duplicate the GIRFT reviews. We have recommended that relevant health board committees receive a progress update against the GIRFT recommendations alongside the Audit Wales national report and the locally tailored data briefing.

4 We have presented the findings in this report under the following headings:

- The scale of the waiting list
- Referrals and demand
- Resources and capacity
- Outpatient models

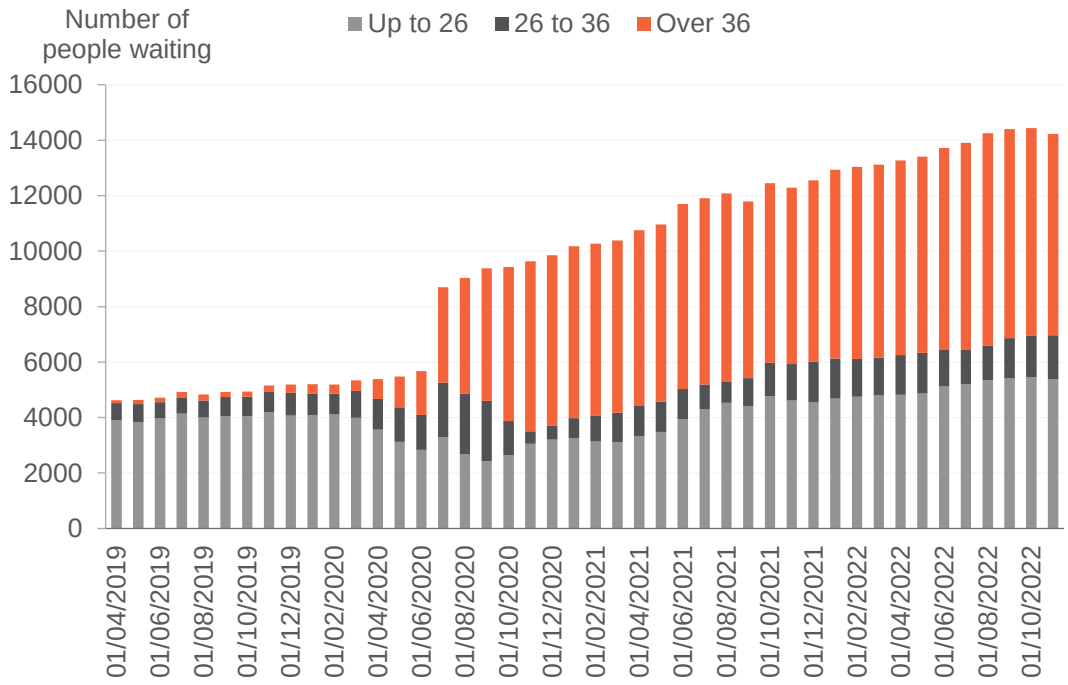
[1] Getting It Right First-Time is a national programme designed to improve the treatment and care of patients through review and benchmarking.

Detailed report

The scale of the waiting list

5 **Exhibit 1** shows the overall trend in orthopaedic waits at the Health Board since 2016. It shows a picture common to most health boards with a sharp increase in the numbers waiting since the start of the pandemic and within those figures, a significant increase in the numbers facing longer waits.

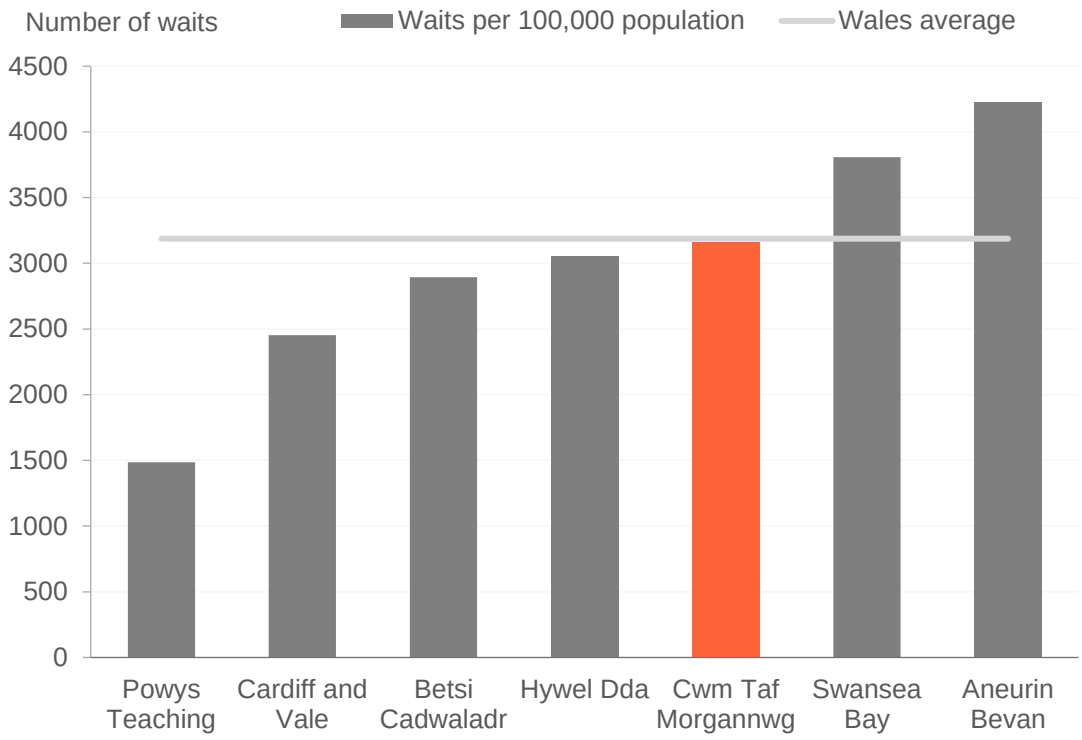
Exhibit 1: total orthopaedic waits, by weeks waiting – Cwm Taf Morgannwg University Health Board (April 2019 – November 2022)



Source: Audit Wales analysis of Stats Wales

6 Comparatively the number of patients on orthopaedic waiting lists relative to population varies across Wales. **Exhibit 2** shows the number of orthopaedic open pathways (waits) per 100,000 population as of November 2022, with the Health Board rate just below the Wales average. This variance may occur because of demographic differences, such as age and deprivation, different primary care referral approaches, different community-based approaches for prevention, treatment, and onward referral. But it is also likely to show that some health boards have been able to a secure a better match between capacity and demand than others.

Exhibit 2: total number of orthopaedic waits per 100,000 population, November 2022



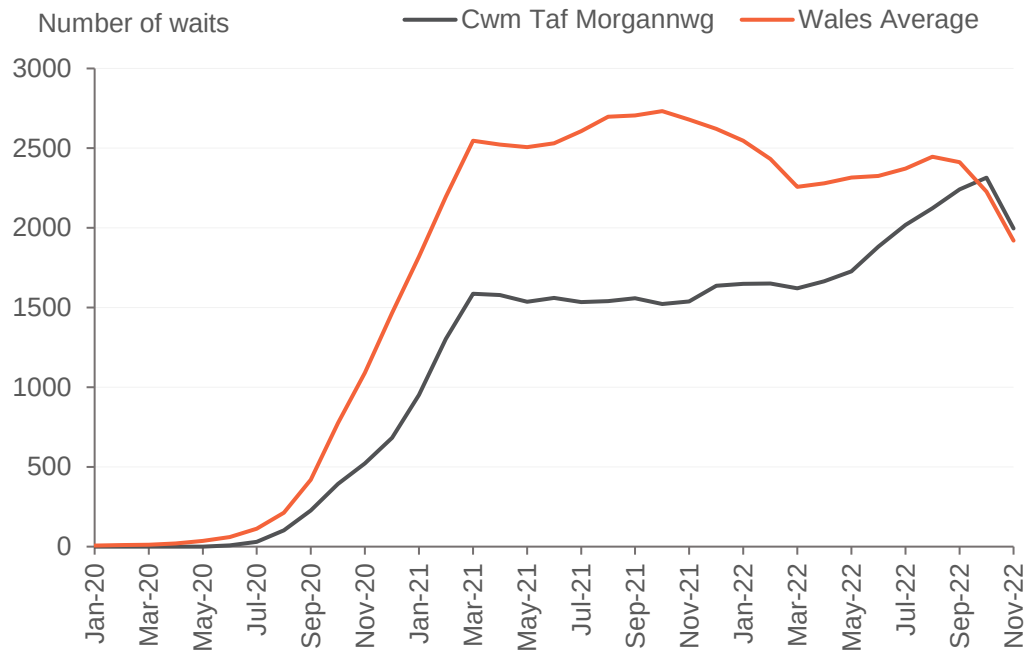
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- What factors are contributing to the Health Board's comparative performance on overall orthopaedic waits relative to population?

7 In April 2022, Welsh Government published its programme for transforming and modernising planned care and reducing waiting lists in Wales. This sets out five ambitions to reduce waiting times in Wales. The first one being 'No one should be waiting longer than a year for their first outpatient appointment by the end of 2022'. **Exhibit 3** shows the number of orthopaedic waits for first outpatient appointment longer than a year. As of November 2022, there were 1,919 patient pathways in the Health Board which were waiting longer than a year.

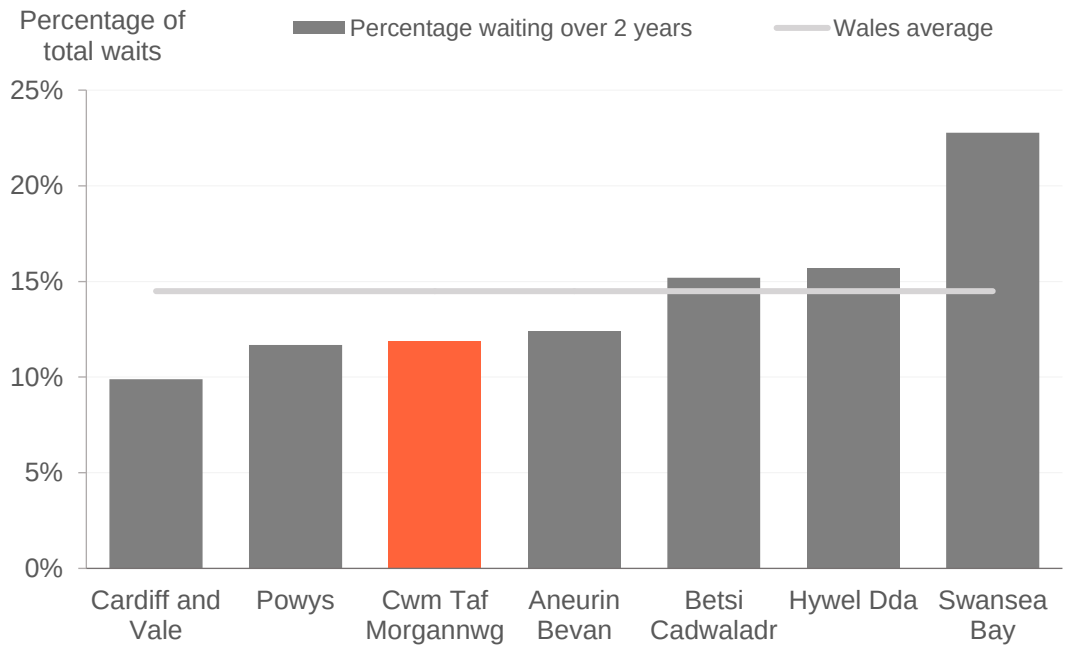
Exhibit 3: total number of orthopaedic waits over a year, waiting for a first outpatient appointment – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales

8 The second key ambition set out in the Welsh Government's planned care programme is to eliminate the number of people waiting longer than two years in most specialities by March 2023. As at the end of November 2022, there were around 1,689 patient pathways waiting over two years for orthopaedic services in the Health Board. This number is the third lowest in Wales. From our wider analysis, the trends across Wales indicate that health boards are now starting to focus on the growth in extremely long waits. But there is clearly more to do and a finite capacity. **Exhibit 4** shows a comparative picture of long waits. As a proportion of total waits, the proportion waiting over two years in the Health Board is below the Wales average. Exhibit 4 indicates that there is inequality for long waits depending on where people live.

Exhibit 4: percentage of orthopaedic waits over 2 years, by residence, November 2022



Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- Is the Health Board likely to meet the targets set out in the Welsh Government's national recovery plan for planned care? If not, when does it anticipate achieving the key milestones set out in the plan?
- How is the Health Board communicating with patients to tell them how long their wait is likely to be and what to do if their condition deteriorates?
- What is the Health Board doing to prioritise those most at risk of coming to harm because of a delay?
- Does the Health Board have information to indicate whether orthopaedic patients are coming to harm because of delays in their diagnosis and treatment? If so, what does this show and what action is being done to minimise the harm?

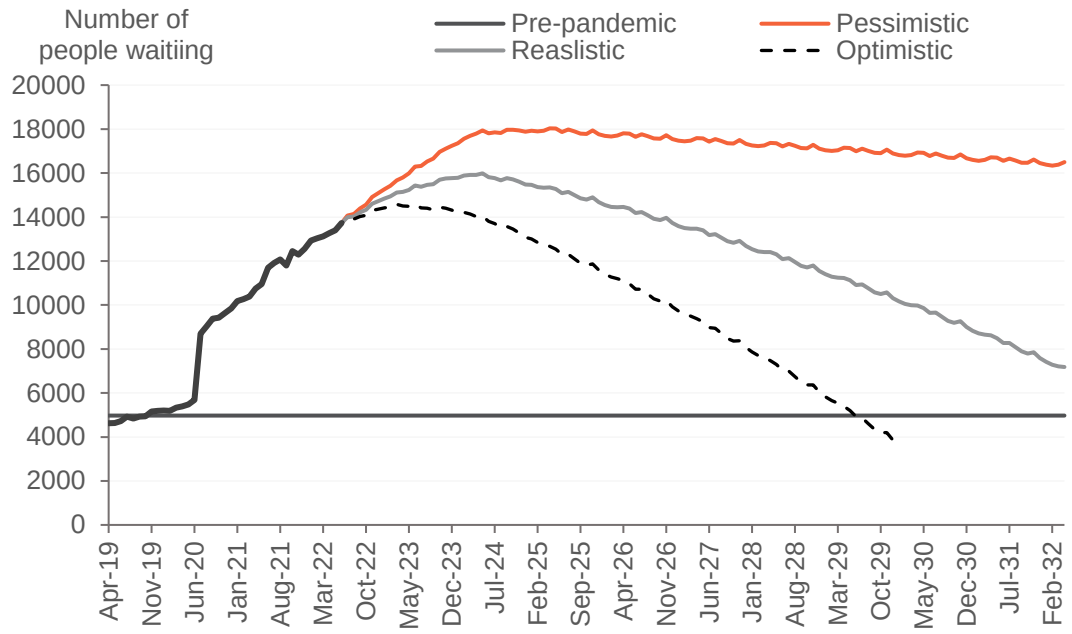
9 **Exhibit 5** provides an illustrative scenario (optimistic, realistic, and pessimistic) for the possible length of time that it could take to return orthopaedic waits to pre-

pandemic levels[2]. Our scenario model is based on pre-pandemic levels of capacity, new demand (additions) and activity (removals), future growth in referral demand, and future growth in capacity and/or activity levels.

10 The scenario model also assumes the levels of pent-up demand hitting the system. Pent-up demand being caused by lower-than-expected referrals since the onset of the pandemic. The model does not assume growth in referral demand due to population changes. The scenarios we have presented are based on assumptions which may alter over the coming years.

11 Even in the most optimistic model scenario, the Health Board's orthopaedic waits would not return to pre-pandemic levels for many years. This is based on a move towards a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels. Clearly the timeframe for recovery will reduce if the pent-up demand does not materialise, demand does not grow year-on-year, the Health Board increases internal capacity or productivity, or if there are opportunities for outsourcing. The realistic and more pessimistic modelling scenarios would not see waiting list number return to pre-pandemic for many years, if at all.

Exhibit 5: illustrative scenarios of orthopaedic waiting list numbers – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales data

[2] **Appendix 1** sets out how we modelled the scenarios.

12 **Exhibit 6** shows the extent of the variation in waits for hip and knee replacement surgery across Wales prior to the pandemic when this data was last available in 2020. At that time, waits for knee and hip replacements in the Health Board were some of the shortest in Wales, except for the Bridgend area. Variation shows differences between service capacity and waiting list management. As health boards across Wales try to reduce waiting lists through outsourcing, there is potential for further widening of inequalities of access to care.

Exhibit 6: mean waiting times (in days) for knee and hip replacement and revision surgery, 2019-20[3]

Health Board	County	Knee	Hip
Betsi Cadwaladr	Isle of Anglesey	609.5	363.9
	Gwynedd	604.4	568.9
	Conwy	409.3	344.3
	Denbighshire	266	212.7
	Flintshire	232.4	221
	Wrexham	236.1	226.6
Hywel Dda	Ceredigion	252.4	213.1
	Pembrokeshire	246.4	238
	Carmarthenshire	221.1	180.9
Swansea Bay	Swansea	362.7	373.2
	Neath Port Talbot	323.1	331.8
Cardiff and Vale	Vale of Glamorgan	229	216.3
	Cardiff	241.9	210.1
Powys	Powys	154.2	147.9
Aneurin Bevan	Caerphilly	185.8	165.2
	Blaenau Gwent	200.2	157.1
	Torfaen	182.1	164.7
	Monmouthshire	180.2	160.2
	Newport	196.6	164.1
Cwm Taf Morgannwg	Rhondda Cynon Taf	177.8	150.8
	Bridgend	317.6	294.9
	Merthyr Tydfil	175.3	161.1

Source: Audit Wales analysis of Health Maps Wales

[3] Table Key: Under 36 weeks 26-36 weeks Over 36 weeks

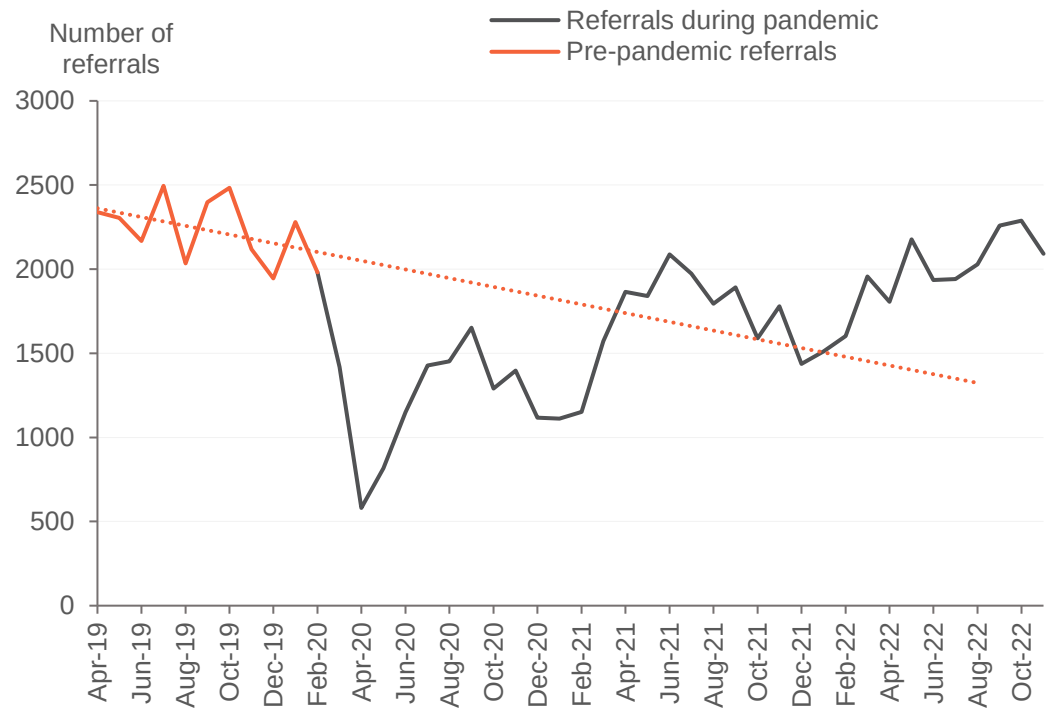
Suggested board member questions

- Has the Health Board undertaken any recent analysis of variation in waiting times by type of surgery and hospital site? If so, what does the analysis show?
- What action is the Health Board taking to reduce variations in lengths of wait for the same treatment across different hospital sites?

Referrals and demand

13 **Exhibit 7** shows the trend in the Health Board's orthopaedic referrals over time and the reduction in referrals during the pandemic. The volume of the Health Board's orthopaedic referrals, unlike many other health boards, has returned to pre-pandemic average referral levels[4].

Exhibit 7: Trend in referrals to the orthopaedic waiting list, April 2012 to November 2022 – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales data

[4] Based on average referral rates for 2019-20

14 The extent of the lower levels of referrals during the last couple of years suggests that patients who would have normally been referred potentially still have a need for treatment. Our calculations suggest around 135,000 orthopaedics latent or 'lost' referrals across Wales. The numbers vary quite significantly by health board with the Health Board having the third highest proportion (**Exhibit 8**). The effect of this latent demand returning to the system and referral demand returning to pre-pandemic levels more generally, will be to make an already challenging waiting list recovery position even more daunting.

Exhibit 8: Number of potentially latent 'lost patients' between March 2020 and March 2022

Health Board	Latent 'lost' referrals	Percentage of all-Wales total
Aneurin Bevan	42,438	32%
Hywel Dda	22,860	17%
Cwm Taf Morgannwg	18,294	14%
Cardiff and Vale	17,576	13%
Betsi Cadwaladr	15,987	12%
Swansea Bay	13,046	10%
Powys	4,204	3%
Total	**134,406**	

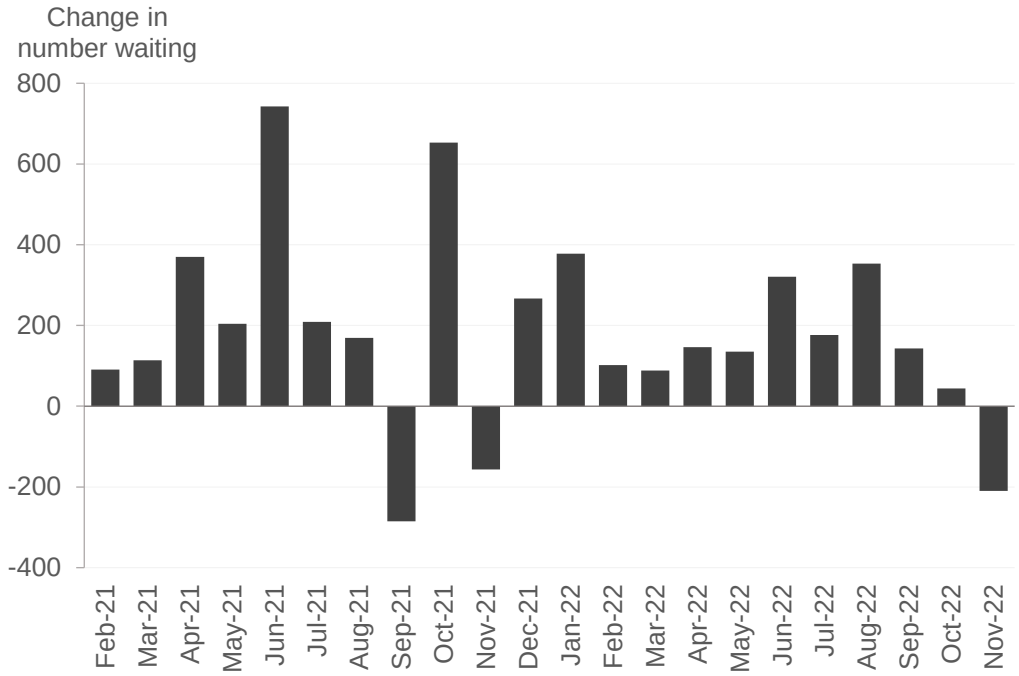
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- To what extent is the Health Board seeing, or expecting to see, the latent demand return? If not expected to return, does the Health Board know where the demand has gone?
- Does the Health Board have a good understanding of the current and future demand for orthopaedic services?
- How is the Health Board ensuring that only appropriate referrals are made into secondary care services?
- Are community-based prevention and treatment approaches such as Clinical Musculoskeletal Assessment and Treatment Services operating effectively, and are there opportunities to exploit community-based services further?

15 **Exhibit 9** shows a month-on-month trend of orthopaedic waits, i.e., whether and by how much each month the waiting list has increased or decreased. Across Wales, some health boards have recently managed to stem the growth in waits in some months, either using short-term additional capacity to meet demand or through validation exercises to cleanse waiting lists. But these reductions have not been sustained. With referrals starting to return to pre-pandemic levels, it illustrates the difficulty health boards are having balancing capacity to meet levels of demand.

Exhibit 9: Month-on-month change in numbers of orthopaedic waits – Cwm Taf Morgannwg University Health Board



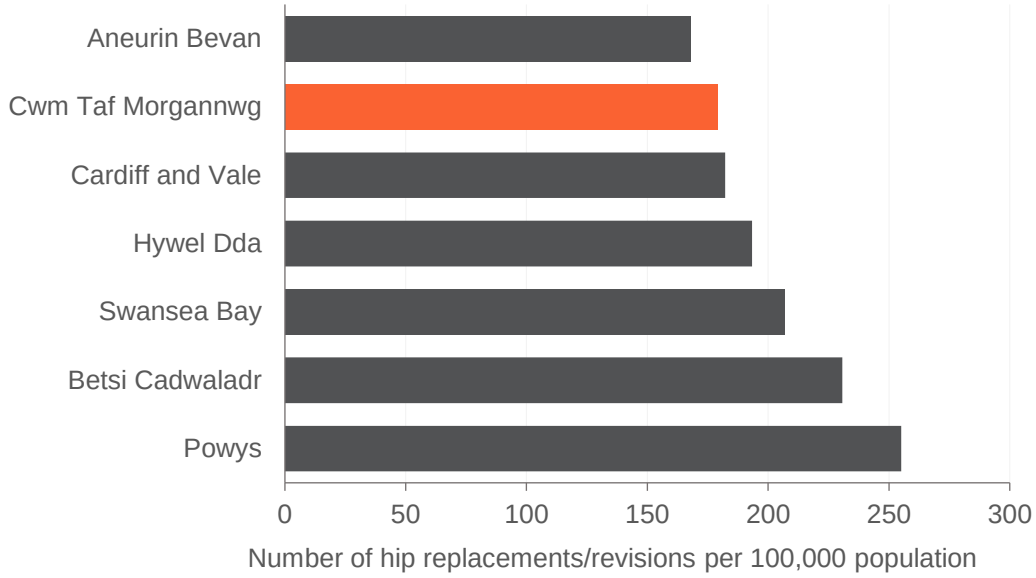
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- What is the Health Board doing to stem the growth in the numbers of people waiting?
- To what extent has list validation been the main factor in reducing waiting lists? To what extent are removals because of validation due to administrative issues? If so, what lessons are being learnt?
- How is the Health Board ensuring the elective orthopaedic capacity is protected from unscheduled care and wider pressures?

16 **Exhibit 10** provides a comparative historical average trend in the rate of hip revisions or replacements over three years from 2017 to 2020 per 100,000 population. While there are demographic differences in each health board, the exhibit shows quite wide variation which is unlikely due to demographics alone.

Exhibit 10: Admission rates for hip replacements/revisions per 100,000 population based on a three-year average, 2017-18 to 2019-20



Source: Audit Wales analysis of Health Maps Wales

Board member questions

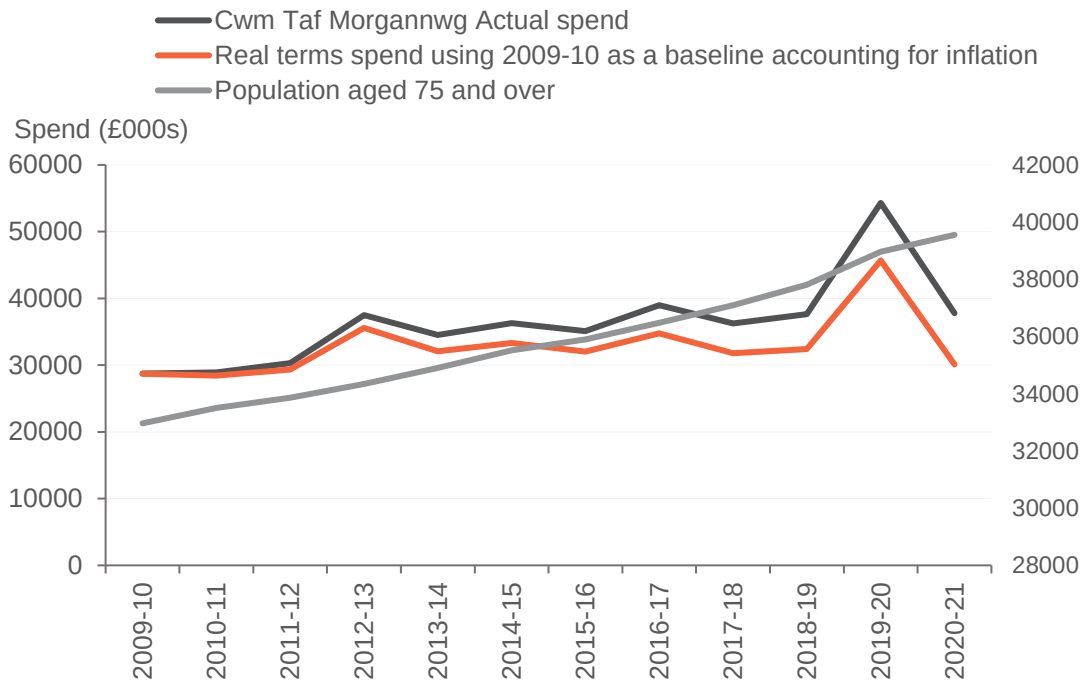
- Has the Health Board undertaken any analysis to understand whether there is a higher or lower rate of procedures, such as hip and knee replacements, than would be expected for the local population? If so, what does it show and are there opportunities for improving productivity and efficiency?
- Does the Health Board understand whether the procedures are delivering positive outcomes for patients?

Resources and capacity

17 **Exhibit 11** provides a long-term perspective on actual spend[5] on orthopaedic services in the Health Board, and the spend adjusted for inflation (i.e., real terms). In general, and across Wales, the pre-pandemic 'real terms' spend on orthopaedics has remained largely static up until the impact of the pandemic. The transfer of Bridgend services however saw an increase in the spend for the Health Board.

18 Service demand is linked to an aging population, with the number of people aged 75 and over increasing by around 19% between 2009 and 2020. This trend is expected to continue. Between 2020 and 2032 across Wales the number of people aged 75 and over is forecast to grow by a further 27%, which could create additional strain on orthopaedic services already struggling to recover.

Exhibit 11: actual spend and real terms spend on orthopaedics vs aging population profile – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales - Health programme budget and population mid-year estimates

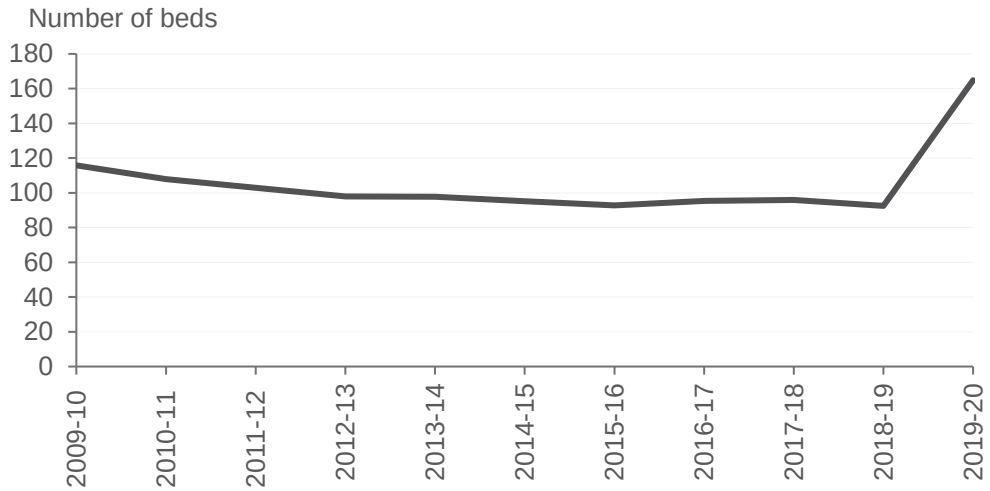
[5] Based on NHS Programme Budget spend for musculoskeletal system problems (excluding trauma)

Suggested board member questions

- If the older population continues to grow, but real terms spend on orthopaedics does not keep pace, can the Health Board ensure that future service models will be sustainable?

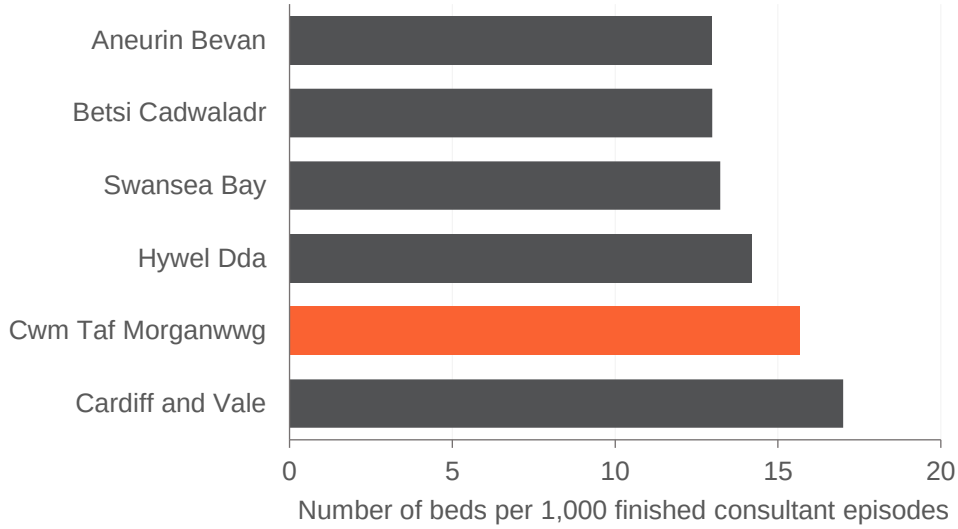
19 **Exhibit 12** and **Exhibit 13** provide trend and comparative data on the number of available orthopaedic beds. The Health Board has the one of the highest level of beds per 1,000 finished consultant episodes, noting the transfer of Bridgend services to the Health Board in April 2019. Given the potential increase in orthopaedic demand due to a growing elderly population, health boards will need to assess whether they can meet demand within existing bed capacity. The extent that efficiencies in bed utilisation can be made and the extent that elective orthopaedic beds can be protected from wider unscheduled care pressures will determine whether current and future demand can be met with the current bed capacity.

Exhibit 12: trauma and orthopaedic bed availability – Cwm Taf Morgannwg University Health Board



Source: Audit Wales analysis of Stats Wales

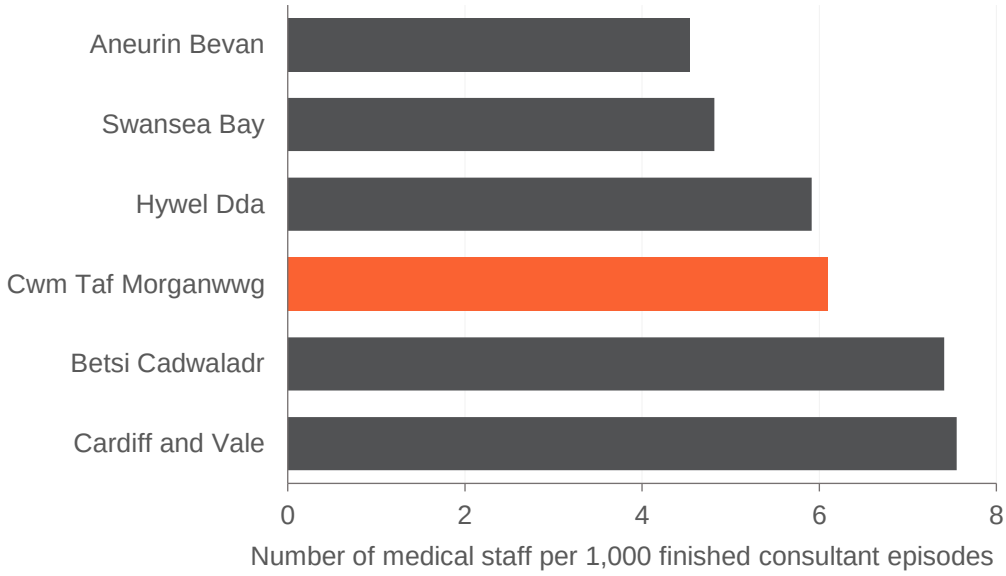
Exhibit 13: comparison of trauma and orthopaedic beds per 1,000 finished consultant episodes 2019-20



Source: Audit Wales analysis of Stats Wales and PEDW data

20 **Exhibit 14** provides a comparative perspective of the medical workforce. The Health Board has the third highest level of medical staff per 1,000 finished consultant episodes. The variation visible across Wales may be due to operational differences in ways of working. However, there is a need to consider optimal staffing levels, efficiencies, productivity, and different pathway models that maximise prudent healthcare principles. As part of this we would expect to see health boards planning on a regional footing to develop high-volume low complexity regional capacity to improve productivity and reviewing consultant job plans as part of pathway redesign.

Exhibit 14: comparison of trauma and orthopaedic medical workforce (WTE) per 1,000 finished consultant episodes 2019-20



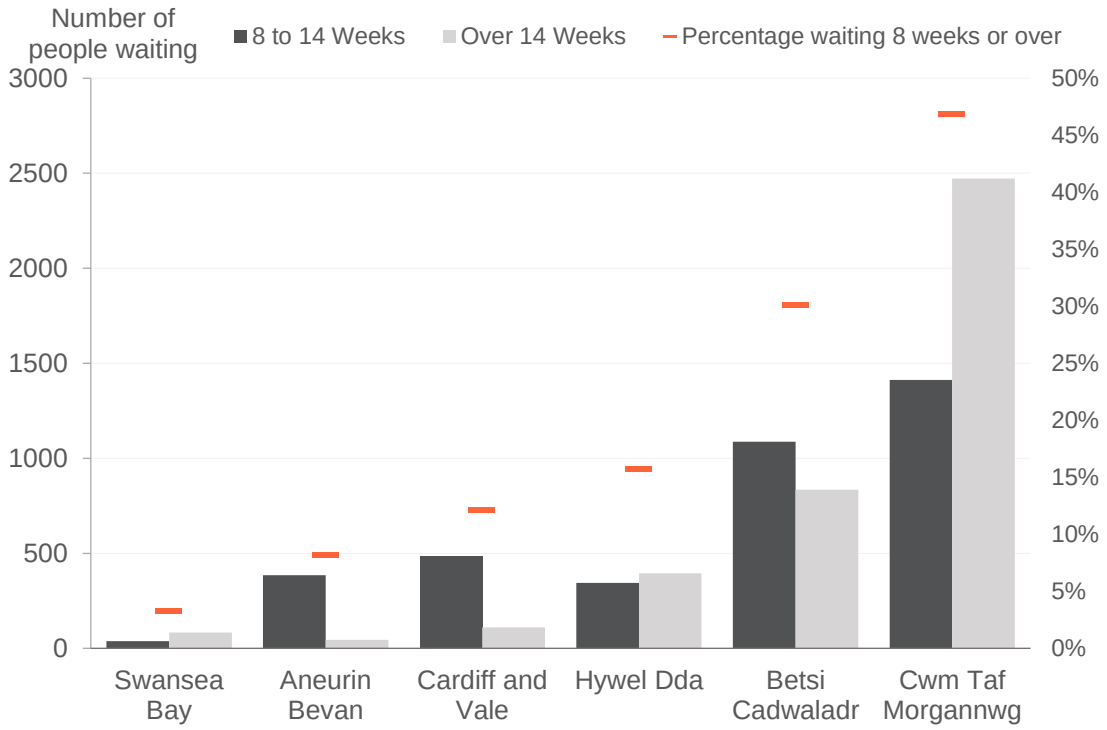
Source: Audit Wales analysis of Stats Wales and PEDW data

Board member questions

- To what extent does the Health Board currently have the capacity to meet orthopaedic service demand? Where are there capacity gaps?
- What are the workforce risks and challenges?
- How is the Health Board working regionally to create high volume low complexity capacity?
- What is the Health Board doing to create greater levels of efficiency in orthopaedic pathways?

21 People with musculoskeletal conditions often need diagnostic tests to provide clarity on the cause and extent of their problems. The Welsh Government targets say that patients should wait no longer than eight weeks for diagnostic tests. The Health Board has the longest waits for diagnostic tests in Wales. Delays in diagnostic tests are likely to impact on the overall timeliness of orthopaedic treatment. At present there is wide variation in the number and proportion of delays in access to radiology services across Wales (**Exhibits 15 and 16**).

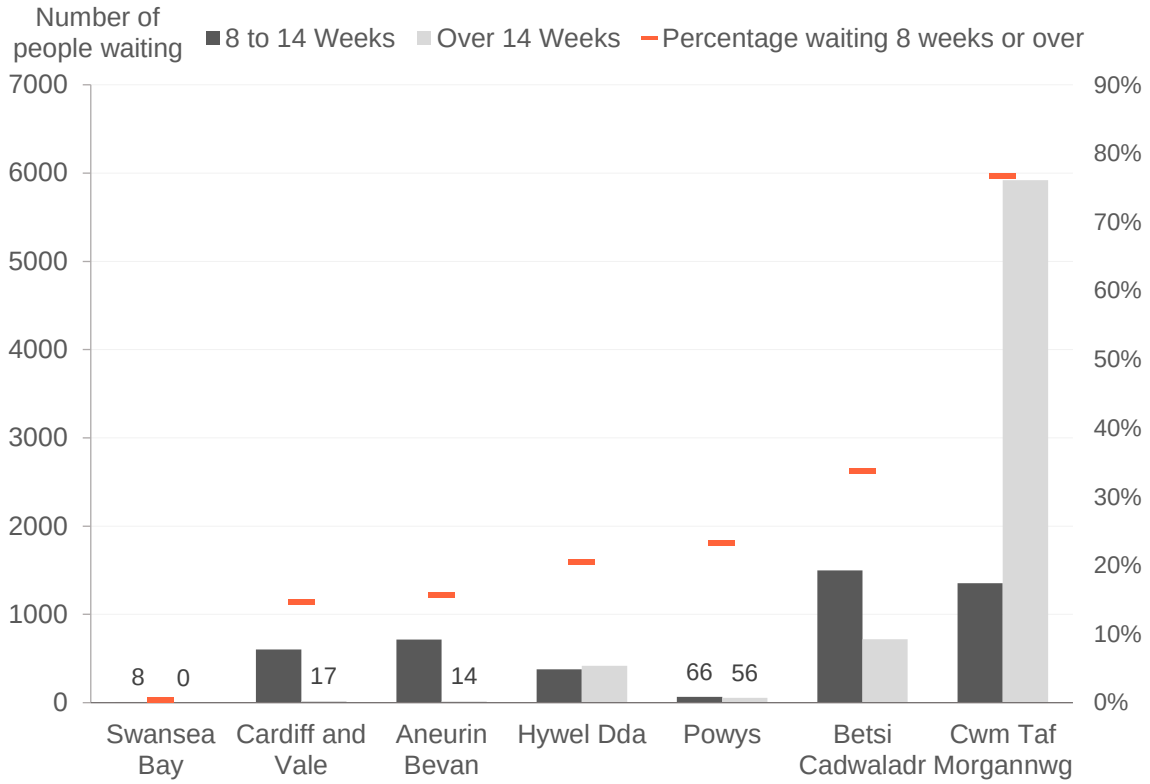
Exhibit 15: number and percentage of waits for consultant referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

Note: Powys consultant referred radiology requests are too low to be visible in the chart.

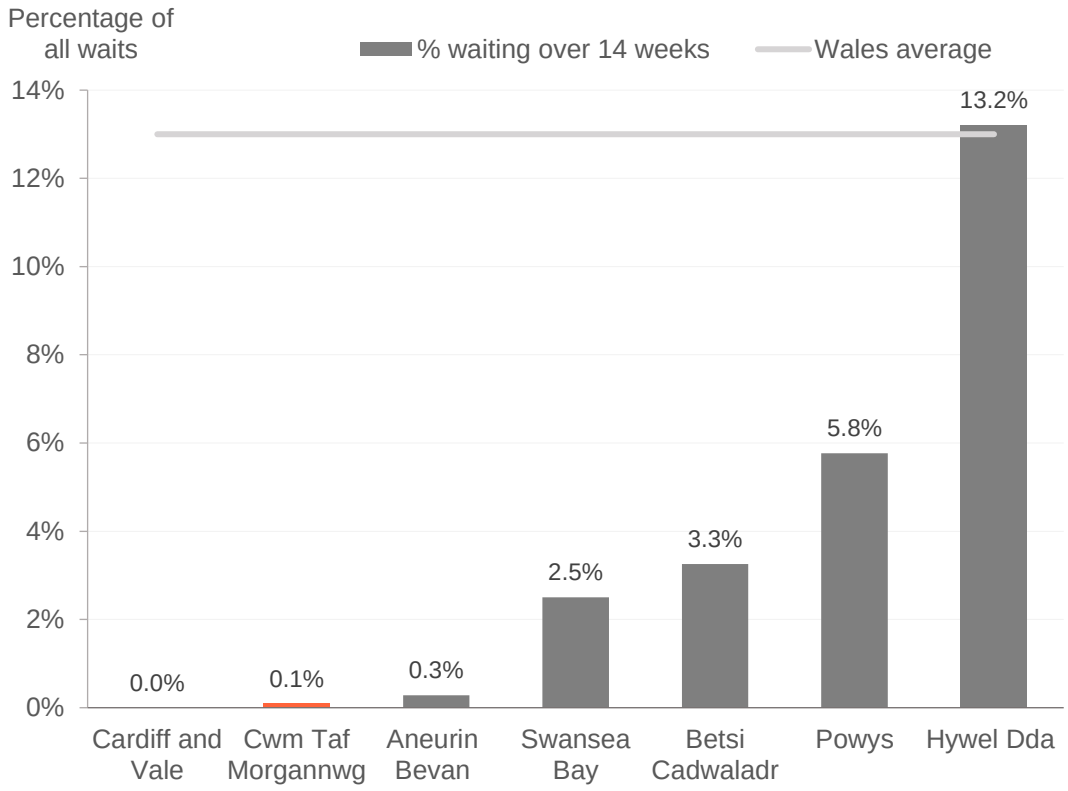
Exhibit 16: number and percentage of waits for GP referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

22 People with musculoskeletal conditions also often require physiotherapy. **Exhibit 17** shows the proportion of people waiting for physiotherapy who are waiting over the Welsh Government target of 14 weeks. The Health Board has very few patients waiting over 14 weeks, and the second-best performance in Wales.

Exhibit 17: percentage of waits over 14 weeks for physiotherapy, November 2022



Source: Audit Wales analysis of Stats Wales

Board member questions

- To what extent is radiology or physiotherapy capacity having an impact on the timeliness of the overall orthopaedic pathway?
- Are there costed plans to match demand and capacity in those areas if required?

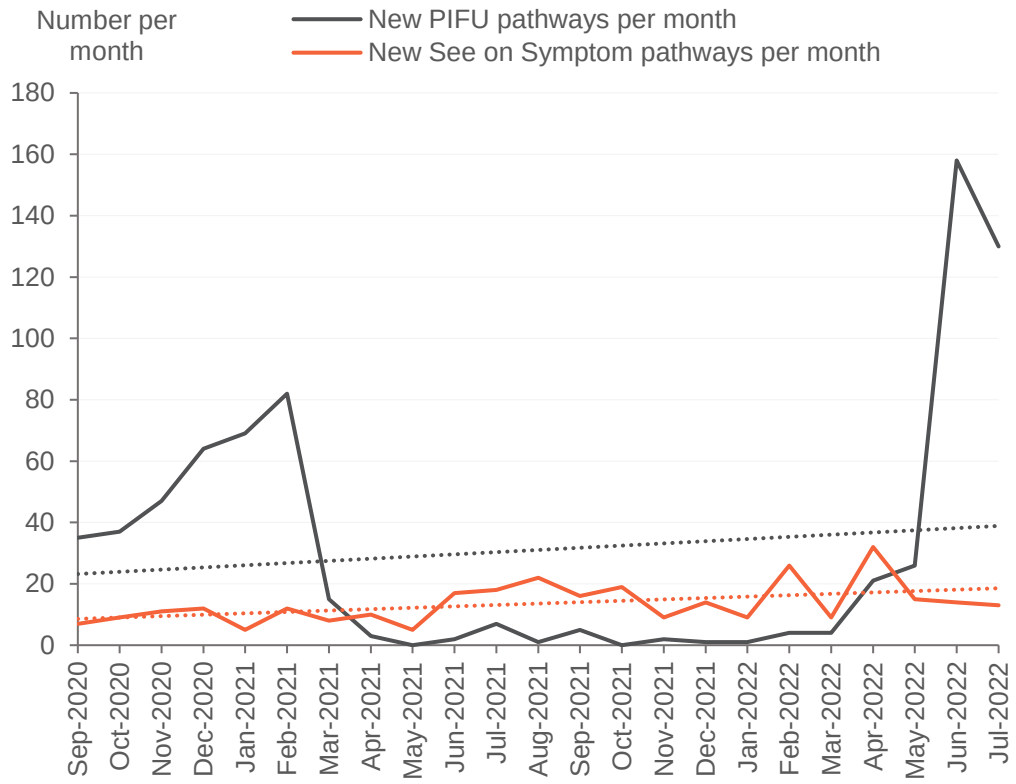
Outpatient models

23 Health boards are implementing new ways of working. The pandemic resulted in a greater extent of 'digitally enabled' working. This helped enable continuation of some services at times where face-to-face appointments were not available. Health boards are also on a journey of implementing new outpatient pathways known as 'see on symptom (SOS)' and 'patient initiated follow up (PIFU).' These approaches are designed to reduce unnecessary follow up outpatient appointments. The aim is

to improve efficiency, reduce unnecessary patient journeys, empower patients to manage their own condition and provide access when they need it.

24 **Exhibit 18 and 19** show the trend in the uptake of new 'see on symptom' and 'patient initiated follow up' pathways. In most health boards in Wales, we are seeing growth in the use of these new pathways but compared to overall numbers of follow up outpatient appointments, these new approaches remain in the minority. For the Health Board, good progress was made with implementing PIFU pathways in 2020-21 but this waned until April 2022. Steady progress has been made with SOS pathways, but overall numbers are low.

Exhibit 18: trend in adoption of new Patient Initiated Follow Up and See on Symptom pathways per month – Cwm Taf Morgannwg University Health Board (September 2020 - July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 19: average number of Patient Initiated Follow Up and See on Symptom pathways per month compared to average number of follow up outpatient appointments (based on 2018-19 activity levels)[6]

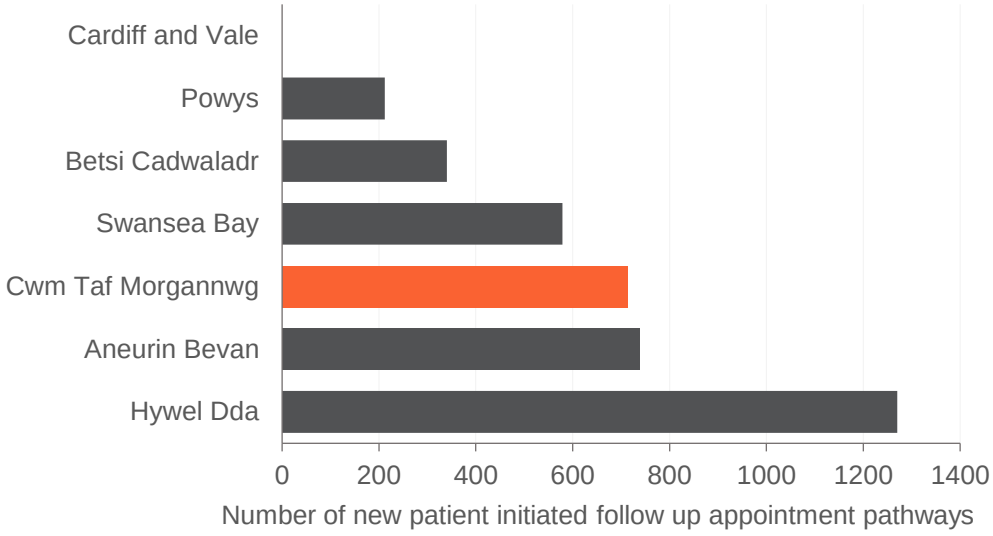
Health Board	Follow up outpatient appointments per month (18/19) average	'Patient Initiated Follow up' pathways per month (21/22)	'See on symptoms' pathways per month (21/22 average)
Abertawe Bro Morgannwg	5283	N/A	N/A
Aneurin Bevan	5840	31	607
Betsi Cadwaladr	4352	15	128
Cardiff and Vale	4317	0	1275
Cwm Taf	2529	N/A	N/A
Cwm Taf Morgannwg	N/A	3	15
Hywel Dda	3428	53	336
Powys	98	11	259
Swansea Bay	N/A	38	507

Source: Audit Wales analysis of Welsh Government provided data

25 **Exhibits 20 and 21** provide a comparison of the numbers of new 'see on symptom' and 'patient initiated follow up' pathways. These are actual numbers and have not been adjusted or weighted for organisational size.

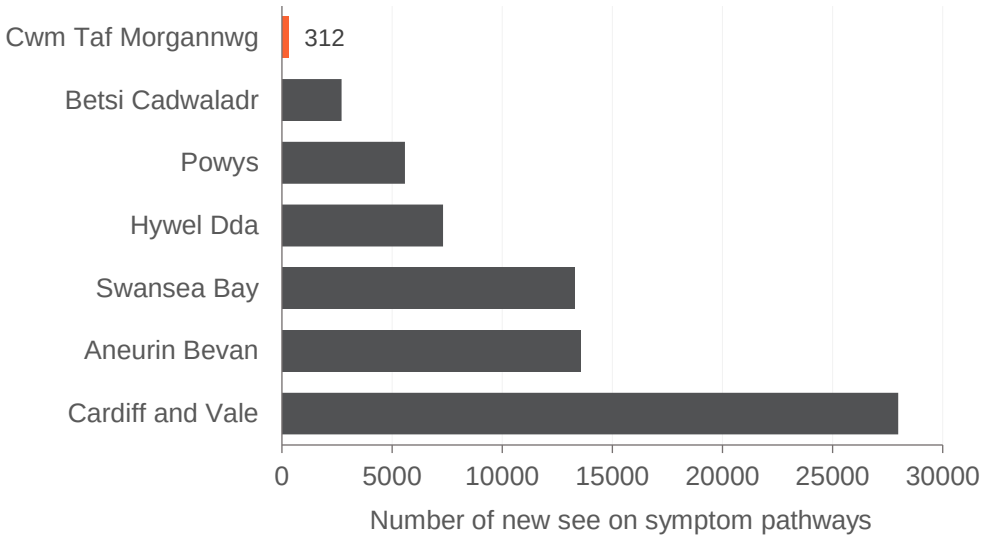
[6] Total follow up outpatient activity levels have not been publicly reported on StatsWales since 2018-19

Exhibit 20: comparison of total new Trauma and Orthopaedic patient initiated follow up appointment pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 21: comparison of total new Trauma and Orthopaedic See on Symptom Pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Board member questions

- Is the Health Board adopting Patient Initiated Follow Ups and See on Symptoms pathways at sufficient pace? If not, what are the barriers?
- Are consultant job plans being reviewed to adapt to new outpatient models and maximise use of their time?
- To what extent are digital/virtual outpatient appointments being used? Is this delivering a better and more efficient service?

Appendix 1

Scenario modelling

Our scenario modelling in **Exhibit 5** draws on some initial modelling work conducted by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit, was:

- Removals are calculated by taking the number of patients waiting over 4 weeks (i.e., they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- Additions are the people reported in the monthly figures who have been waiting less than 4 weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their 'clock' reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 5**). We accounted for the possible pent-up demand (**see Exhibit 8**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario. **Exhibit 22** sets out our modelling assumptions.

Exhibit 22: waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90%	85%
Annual increase in additions 2025 onwards	99%	100%	98%
Latent 'missing' referral demand presenting	5%	10%	0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80%	80%	80%
2023-24	90%	85%	95%
2024-25	100%	95%	105%
2025 onwards	102.5%	100%	105%

Source: Audit Wales

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.

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Archwilio Cymru
Audit Wales

Organisational response

Report title: Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Completion date: April 2023

Document reference: National Report and 3292A2022

Ref[1]	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	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	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.	Requirement of funding April 2024	COO / Planned Care Director/Clinical Restart Manager

	b) ensure that clear action plans are in place to address the things that get in the way of improvement.	• 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	March 2024 (Cost and scope TBC)	COO / Planned Care Director
		• 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.	November 2023	COO / DTS Director
		• 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.	Development of service for Quarter 3	COO / USC Care Director
		• Introduce a FLS service to prevent repeat fractures –timing will depend upon funding.	Case to be developed for 2024/25	COO / Planned Care Director
		• Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput.	November 2023	COO / DTS Director
			To be considered in future elective centres. 2024/25	COO / Planned Care Director

		• 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.	1 CTMUHB CD appointed May 23 September 2023 Ongoing	COO / Planned Care Director / Planned Care Medical Director
R4	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	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.		
R5	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and	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	Requirement of funding April 2024 Requirement of funding April 2024 Requirement of funding April 2024	COO / Planned Care Director COO / Planned Care Director COO / Planned Care Director

	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.	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	Requirement of funding April 2024 March 2024 April 2023 September 2023	COO / Planned Care Director Medical Group Director Planned Care Director Clinical Director

Page	Board member question	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations
6	[insert relevant board member questions e.g. What factors are contributing to the Health Board’s comparative performance on overall orthopaedic waits relative to population?]	

Cwm Taf Morgannwg University Health Board – Detailed Audit Plan 2023

Audit year: 2023-24

Date issued: May 2023

Document reference: 3566A2023

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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

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Our aims and ambitions

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

Contents

Introduction

I have completed most of my planning work.

This Detailed Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2023.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.

Adrian Crompton
Auditor General for Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', the regularity of the income and expenditure, and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the financial statements being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

The majority of my performance audit work is conducted using INTOSAI (International Organisation of Supreme Audit Institutions) auditing standards. INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Your audit at a glance

My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

The current significant financial statement risks include:

- compliance with the rolling three-year resource limits under the NHS Finance (Wales) Act 2014;
- the valuation of the Health Board's estate;
- the introduction of the new accounting standard (IFRS16)[1] leases;
- the accuracy of the remuneration report disclosures;
- the regularity of the salaries for those officers disclosed in the remuneration report;
- the accuracy and completeness of the related party disclosures; and
- management override of the controls in place.

Other areas of audit focus:

- the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff.

My performance audit will include:

- Structure Assessment – Core
- Structured Assessment – Deep dive review of investment in digital
- All Wales thematic review of planned care service recovery
- Local project work - Follow-up of 2018 Review of Primary Care Services

[1] International Financial Reporting Standard 16.

Materiality

Materiality	£15.2 million
Reporting threshold	£760,000

Financial statements materiality

Materiality £15.2 million

My aim is to identify and correct material misstatements, that is, those that might other cause the user of the accounts into being misled.

Materiality is calculated using:

- 2022-23 gross expenditure[2] of £2.4 billion
- Materiality percentage of 0.63% (rounded)

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).

Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts and we have set a lower materiality level for these:

- Remuneration report (including exit packages), £1,000, or lower if a misstatement results in the wrong remuneration-banding being disclosed for an individual;
- Related party disclosures, £10,000; and
- Outturn against the revenue and capital resource limits, £1.

[2] Based on the draft 2022-23 financial statements, which we keep under review to the final audited statements.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks. My planning to date has identified the following risks.

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.
Under the NHS Finance (Wales) Act 2014, health boards moved to a rolling three-year resource limit for both revenue and capital. For 2022-23 the Health Board has exceeded its revenue resource limit by £24.481 million; and by £24.221 million for the three financial years to 31 March 2023[3]. This outcome could affect my regularity opinion.	I monitor the Health Board's financial position for 2022-23 and the cumulative three-year position to 31 March 2023. My review will also consider the impact of any relevant uncorrected misstatements over the three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2022-23 financial statements. I would also expect to place a substantive report on the statements to explain

[3] Based on the draft financial statements submitted for audit.

	the basis of the qualification and the circumstances under which it had arisen.
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date of 31 March 2023.	I will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Welsh Government's Manual for Accounts; and consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.
A new accounting standard, IFRS16[4] Leases, has been introduced from 2022-23. The standard significantly changes how most leased assets are to be accounted for, with leased assets needing to be recognised as assets and liabilities in the Statement of Financial Position (the balance sheet). There are also significant additional disclosure requirements specific to leased assets that need to be reflected in the financial statements.	I will: • consider the completeness of the lease portfolios identified by the Health Board, as needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the new requirements; and • ensure that all material disclosures have been made. As part of my audit planning I have liaised with officers and provided them with the main audit questions to be raised.

[4] International Financial Reporting Standard 16.

I audit some of the disclosures in the remuneration report to a far lower level of materiality, as set out on page 8. The disclosures are therefore more prone to material misstatement. In some of the past audits I have identified material misstatements in the remuneration report, which the Health Board corrected. I therefore judge the 2022-2023 disclosures to be at risk of misstatement. There is also the regularity risk that the Health Board remunerates a senior officer(s)[5] above the Welsh Government's approved pay bands, but without the Welsh Government's formal approval for any salaries that exceed its bandings.	I will examine all entries in the remuneration report to verify that they are materially accurate, and that remuneration is at the appropriately Welsh Government approved levels.
I also audit the disclosure of related party transactions and balances to a far lower level of materiality. In some of my past audits I have identified omitted or incorrect disclosures, which were material and required correcting.	I will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations also include other means of testing, such as my review of Companies House records using data analytics.

[5] For those officers disclosed in the remuneration report.

Other areas of focus

I set out other identified risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

Audit risk	Our planned response
The ongoing impact if the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff. Last year I qualified my regularity opinion, and I placed a substantive report on the statements to explain the reasons. Principally, that the expenditure relating to the scheme contravenes the requirements of Managing Welsh Public Money.	Last year, I qualified my regularity opinion in respect of clinician's pension tax compensation scheme and placed a substantive report on the financial statements explaining my rationale. For 2022-23, whilst any transactions included in the Health Board's financial statements strictly remain irregular, I am not classifying them as material by their nature. I consider that a further qualification of my regularity opinion would have a diminishing value, particularly against the backdrop of the Chancellor of the Exchequer abolishing the Lifetime Allowance in his March 2023 budget statement".

Financial statements audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	February to March 2023	March 2023
2023 Detailed Audit Plan	February to May 2023	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements • Audit of Financial Statements Addendum Report	February to July 2023	July 2023 July 2023 September 2023

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Theme	Approach	Timescales
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2023 structured assessment work will review the following core areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2023 with reporting by the end of October 2023.
Structured Assessment - deep dive review of investment in digital	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth.	Fieldwork to commence during the autumn of 2023 and reporting by April 2024.

	This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	
All Wales thematic review of planned care service recovery	I plan to undertake work following on from my national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork to commence between November and December 2023 and reporting by April 2024.
Follow-up of 2018 Review of Primary Care Services	My audit team will review the Health Board's progress in addressing the recommendations I made in my 2018 review of primary care services.	Fieldwork has commenced and we aim to report our findings by September 2023.

Further to the outputs set out in **Exhibits 3** and **4**, we will also produce an Annual Audit Report for 2023.

Fee and audit team

In January 2023 I published the fee scheme for the 2023-24 year as approved by the Senedd Finance Committee. My fee rates for 2023-24 have increased by 4.8% for inflationary pressures. In addition, my financial audit fee has a further increase of 10.2% for the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**.

I estimate your total audit fee will be £467,328.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables sets out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee[6]

Audit area	Proposed fee for 2023 (£)[7]	Actual fee for 2022 (£)
Audit of Financial Statements	280,386	238,675[8]
Performance audit work:		
• Structured Assessment	84,606	82,378
• All-Wales thematic review	45,632	43,263
• Local projects	56,704	47,315
Performance work total	**186,942**	**172,956**
Total fee	**467,328**	**411,631**

[6] There will be a separate audit plan for the audit of the 2022-23 charity account.

[7] The fees shown in this document are exclusive of VAT, which is not charged to you.

[8] The 2022 fee estimate was £243,814. The actual fee was £238,675 because there was a rebate of £5,139.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact details
Dave Thomas	Engagement Director & Audit Director (Performance Audit)	dave.thomas@audit.wales 02920 320604
Anthony Veale	Audit Director (Financial Audit)	anthony.veale@audit.wales 02920 320585
Mark Jones	Audit Manager (Financial Audit)	mark.jones@audit.wales 02920 320631
Darren Griffiths	Audit Manager (Performance Audit)	darren.griffiths@audit.wales 02920 320591
Steve Stark	Audit Lead (Financial Audit)	steve.stark@audit.wales 02920 829347
Sara Utley	Audit Lead (Performance Audit)	sara.utley@audit.wales 02920 829399

I can confirm that my team members are all independent of the Health Board and your officers.

Staff secondment

Zain Ali, one of our apprentice auditors, was seconded to the Health Board between 6 September 2022 and 3 March 2023. To safeguard against any potential threats to auditor independence and objectivity, the following restrictions apply in line with the FRC's Revised Ethical Standard 2019:

- the secondee will not undertake any line management or management responsibilities; and
- the secondment is restricted to a set maximum of six months.

I can confirm that Zain is not assigned to the 2022-23 audit.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2021.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

Appendix 1

The key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.

Key change	Potential impact on your organisation
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

Through our Good Practice work we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.

Our newsletter provides you with regular updates on our public service audit work, good practice and events, which can be tailored to your preferences.

For more information about our Good Practice work click here.

Sign up to our newsletter here.

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

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee
Internal Audit Progress Report

June 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 **13 June 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 April meeting of the Committee three reports have been finalised, seven reports have been issued in draft, and we have ongoing fieldwork in relation to six reviews. A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
Welsh risk pool	1	2	1	4	Reasonable
Follow up – Concerns	-	2	3	5	Reasonable
Arrangements for managing SLAs	3	2	-	5	Limited

3 Delivering the Plan

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

Table 2 – Performance Indicators 2022/23

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	96%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Amber	65%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 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. In 2022/23 we have issued the questionnaires in relation to the finalised reports, and have received seven responses to date.

5 Other activity

Meetings

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

Appendix A – 2022/23 Programme of work

Table 3: Core programme of work – status of reviews not previously finalised

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
24	Welsh Risk Pool	Reasonable	4	Final	Y	N	-
29	Follow up - Concerns	Reasonable	4	Final	Y	Y	-
17	Arrangements for managing SLAs	Limited	3	Final	Y	N	-
N/A	Follow up - Facilities governance	Reasonable	3	Draft	Y	Y	-
15	Integrated performance report	Reasonable	3	Draft	Y	N	Draft report issued 21.04.23
7	Arrangements for financial savings	Reasonable	~~2~~ 4	Draft	Y	-	Draft report issued 31.05.23
5	National incident framework	-	~~1~~ 4	WIP	-	-	Delays getting reports from Datix. Fieldwork complete
11	Interventions Not Normally Undertaken (INNU)	-	~~2~~ 4	WIP	-	-	Delay getting information
25	Decontamination	-	4	WIP			Fieldwork concluding

Table 4: Status of PCH plan work not previously finalised 2022/23

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

Assignment	Status	Assurance	Notes
Change, risk and contingency	Draft	Reasonable	Combined draft report issued 06.04.23
Governance	Draft	Reasonable	
Community benefits	Draft	Reasonable	
Programme performance	Draft	Reasonable	

Appendix B – 2023/24 Programme of work

Table 5: Core programme of work for Q1 and Q2

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
4	Estates Assurance / condition	-	Q1	WIP	-	-	Fieldwork started 15.05.23
22	Follow up – Radiology – workforce	-	Q1	Drafting report	-	-	Fieldwork started 22.05.23. Fieldwork complete
19	IT Infrastructure	-	Q1	WIP	-	-	Fieldwork ongoing
3	Performance management of 4-hour target	-	Q1	Planned	-	-	Brief agreed 31.05.23
2	Gastro-intestinal pathway	-	Q1	Planning	-	-	Had initial scoping meeting
6	Management of controlled drugs	-	Q2	Planning	-	-	Scoping meeting 29.06.23
7	Deprivation of Liberty Safeguards (DoLS)	-	Q2	Planning	-	-	Scoping meeting 20.06.23
9	Adult mental health – CSG review	-	Q2	Planning	-	-	Scoping meeting 10.07.23
5	Charitable funds	-	Q2	Planning	-	-	-

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
18	IT Service Management	-	Q2	Planning	-	-	-
1	Leadership and management development	-	Q1	-	-	-	Moved to Q3 as internal development ongoing.
8	Finance - Budgetary controls	-	Q2	-	-	-	-
23	Follow up – medical variable pay	-	Q2	-	-	-	-

Table 6: Status of PCH plan 2023/24

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

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

Table 5: Hosted bodies programme of work – Q1 and Q2

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	WHSSC – Integrated commissioning plan (ICP)	-	Q1	Planning	-	-	Scoping meeting 06.06.23
2	WHSSC – Welsh Kidney Network	-	Q2	Planning	-	-	Draft brief issued 08.06.23

Welsh Risk Pool Claims
Final Internal Audit Report

May 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

Review reference:	CTMUHB-2223-24
Report status:	Final
Fieldwork commencement:	14 March 2023
Fieldwork completion:	04 April 2023
Debrief meeting:	05 April 2023
Draft report issued:	05 April 2023
Management response received:	31 May 2023
Final report issued:	31 May 2023
Auditors:	Elizabeth Vincent – Principal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Greg Dix, Executive Director of Nursing, Midwifery & Patient Care
Distribution:	Stephanie Muir, Assistant Director of Concerns and Claims Kellie Jenkins Forrester, Head of Concerns & Business Intelligence Bahar Chowdhury, Head of Claims and Interest Carla Snook, Legal Services Manager
Committee:	Audit & Risk Committee

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

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

To provide assurance that the correct processes has been followed and reimbursements are compliant with the Welsh Risk Pool standard and claims are accurate.

Overview

The matters requiring management attention include:

- Ensuring that the status recorded on Datix have been correctly classified when cases are closed, and the SOPs are updated to reflect this process.
- Ensuring the completion of documentation in line with WRP timeframes.
- Ensuring that staff are aware of the need to save relevant information to Datix.
- Ensuring consistency in approach when capturing information in Datix, including dates and financial transactions.

The advisory point is detailed within the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔ 2021/22

Assurance summary[1]

Objectives		Assurance
1	Completed documents within set timescales	Limited
2	Evidence to support costs incurred	Substantial
3	Appropriate authorisation	Substantial
4	Accurate claims data within Datix	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	Accuracy of 'closed' case reports	1	Operation	Medium
2	Compliance with submission timeframes	1	Operation	High
4	Accuracy and approach to capturing information	1	Operation	Medium

1. Introduction

1.1 Our review of Welsh Risk Pool concerns and compensation claims was completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Compensation claims usually take a number of years from receipt of claim to settlement and can involve a large number of payments and repayments; this gives rise to a potential for mistakes to occur. Welsh Risk Pool (WRP) Services requires that claims for reimbursement and repayment are made within specific timescales.

1.3 WRP have developed a standard: The Compensation Claims Management Standard, to ensure that NHS bodies:

- Have an effective process for managing concerns raised by patients and staff.
- Have an effective process for managing legal claims for financial compensation.
- Ensure that there is good organisational learning from all events.

1.4 Reimbursement of settled claims are either under NHS indemnity, or through redress cases.

1.5 The WRP standard requires Internal Audit to review the accuracy of a representative sample of compensation claims for reimbursement by Welsh Risk Pool Services.

1.6 During 2022 the Health Board worked with WRP Services to help resolve the backlog of Learning From Events relating to older, legacy claims.

1.7 Recently, a new cloud based Once for Wales Datix system has been introduced, referred to as DCIQ. Our testing spanned both the old web based Datix system and the new system, due to the historic nature of some cases.

1.8 As part of our review, we have followed up on the progress made implementing recommendations from our previous audit. We acknowledge that a comprehensive set of Standard Operating Procedures (SOPs) is now in place, setting out processes set by step. We have made some further recommendations to enhance the SOPs and would encourage management to discuss them with those involved in the process to ensure they are understood, accurate and complete.

1.9 The potential risk considered in this review is that claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Health Board's senior management.

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

2. Detailed Audit Findings

Objective 1: An appropriately completed learning from events report, case management report, case financial record and a schedule of costs has been completed for each reimbursement claim within set timescales.

2.1 Datix reports of 'closed' cases were received for Clinical Negligence (CN), Personal Injury and Redress for the financial year 2022-23. There were 65 'closed' cases identified on the CN report, 28 Personal Injury and 69 Redress. We identified that many of the cases did not have the correct status in Datix. Either it had not been correctly updated to the correct stage (for example, reimbursement received), or had no stage showing at all. Our testing focused on those cases that had been correctly closed. We are aware that management are in the process of developing dashboards to allow monitoring and reporting on cases. As such, ensuring the correct classification is essential to making the dashboard reporting accurate and meaningful. **(Matter Arising 1)**

2.2 We tested a sample of 23 cases across the three areas of, Clinical Negligence, Personal Injury and Redress to confirm that each case had an appropriately completed Learning from Events (LFE) report, Case Management Report (CMR), a Finance Case Record checklist (U1/U2), and a Losses and Special Payments Register (LASPAR) schedule of costs. While the documentation had largely been produced, email trails to WRP had not always been recorded in Datix.

2.3 As part of the WRP standards, claims management teams complete a LFE report within 60 days of the 'decision to settle' date. While this requirement became effective for claims received after October 2019, the Health Board is also required to complete legacy LFE reports. We note that the claims management team reviewed the deferred LFE reports in March 2023. There are currently 74 claims and 30 Redress cases with deferred LFR reports, of which 24 have outstanding information and have been deferred for more than nine months. Our testing included 12 legacy claims that were received before October 2019. None of these legacy claims had met the agreed WRP target date of February 2020 for legacy LRFs to be submitted. For the remaining cases in our sample, 9/11 did not meet the 60-day target. **(Matter Arising 2)**

2.4 Claims management teams must complete and submit a CMR and checklist and Finance Case Record (U1/U2) to WRP within 4-months of the final payment date. Our testing identified one case that had been incorrectly categorised within the stages in Datix and so did not require a CMR. The Health Board did not meet the 4-month target for 9/22 cases. The Health Board is at risk of incurring WRP penalty charges if it continues to not meet the target submission dates. **(Matter Arising 2)**

2.5 We compared the key dates on the LFE report, the CMR, and the finance checklist U1/U2 to Datix and found differences with the 'Decision to Settle' date and the 'Final Payment' date. These differences could impact on the monitoring of the target dates. **(Matter Arising 4)**

Conclusion:

2.6 All cases that we tested had the relevant documents. However, there were instances where information had not been submitted to WRP within the required timeframe. We also identified errors in the monitoring reports and differences between the key dates when comparing the documents to Datix.We have provided **limited** assurance against this objective.

Objective 2: There is appropriate evidence to support the costs incurred.

2.7 From our sample of 23 cases, we saw sufficient evidence to support the costs incurred. We had some technical issues when using Datix. We understand that this is not the first occurrence. As such, we recommend retaining copies of information locally until the issue is resolved. **(Matter Arising 3)**

2.8 We also reviewed the LASPAR schedules for each case in our sample to ensure that they reconciled to the amounts reimbursed from WRP. In all cases there was evidence to support that the costs were accurate, and values reconciled to the LASPAR schedule.

Conclusion:

2.9 We confirmed that all the cases that we tested had been appropriately authorised. As such, we have provided **substantial** assurance against this objective.

Objective 3: Forms have been appropriately authorised aligning with delegated limits within the organisation.

2.10 The claims within our sample had an appropriate governance and case manager declaration, and had been appropriately authorised prior to submitting to the WRP.

Conclusion:

2.11 We confirmed that all the cases that we tested had been appropriately authorised. As such, we have provided **substantial** assurance against this objective.

Objective 4: Claims submitted are accurately entered onto the Datix risk management database.

2.12 Reimbursements that we tested were appropriately approved by WRPS, and the amounts received reconciled to the U1 checklists and the finance schedules that were submitted to WRPS.

2.13 The financial information for the claims in our sample had been accurately recorded in Datix and the values reconciled to the relevant checklists.

Conclusion:

2.14 We can confirm that the claim submitted was accurately entered onto the Datix risk management database. As such, we have provided **substantial** assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Accuracy of Closed Case Reports (Operation)	**Potential Impact**
As cases progress though the claims process, their status on Datix should be updated. We were provided with reports of Clinical Negligence (CN), Personal Injury (PI) and Redress cases that showed the cases closed in 2022/23 to date. However, we identified that 41/65 'closed' CN cases and 16/28 'closed' PI cases either had either an incorrect status or no status recorded on Datix. We understand that management are introducing dashboards to be used for monitoring cases. Reporting incorrect stages could affect the results and potentially provide incorrect monitoring data. As a result of recommendations made in our 2021/22 report a series of Standard Operating Procedures (SOPs) have been developed. We reviewed the relevant SOP and note that while the 'Closure' section states that *'officers must ensure that all stages are completed',* it does not elaborate on what the correct closure stages should be.	• Incorrect reporting of data could impact on decision making and statutory reporting requirements

Recommendations		**Priority**
1.1a 1.1b	Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases. Regular monitoring of the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported.	**Medium**
1.2a 1.2b	The 'closure' section within the SOP should be reviewed and updated with clear guidance on what the stages are for closed cases in Datix. Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1a	Staff will be reminded of importance in next meeting in respect of closure.		Head of Claims & Inquest
	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.	09.06.23	Legal services Manager
	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.	30.06.23	Head of Claims & Inquests Head of Concerns & Business Intelligence
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.	30.06.23	Head of Concerns & Business Intelligence
1.2a	The relevant section of the Standard Operating Procedure will be reviewed to ensure that it clearly outlines all requirements associated with the closure of claim file, including the Datix Cymru components.	09.06.23	Head of Claims & Inquest Legal services Manager
1.2b	The updated Standard Operating Procedure will be shared with all staff and training will be provided at the next team day following update. This will include training on the Datix Cymru System.		Head of Concerns & Business Intelligence

Matter Arising 2: Timeliness of submission to WRPS (Operation)	**Potential Impact**
We reviewed a sample of 23 cases, a mixture of CN, PI and redress. Our testing identified: Learning from Events (LFE) Reports The claims management team complete and submit several documents to WRP within specified timeframes. For cases received by the Health Board after October 2019 LFE report within 60-days of the decision to settle date. For cases received before October 2019 a legacy LFE was to be sent to the WRP before February 2020. • 21/23 cases were not submitted to WRP within the 60-day target, this included 12 legacy cases that did not achieve the agreed target date. • 2/23 cases appear to have been submitted within the 60-day target, but key date information was not clear in Datix. Case Management Reports (CMR), U1/U2 Finance Checklist The claims management teams complete and submit a CMR and U1/U2 checklist to WRP within 4-months of the final payment date. • 1/23 cases was incorrectly classified so no CMR or U1/U2 checklist was required. • 9/22 cases did not meet the 4-month target date, with two cases taking over a year to be submitted. • 2/22 the key dates to determine the 4-month target date were not clear from the information available. We are aware that in the past, the Health Board has been at risk of having a penalty imposed by WRP where submissions are late.	• Financial loss to the Health Board.

Recommendations		**Priority**
2.1	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**

2.2	Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	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.	30.06.23	Head of Claims & Inquest
2.2	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.	26.05.23 09.06.23	Legal services Manager Head of Concerns & Business Intelligence

Matter Arising 3: Access to Datix (Operation)			**Potential Impact**
When undertaking our testing, we experienced difficulties opening documents within Datix. We understand that this matter has happened to others on a number of occasions.			• Appropriate evidence trail not available.
Recommendations			**Priority**
3.1	The reasons for not being able to access all information saved to Datix should be identified and attempts made to resolve the issue.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The Staff member has been identified and the issue will be raised with IT. This will be followed up by the Legal Services manager to ensure this issue is swiftly resolved	26.05.23	Legal services Manager
	Issues in relation to accessing the documents within Datix (Web or Cymru) will be addressed by the Business Intelligence Team. A reminder will be issued to escalate system issues to the Business Intelligence Team as they arise.	09.06.23	Head of Concerns & Business Intelligence

Matter Arising 4: Accuracy and approach to capturing final payment information (Design)	**Potential Impact**
Claims management teams must complete and submit a CMR and checklist and Finance Case Record (U1/U2) to WRP within 4-months of the final payment date. We found 12/22 cases where the 'Final Payment' date recorded on the paperwork sent to WRP did not agree to the date of the final invoice shown within Datix. The 'Final Payment' date should originate from the date of the last invoice received relating the case. However, there were differences in approach with some staff using the invoice date and some using the date the invoice was paid. We identified the same issue as part of our 2021/22 review and are aware that in response to last year's recommendation, management have undertaken work to review and update their Standard Operating Procedures. However, based on the results of our testing this year, our review of the SOP, and through discussion with Head of Claims and Interest, we have identified that greater clarity is still needed around the 'final payment' date. Furthermore, the SOP should be added to include the process for when invoices are disputed and how this impacts the final payment date and the required amendments to the Datix.	• Inaccurate reporting and monitoring. • Statutory submission deadline missed resulting in financial penalty.

Recommendations		**Priority**
4.1a	The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed.	**Medium**
4.1b	Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process.	

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1a	The relevant section of the SOP will be reviewed and updated as recommended.	26.05.23	Head of Claims & Inquest
4.1b	The updated SOP will be shared with all staff and offer of training will be provided at the next team day following update.	26.05.23	Legal services Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Follow-up: Concerns
Final Internal Audit Report

May 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

Review reference:	CTM 22/23-29
Report status:	Final
Fieldwork commencement:	22 March 2023
Fieldwork completion:	2 May 2023
Draft report issued:	12 May 2023
Debrief meeting:	18 May 2023
Management response received:	31 May 2023
Final report issued:	31 May 2023
Auditors:	Stuart Bodman – Principal Internal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Greg Dix - Executive Director of Nursing, Midwifery and Patient Care
Distribution:	Stephanie Muir – Assistant Director of Concerns and Claims Kellie Jenkins-Forrester - Head of Concerns & Business Intelligence Louisa Hayhurst – Complaints Team Manager
Committee:	Audit and Risk Committee

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

Acknowledgement

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

Executive Summary

Purpose

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

Overview of findings

A total of 11 High and Medium priority recommendations were made in our original review, though many of those had sub-parts to them.

From our meetings with staff, our review of documentation, and undertaking sample testing we have confirmed that six recommendations have been fully implemented, and work has commenced on implementation of the remaining five.

Since our original review, the Health Board has commenced an organisational restructure that has impacted the concerns team. Despite this, work has progressed on updating the concerns policy and associated procedures, and whilst not finalised, staff are working to the principles of them. However, training in relation to the revised procedures is yet to fully rolled out.

Further work is required in relation to the classification of early resolution cases and the subsequent reporting of them.

Follow-up Report Classification

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

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Policy and operating procedures	High	⇧	Low
2	Capturing complaints	Medium	⇧	Closed
3	Training	High	⇧	Medium
4	Early resolution classification	Medium	⇔	Medium
5	Accurate records	Medium	⇧	Closed
6	Quality assurance	High	⇧	Closed
7	Re-opened cases	Medium	⇧	Closed
8	Aged open cases	Medium	⇧	Low
9	Lessons learnt	High	⇧	Low
10	Monitoring within ILGs	Medium	⇧	Closed
11	Health Board monitoring	High	⇧	Closed

1. Introduction

1.1 A follow up review of Concerns was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original review of the processes that the Health Board had in place for dealing with concerns was completed in November 2021. We issued a 'limited' assurance report and made eleven high or medium priority recommendations. Management responses to address the recommendations were provided, and during 2022 the Audit and Risk Committee has used the Internal Audit recommendations tracker to monitor the progress made in implementing the management actions.

1.3 This follow up review does not aim to provide assurance against the full review scope and objectives of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

1.4 The risks considered during our original review were:

- Learning from complaints does not take place meaning improvements in quality, reduction in adverse events and avoidable harm does not happen.
- Complaints are not investigated in timely, open, honest, consistent or impartial fashion, causing distrust in the process.
- Financial implications where there is a failure to meet regulatory requirements for responses.
- Reputational damage.

1.5 Since our original audit, executive responsibility for Concerns has changed. The lead is now the Executive Director of Nursing, Midwifery and Patient Care.

2. Findings

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

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	5	2	3	-
Medium	6	4	2	-
Low	1	1	-	-
Total	**12**	**7**	**5**	**-**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

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

- The Health Board's internet pages relating to raising concerns have been reviewed and updated to provide clear information to patients, families and carers. The revised policy will be added to the website once formally approved.
- Our sample testing confirmed that accurate records were retained in the Datix system to support the concerns investigations undertaken.
- A revised quality assurance checklist forms part of the new concerns policy. We confirmed that quality checks were undertaken at various stages ahead of response letters being sent to complainants. The response letter template has been updated and we note that letters appear to be more empathetic and provide greater clarity in relation to the outcomes and any lessons learnt.
- In relation to early resolution cases, a dedicated standard operating procedure has been created. Our testing of a sample of cases confirmed suitable information was retained in Datix to support the closure at an early resolution stage. However, we note (Matter Arising four, below) that there are some issues with the reporting of cases classed as early resolution.
- Weekly, executive led, patient safety meetings are in place, where concerns, incidents, and claims data is presented. The data is broken down by Care Group to allow for scrutiny and challenge at a more granular level.
- Patient and quality safety dashboard reports are routinely presented to the Quality and Patient Safety Committee.

2.4 Five recommendations remain open, but we have seen that action has been taken to start to address these findings. As a result, the priority rating of four of these recommendations has reduced, while one has remained the same.

Appendix A: Management Action Plan – for outstanding matters arising

Previous Matter Arising 1: Policy and Standard Operating Procedures not up to date (Control Design)			
Original Recommendation			Original Priority
1.1	The concerns policy should be reviewed and updated to accurately reflect the structure, roles, responsibilities and active involvement of the corporate function and the ILGs in respect of the management, investigation and reporting arrangements relating to concerns and complaints.		**Medium**
1.2	A comprehensive set of Standard Operating Procedures should be developed setting out the process to follow from the point a concern or complaint is received though to the provision of a response. The SOP should include concerns from all sources such as those received via the dedicated email accounts, those made in person or issues raised via local MPs or MSs. The responsibilities of the Corporate Concerns Team and the ILGs should be clearly set out.		**High**
Management Response		Original Target Date	Responsible Officer
1.1	Changes will be made to the Concerns Policy and management process in line with the Concerns Improvement project. This will be undertaken via a collaborative process between Corporate and the ILGs and in light of any changes to the Operating Model following the current review.	June 2022	Interim Head of Concerns, Redress & Legal
1.2	Review the PTR Guidance alongside the CTM structures to identify what Standard Operating Procedures are required and develop and implement to support the new process.	June 2022	Interim Head of Concerns, Redress & Legal
Current findings			**Residual Risk**
The concerns policy has been updated to reflect the revised Health Board structure and the roles and responsibilities of the centralised concerns team including their interface with the new care groups.			Complaints are not investigated in timely, open, honest,

An updated concerns Standard Operating Procedure (SOP) has been drafted. We reviewed the draft document and made some minor observations: • The title and introduction may be misleading to the reader, as they refer to the SOP being for 'formal written concerns'. However, the SOP covers the process for concerns raised by email, letter, telephone, and in person. • No cross reference is made to the supplementary SOPs / documents that have been drafted such as the Early Resolution SOP and Quality Assurance /Audit SOP. • A number of the introductory sections of the SOP are yet to be populated. Whilst the revised policy and updated SOP has yet to be formally approved, in the main, the documents became operational from February 2023. We understand that approval will take place at the forthcoming Quality and Safety Committee meeting after which time the CTM internet will be updated.		consistent or impartial fashion, causing distrust in the process.
New Recommendations		**Priority**
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.	**Low**
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.	
Management Response	**Target Date**	**Responsible Officer**
1a	The Concerns SOP will be reviewed in line with the recommendation above and will be renamed and written concerns will be explained.	May 2023	Head of Concerns & Business Intelligence
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.	August 2023	Head of Concerns & Business Intelligence

Previous Matter Arising 3: Training plans and activity (Operation)			
Original Recommendation			Original Priority
3.1a 3.1b	A training programme should be developed and rolled out across the Health Board to ensure that staff are suitably trained for the roles they are performing in relation to the Concerns process. A training needs analysis should be undertaken in each ILG and for corporate teams to identify the staff that fall into the three levels of training outlined in the Concerns Training Plan. The PADR process could be used in the future to help identify training needs.		**High**
3.2	Those staff who may have received training previously or are experienced in the role of investigator or quality assurance, should receive 'refresher' training to ensure awareness of current processes and the application of consistent practices across the Health Board.		**Medium**
3.3	Records of all training attended in relation to both PTR/Concerns training and Datix Once for Wales Training should be retained.		**Medium**
Management Response		Original Target Date	Responsible Officer
3.1a 3.1b	CTM Concerns Management training programme to be developed encompassing Putting Things Right, the Once for Wales Concerns Management System and Welsh Risk Pool procedures, more specifically Learning from Events Reports. Training Needs Analysis Template to be developed following development of Concerns Management training programme. To be shared with the ILGs for completion and identification of all staff who should receive the training.	April 2022 June 2022	Interim Head of Concerns, Redress & Legal Interim Head of Concerns, Redress & Legal/ILG Heads of Quality & Safety
3.2	This will be picked up as part of the Training Needs Analysis in 3.1b and where relevant, training will be provided as part of the training programme.	June 2022	Interim Head of Concerns, Redress & Legal

3.3	Undertake scope on training record management and how this is captured within CTM if it is not retained within ESR Discussion with ESR team to ascertain whether training records can be included on ESR for Concerns Management training. Discussion with Organisational Development regarding retention of training records and how this links to PADRs.	February 2022	Interim Head of Concerns, Redress & Legal

Current findings	**Residual Risk**
Over the past year incident management training has been provided to a number of staff. This training provides a small element of concerns training, specifically the link to the management of serious incidents. More recently, as the concerns policy and SOPs have come close to finalisation, specific concerns training has been provided to the central concerns team and some clinicians. This training provision has allowed additional feedback on the SOPs to be provided and further refinement ahead of approval. Work has also commenced on developing a training prospectus and a training needs analysis. The newly formed care groups will be required to identify who will receive training appropriate to their role and involvement with the concerns process, this will incorporate staff that may need refresher training. At the time of our fieldwork, management had yet to decide if the concerns team will hold a central training record that captures the training that staff have undertaken, or whether concerns training undertaken will be recorded on an individual's ESR record.	Staff are unaware of their responsibilities in relation to the concerns process. Reviews and investigations are carried out in an inconsistent way.

	New Recommendations	**Priority**
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.	**Medium**
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.	

Management Response		Target Date	Responsible Officer
3.1a	Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training	August 2023	Head of Concerns & Business Intelligence
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	October 2023	Head of Concerns & Business Intelligence
3.1c	Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	October 2023	Head of Concerns & Business Intelligence

Previous Matter Arising 4: Classification of early resolution concerns (Operation)			
Original Recommendation			Original Priority
4.1	A review should be carried out to establish why Bridgend ILG is closing less of its concerns at an early resolution stage in comparison to the other ILGs. The review should include identifying if there is a link between concerns closed at early resolution stage and concerns re-opened. Any learning identified from the review should be shared across the ILGs and where necessary processes followed should be captured in a Standard Operating Procedure.		**Medium**
4.2a 4.2b	Management should understand why RTE has not been re-categorising early resolution concerns that were not resolved in the timeframe and take appropriate action to resolve and accurately record in Datix. To ensure consistency, a Standard Operating Procedure (SOP) should be in place outlining the process for re-categorising concerns, including who is responsible for performing this task. Training should be provided where necessary.		**Medium**
Management Response		Original Target Date	Responsible Officer
4.1	Audit of Complaints Management to be reintroduced looking at all aspects of complaints management. Audit will commence with BILG to address this risk and will then be conducted across the other sites. A programme of on-going audit will be re-introduced.	April 2022	Complaints Manager
4.2a	As 4.1 above	April 2022	Complaints Manager
4.2b	Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above.	April 2022	Interim Head of Concerns, Redress & Legal
Current findings			**Residual Risk**
Management identified that, at the time of our original fieldwork, staffing pressures in the Bridgend ILG had contributed to problems resolving early resolution stage cases in comparison to the other ILGs. Management plan to undertake audits of cases and data, to allow the team to identify and investigate trend and anomalies and strengthen working practices. A draft Quality Assurance / Audit checklist and SOP has been created.			Information is inaccurately reported, and potential issues are not identified.

	However, at the time of our follow up fieldwork, the central concerns team had only been in place for a few months. As such, work in relation to carrying out audits had yet to start. In the absence of the team performing their own audits, we undertook testing. We reviewed a report of early resolution cases for the period February to March 2023, and identified: • 22% cases (60 of 269) remained open but had already exceeded the two-day early resolution timeframe and had not been reclassified. • 38% (80 of 209) of the closed cases, had been closed as early resolution, but had exceeded the two-day timeframe. In the worst case, a case was closed on day 44, but still classified as early resolution. As such, the matter with regards to the reclassification of early resolution cases does not appear to be fully resolved. A separate Early Resolution SOP has been prepared which provides some information about the re-classification of concerns from an early resolution status to a full Putting Things Right (PTR) status, if resolution in the two-day time period is not possible. However, the SOP is not detailed in relation to the exact time frame and process in Datix for re-classifying cases. We acknowledge that closure or reclassification is reliant on timely responses from care groups and / or clinicians, which can be challenging within the two-day timeframe. We understand that until responses are received, then re-classification could be erroneous. However, it is our view that cases should not be left in early resolution status as this may lead to inaccurate reporting.	
New Recommendations		**Priority**
4.1	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**
4.2	Regular monitoring should be undertaken of cases that remain open and classified as Early Resolution, to ensure they do not remain open indefinitely while waiting for a response. Responses should be chased up frequently for those cases that are open longer, and where necessary a decision should be made to re-classify as a PTR case if the context is appropriate.	**Medium**
4.3	Consideration should be given to enhancing the Quality Assurance /Audit checklist and SOP by including steps for capturing the outcomes and actions arising from the audits, that can be used for future identification or trends, patterns and training needs.	**Low**

Management Response		Target Date	Responsible Officer
4.1	Early Resolution SOP to be reviewed in line with the updated PTR Guidance, with more clarity around timeframes and process.	June 2023	Concerns Manager
4.2	Monitor already occurs on a regular basis. However, in addition quality assurance audits will be undertaken on a minimum of a monthly basis.	June 2023 and ongoing	Concerns Manager
4.3	Quality assurance checklist and SOP to be reviewed and Audit template developed to ensure findings and actions/learning is captured and actioned.	June 2023	Concerns Manager

Previous Matter Arising 8: Review and monitoring of aged and open concerns (Operation)			
Original Recommendation			Original Priority
8.1	In relation to aged open concerns, it should be ensured comprehensive Datix records are maintained including recording the reason / justification for why the case has remained open and that relevant management are aware of it remaining open.		**Medium**
8.2	Where cases remain open beyond 30 days, ongoing progress contact should be maintained with the complainant and evidence of this retained within Datix.		**Medium**
Management Response		Original Target Date	Responsible Officer
8.1	Process already in place which includes dashboards and is monitored via Patient Safety Executive Meeting. The importance of recording regular updates on Datix will be included as part of 3.1a training programme	April 2022	Interim Head of Concerns, Redress & Legal
8.2	Will be addressed in the development of the SOPs as per 1.2 and included as part of the training programme as per 3.1a.	April 2022	Interim Head of Concerns, Redress & Legal
Current findings			**Residual Risk**
We confirmed that the monitoring of aged open concerns takes place at the weekly patient safety meeting. Our testing of a sample of five cases that remained open after 30 days established that in all cases Datix records had been kept up to date with progress and reasons for delays. However, in one case there was no evidence to demonstrate ongoing contact with the complainant to inform them of the progress being made with their concern. The revised concerns policy and associated SOP reference the need for maintaining written contact with the complainant, however there is no information on the frequency of this contact.			Reputational damage and perceived lack of trust in the process if complaints feel uninformed.

New Recommendation		Priority
8	Consideration should be given to revising the concerns policy and SOP to give an indication of the regularity that contact should be made with complaints for cases that remain open beyond 30 days.	**Low**

Management Response		Target Date	Responsible Officer
8	Concerns Policy and SOP will be reviewed and updated to include frequency of contact for complaints open beyond 30 working days.	June 2023	Concerns Manager

Previous Matter Arising 9: Lessons learnt (Operation)			
Original Recommendation			Original Priority
9.1a	A formalised process should be put in place to ensure there is shared learning from the outcome of concerns, complaints and incidents and also the processes followed when dealing with concerns and complaints. This should include how data will be collected and analysed in order High Concerns Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 33 to identify trends and patterns for example across CSGs, ILGs, specialities or by type of concern. Lessons learnt information should then be shared in a consistent way across the Health Board.		**High**
9.1b	Subsequently, ILGs should ensure they have suitable processes and methods in place for the dissemination of lessons learnt across all of their CSGs.		
9.2	The 'Shared Listening and Learning Forum' meetings should be held on a regular basis and be appropriately attended by ILG and Corporate staff if they are to be an effective platform for learning to take place.		**Medium**
Management Response		Original Target Date	Responsible Officer
9.1a	Regular reports are provided from Datix and monitored via various groups and committees. The quality of information provided will be strengthened with engagement with the RL Datix team.	January 2022	Datix Manager
	Development of a Learning Framework underway to ensure learning is captured from various avenues and shared across the organisation.	January 2022	AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal
9.1b	This will form part of the Learning Framework as per 9.1a and included in the SOPs as per 1.2.	January 2022	
9.2	The Listening and Learning forum Terms of Reference have been reviewed and the membership will be expanded to include more clinical and multidisciplinary representation. The forum will also be held as an 'open forum' from Feb 2022 rather than by invitation only as previously.	February 2022	Joint Chairs of Listening & Learning Forum

Current findings		Residual Risk
9.1	The Health Board has a formalised 'Listening and Learning Framework' and a shared learning repository has been established that is accessible to staff. We also saw evidence of the weekly concerns and complaints reports that are provided to care group directors and to the heads of quality & safety within the care groups to allow timely monitoring.	Learning from complaints does not take place meaning improvements in quality, reduction in adverse events and avoidable harm does not happen.
9.2	There is evidence that the Shared Listening and Learning Forum meetings are held regularly, and that each of the past three meetings (September and December 2022, April 2023) were well represented by both Corporate and Care Group management. The terms of reference for the meeting have been circulated for comment, but at the time of our fieldwork, were still under review, awaiting the commencement of the newly appointed Assistant Director of Quality & Safety into post.	

New Recommendation		Priority
9	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**

Management Response		Target Date	Responsible Officer
9	Listening and Learning Forum TOR to be reviewed.	June 2023	Assistant Director of Quality & Safety

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Arrangements for managing Service Level Agreements

Final Internal Audit Report

June 2023

Cwm Taf Morgannwg University Health Board

Contents

Review reference:	CTMUHB-2223-17
Report status:	Final
Fieldwork commencement:	18 January 2023
Fieldwork completion:	30 April 2023
Debrief meeting:	5 May 2023
Draft report issued:	4 May 2023
Management response received:	6 June 2023
Final report issued:	6 June 2023
Auditors:	Paul Dalton, Head of Internal Audit Emma Samways, Deputy Head of Internal Audit Geoffrey Woolley, Principal Internal Auditor
Executive sign-off:	Linda Prosser, Executive Director of Strategy & Transformation
Distribution:	Elizabeth Beadle, Assistant Director of Transformation
Committee:	Audit & Risk Committee

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

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

Executive Summary

Purpose

The objective of the review was to assess the arrangements the Health Board has in place in relation to Service Level Agreement (SLA).

Overview

We have issued limited assurance on this area. The high priority matters which require management attention are:

- The system for capturing SLA agreements does not adequately allow centralised capture, monitoring and oversight on a regular and timely basis.
- We were unable to confirm to what extent reviews of the SLAs we tested has been undertaken and have not seen evidence of supporting data being obtained to support reviews.
- We have not seen consistent evidence of financial monitoring taking place.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Guidance is in place	Limited
2	System exists to capture SLAs	Limited
3	SLAs contain suitable information	Reasonable
4	SLAs are reviewed in line with timeframes	Reasonable
5	Data is provided in line with SLA requirements	Limited
6	Financial monitoring takes place	Limited

[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	SLA guidance is in place	1	Design	High
2	A system to accurately capture SLA agreements	2	Operation	High
3	Completeness of SLAs	3	Operation	Medium
4	Timely review of SLAs	4	Operation	Medium
5	Provision of information to undertake monitoring	5 & 6	Operation	High

1. Introduction

1.1 Our review of Service Level Agreement arrangements was completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 A Service Level Agreement (SLA) sets the expectations between the service provider and the customer and describes the services to be delivered, costs associated with service delivery, and the metrics by which the effectiveness of the process is monitored and approved. SLAs should contain the necessary information to use and manage the service being provided.

1.3 Our review focused on SLAs that the Health Board has with other health boards and trusts within Wales.

1.4 The associated risks were:

- Patient harm and reputational damage if services provided on behalf of Health Board are not of a suitable quality.
- Inability to effectively monitor performance and take corrective action if performance data is not provided or inaccurate.
- Financial pressures arise if service delivery and associated costs are not monitored.
- Opportunities for improvement are either not identified or implemented.

1.5 Audit Wales has recently published a report in relation to the Long Term Agreements (LTAs) and SLA arrangements between the Health Board and Swansea Bay University Health Board. As such, we did not include the arrangements between these organisations within our review.

1.6 Furthermore, we note that the Health Board has recently concluded its own review of SLAs with third sector organisations. As such, we excluded third party organisations from our testing.

2. Detailed Audit Findings

Objective 1: Guidance is in place for those entering into SLA agreements that includes responsibilities and ensures a consistent approach is adopted that is compliant with the Scheme of Delegation.

2.1 We understand that the Health Board's central commissioning team is reviewing the SLA arrangements that the Health Board has in place. As part of this work, a group has been created, which includes representatives from Planning, Finance and operational service areas, to review all aspects of SLA agreements. Aligned to this, the Health Board's Value and Effectiveness workstream will also consider SLA arrangements.

2.2 At the time of our fieldwork management were developing and consulting on guidance notes and templates. These include:

- An SLA procedure document. We note that this document provides guidance from the point that the central commissioning team receives a request for support from a service.
- A service specification template, and template SLA award letter.
- An example SLA agreement and terms and conditions.

2.3 However, there does not appear to be overarching SLA guidance, which addresses where the roles and responsibilities lie for setting up an SLA and the ongoing monitoring of agreements. We note that some directorates have developed their own SLA procedures. As such services may be agreeing SLAs without the support of central commissioning team or adhering to the Health Board's scheme of delegation. **(Matter Arising 1)**

Conclusion:

2.4 Guidance is being used by the central commissioning team but it is yet to be finalised. Wider, Health Board guidance is not yet in place. We have provided limited Assurance for this objective.

Objective 2: A system exists to capture the SLA agreements the Health Board has in place and allow centralised monitoring and oversight.

2.5 The central commissioning team holds a spreadsheet listing SLAs within the Health Board. However, the spreadsheet only captures agreements that have been identified by the team and we have been unable to determine when the spreadsheet was created or last updated. The spreadsheet appears to show in excess of 200 SLAs and LTAs. We note that while the spreadsheet captures information such as who the agreement is with, the lead contact in the Health Board, the financial value, and relevant dates, the data was not complete for all of the entries. **(Matter Arising 2)**

2.6 The spreadsheet did not include information relating to periodic reviews of SLAs, or a space to capture if issues have occurred during the SLA period. Such information can be referenced when considering new agreements. **(Matter Arising 2)**

Conclusion:

2.7 While the Health Board has a register of SLAs, it was not clear if the document was complete and accurate. As such, appropriate oversight of SLA agreements may not be happening, timely renewals may not take place, and currently there is no method to capture issues experienced with providers. We have provided Limited Assurance for this objective.

Objective 3: SLAs contain suitable information on matters such as 'contract owners' performance measures, quality targets, financial requirements, escalation processes.

2.8 Our analysis of the spreadsheet register identified six active SLAs. We tested a sample of two of these. The initial population was larger, however due to other

recent reviews we had agreed no not undertake testing in relation to SLAs with Swansea Bay UHB or third sector organisation. Our interrogation of the remaining agreements captured on the spreadsheet identified agreements that were either no longer active or contracts and grants that should not be recorded as an SLA. **(Matter Arising 2)**

2.9 For our sample of current SLAs, we note that the information included in the documents was similar to that identified in the SLA template document, and included performance measures, quality targets, financial requirements and the escalation process. However, details such as the lead contact was not complete. We also note that the documents had not been signed by the service provider until some months into the start of the SLA period and neither had been signed by the Health Board. **(Matter Arising 3)**

Conclusion:

2.10 The two SLAs we tested aligned to the template SLA and contained suitable information. However, some key information was missing from both SLAs and neither had been signed on behalf of the Health Board as Commissioner and both SLAs were not signed by the provider until getting on for halfway through the period to which they applied. We have provided Reasonable Assurance for this objective.

Objective 4: SLAs are reviewed in line with timeframes set out within them to ensure they remain relevant and up to date.

2.11 Our sample testing confirmed that the agreements were current and had been set up in a timely manner following the end of the previous SLA period with the provider.

2.12 However, our review identified a number of agreements within the spreadsheet register where the end date had passed, six of which had ended in March 2019. **(Matter Arising 4)**

Conclusion:

2.13 Based on the spreadsheet register provided, it would appear that not all SLAs are being reviewed and renewed in line with the timeframes set out within them, which may present a risk to the Health Board where service provision continues, and issues arises. We have provided Reasonable assurance against this objective.

Objective 5: Data is provided in line with the SLA requirements to allow the effective performance and quality monitoring to take place.

2.14 Each of the two SLAs we tested contained information in relation to performance monitoring arrangements and the information that providers are required to submit to the Health Board. This included the submission of information within 30 days following the end of a quarter and the need for regular and annual performance reviews.

2.15 However, for one of the SLAs we did not see information relating to performance monitoring. For the second SLA, while the Health Board had sought performance

information from the provider, performance information was not supplied by the provider. While management have advised us that routine monitoring meetings take place these are not documented. **(Matter arising 5)**

Conclusion:

2.16 Whilst the SLAs adequately set out their review and performance monitoring process, and we received some indication of action being taken by the Health Board to obtain monitoring information, we have been unable to evidence performance monitoring taking place. We have provided Limited Assurance for this objective.

Objective 6: Financial monitoring takes place to ensure accurate information and data is received from providers in line with the SLA requirements to support payments made.

2.17 We saw evidence of some financial monitoring in relation to one of the SLAs in our sample, however, due to the lack of performance monitoring information provided, we have not been able to confirm if the Health Board only pays for the services provided. **(Matter arising 5)**

Conclusion:

2.18 We have only seen evidence of limited financial monitoring for one of the two SLAs that we tested. As such we have provided Limited Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: SLA guidance is in place (Design)	**Potential Impact**
At the time of our fieldwork there was no overarching policy or guidance on the Health Board's approach to entering into SLAs. It is unclear if the process for entering to an SLA should be undertaken by the centralised commissioning function, or something that services are able to do, and if so, what the level of involvement from the central team should be. Whilst the central commissioning team have draft SLA procedure notes, these provide guidance from the point of a request being received by the commissioning team from a Service Manager and do not contain any information on the process for Service Managers prior to contacting the central team. Our fieldwork identified an SLA procedure that had been created by a service directorate. The procedure did not contain information about the central commissioning team, or the scheme of delegation. As such, there is a risk that services are entering into SLAs with a lack of centralised oversight, or standard guidance. Our review of other template documents created noted some refer to 'Trust' and not the Health Board.	SLA agreements may be set up or implemented inconsistently resulting in financial loss or reputational damage.

	Recommendations	**Priority**
1	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**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1	A project team has been set up to develop the guidance required for development of SLAs. This includes Strategy and Transformation, Finance (Commissioning) leads	September 2023	Assistant Director of Transformation and project team

	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.		

Matter Arising 2: A system to accurately capture SLA agreements (Operation)	**Potential Impact**
The draft SLA procedure document refers to a 'Register of Agreements'. This is the spreadsheet system used by the commissioning team to capture the SLAs and LTAs known to them. These may be SLAs that the team have been involved in setting up, or ones set up by others in the Health Board. We reviewed the spreadsheet register and note: • While the spreadsheet identified in excess of 200 SLAs and LTAs, parts of the spreadsheet are not complete with information such as the lead officer and relevant dates missing. • There is no field to capture issues that may have occurred with a provider, ensuring that knowledge is not lost and can be referred to when considering extending an SLA agreement or entering into a new SLA agreement with that provider. • Whilst the spreadsheet is named 'updated 20062022', and we have been unable to confirm if this is the date it was last updated, or if this was when it was created and there have been subsequent updates. The register of agreements captures SLAs known to the central commissioning team. Given that our fieldwork identified instances where service areas had developed their own SLA procedures, and that the current draft procedures relate to the process within the central team, it is not clear if the current register is a complete and accurate record of SLAs within the Health Board. Our sample testing identified agreements identified as SLAs that were no longer operational, or were contracts or grants.	Financial loss and reputational damage if the system in place for SLA agreements does not adequately allow centralised capture, monitoring and oversight on a regular and timely basis.

	Recommendations	**Priority**
2	• 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.	**High**

	• 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.		
Agreed Management Action		**Target Date**	**Responsible Officer**
2	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.	31 August 2023	Assistant Director of Transformation supported by the Commissioning Manager and Planning Assistant

Matter Arising 3: Timeliness of SLA sign-off (Operation)			**Potential Impact**
For the two SLAs in our sample, neither had been signed on behalf of the Health Board as the commissioning body. Both SLAs covered the period April 2021 to March 2024, but were not signed by the provider until May 2022 and August 2022 respectively, so 14 and 16 months into the three-year period.			The Commissioner and provider's responsibilities may be unclear.
Recommendations			**Priority**
3	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**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	September 2023	Assistant Director of Transformation and project team

Matter Arising 4: Timely review of SLAs (Operation)			**Potential Impact**
Our review of the SLA spreadsheet register identified that 28 of the 188 agreements listed as SLAs (including Swansea Bay and third sector) had passed their end date. Six were showing March 2019 as the date the SLA ended. It is our understanding that these are ongoing SLAs. A number have notes against them stating that they will be updated once the 2022/23 values are agreed, thus indicating that either the SLAs have not been appropriately renewed or, the register has not been updated to reflect the renewal.			SLAs may not be relevant and up to date. The Commissioner and provider's responsibilities may be unclear.
Recommendations			**Priority**
4	SLAs should be reviewed in line with timeframes set out within them and the spreadsheet register kept up to date with renewal dates.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4	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.	September 2023	Assistant Director of Transformation and Commissioning Manager

Matter Arising 5: Provision of information to undertake monitoring (Operation)	**Potential Impact**
The two SLAs in our sample contained information in relation to performance monitoring and the information that the provider should supply to the Health Board to allow effective monitoring. However, we have been unable to confirm if the data has been provided or if monitoring has taken place. For one of the SLAs we did not see information relating to performance monitoring. For the second SLA, while the Health Board had sought performance information from the provider, this has not been provided to the Health Board. While management have advised us that routine monitoring meetings take place, these are not documented. In relation to financial data, again for one SLA, we were not provided with any evidence regarding financial monitoring. The second SLA relates to the provision of four services by the provider, with equal quarterly payments. We were provided with a spreadsheet which records and compares the annual SLA value with the four quarterly payments for each of the four service areas. From reviewing this, we could confirm that all values reconciled, however, as no performance data is provided, there is a risk that the Health Board is paying for services not fully being received.	Effective performance and quality monitoring of SLAs does not take place. Inappropriate payments may be made.

Recommendations		**Priority**
5	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**

	Agreed Management Action	Target Date	Responsible Officer
5	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.	September 2023	Assistant Director of Transformation and Commissioning Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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