Audit & Risk Committee

Tue 24 October 2023, 14:00 - 16:00

Virtually via Microsoft Teams

Agenda

14:00 - 14:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Patsy Roseblade, Committee Chair/Independent Member*

1.2. Apologies for Absence

Information *Patsy Roseblade, Committee Chair/Independent Member*

1.3. Declarations of Interest

Information *Patsy Roseblade, Committee Chair/Independent Member*

14:05 - 14:10
5 min

2. CONSENT AGENDA

Decision *Patsy Roseblade, Committee Chair/Independent Member*

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the Meeting held on 16 August 2023

Decision *Patsy Roseblade, Committee Chair/Independent Member*

2.1.1 Unconfirmed Minutes CTMUHB ARC 16 August 2023 ARC 24 October 2023.pdf (11 pages)

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

Decision *Patsy Roseblade, Committee Chair/Independent Member*

2.1.2 Minutes CTMUHB In Committee ARC 16 August 2023 ARC 24 October 2023.pdf (2 pages)

2.1.3. Amendment to Standing Financial Instructions

Decision

2.1.3a Amendments to SFIs Model Review 2023 - ARC Oct 23 Cover Paper.pdf (4 pages)
2.1.3b App 1 - Amendments to SFIs - Draft Model Review 2023 ARC 24 October 2023.pdf (85 pages)

2.2. FOR NOTING

2.2.1. Audit & Risk Committee Annual Cycle of Business

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

2.2.1a Committee Annual Cycle of Business ARC 24 October 2023.pdf (3 pages)
2.2.1b Audit Risk Committee Cycle of Business ARC 24 October 2023.pdf (4 pages)

2.2.2. Audit & Risk Committee Forward Work Programme

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

2.2.2 Audit & Risk Committee Forward Work Plan ARC 24 October 2023.pdf (4 pages)

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

Information *Dom Hurford, Medical Director*

2.2.3 National Review of Consent to Examination & Treatment ARC 24 October 2023.pdf (4 pages)

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

Information *Gethin Hughes, Chief Operating Officer*

It has been agreed that this item will be deferred to the June meeting of the Audit & Risk Committee

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14:10 - 14:15
5 min

3. MAIN AGENDA

3.1. Audit & Risk Committee Action Log

Discussion *Gareth Watts, Director of Corporate Governance*

3.1 Audit & Risk Committee Action Log ARC 24 October 2023.pdf (5 pages)

3.2. Matters Arising not Contained within the Action Log

Discussion *Patsy Roseblade, Committee Chair/Independent Member*

14:15 - 14:45
30 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

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

4.1a Local Counter Fraud Update Report ARC 24 October 2023.pdf (3 pages)
4.1b Local Counter Fraud Update Report ARC 24 October 2023.pdf (4 pages)
4.1c Appendix -Counter Fraud Investigations Update ARC 24 October 2023.pdf (11 pages)

4.2. Procurement & Scheme of Delegation Report

Discussion *Sally May, Executive Director of Finance*

4.2 Scheme of Delegation Report ARC 24 October 2023 (2).pdf (8 pages)

4.3. Post Payment Verification Mid Year Update

Discussion *Amanda Legge, All Wales Post Payment Verification Manager*

4.3a PPV mid-year report Audit Committee 2023 ARC 24 October 2023.pdf (5 pages)
4.3b Mid-Year report 2023 CTMHB ARC 24 October 2023.pdf (1 pages)

4.4. Changes to the Welsh Risk Pool Agreement

Discussion *Nigel Downes, Assistant Director of Quality & Safety*

4.4 WRP Risk Sharing Agreements ARC 24 October 2023 1.pdf (5 pages)

14:45 - 15:45
60 min

5. IMPROVING CARE

5.1. Organisational Risk Register

Discussion *Gareth Watts, Director of Corporate Governance*

- 5.1a Org Risk Register - September 2023 - ARC 24 October 2023.docx (6 pages)
- 5.1b Master Organisational Risk Register -Final Draft September 2023 - ARC 24 October 2023.xlsx (11 pages)

5.2. Audit Recommendations Tracker

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

- 5.2a Audit Recommendations Tracker Cover Report ARC 4 October 2023.docx (7 pages)
- 5.2b Internal Audit Recommendations Tracker ARC 24 October 2023.xlsx (23 pages)
- 5.2c External Audit Recommendations Tracker ARC 24 October 2023.xlsx (4 pages)

5.2.1. Update on Consultant Job Planning

Decision *Dom Hurford, Medical Director*

- 5.2.1 Consultant Job Plannning ARC 24 October 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 CTMUHB October 2023 AW Audit Update ARC 24 October 2023.pdf (12 pages)

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

Discussion *Sara Utley, Audit Wales*

- 5.3.2 2023 CTMUHB Joint Review Follow-up Final Report (English) ARC 24 October 2023.pdf (35 pages)

5.4. INTERNAL AUDIT

5.4.1. Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

- 5.4.1 IA Progress Report ARC 24 October 2023.pdf (8 pages)

5.4.2. Interventions Not Normally Undertaken (Limited Assurance)

Discussion *Paul Dalton, Head of Internal Audit*

- 5.4.2 IA CTMUHB INNU Final Internal Report ARC 24 October 2023.pdf (15 pages)

5.4.3. Facilities Governance (Limited Assurance)

Discussion *Paul Dalton, Head of Internal Audit*

- 5.4.3 IA CTM2223.42 Facilities Governance Follow Up Final Report.pdf (21 pages)

5.4.4. IT Infrastructure (Reasonable)

Discussion *Paul Dalton, Head of Internal Audit*

- 5.4.4 IA CTM-2324-19 IT Infrastructure final ia report ARC 24 October 2023.pdf (15 pages)

15:45 - 15:50
5 min

6. CLOSE OUT BUSINESS

6.1. Any Other Business

Discussion *Patsy Roseblade, Committee Chair/Independent Member*

6.2. How Did we do in this Meeting

Discussion *Patsy Roseblade, Committee Chair/Independent Member*

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

Is there anything we should do more or less of?

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

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

Have we received sufficient assurance from a range of sources?

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

6.3. Highlight Report to Board

Discussion *Patsy Roseblade, Committee Chair/Independent Member*

15:50 - 15:55
5 min

7. PRIVATE/IN COMMITTEE SESSION

Information *Patsy Roseblade, Committee Chair/Independent Member*

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

- Organisational Risk Register - Cyber Security Risks

15:55 - 15:55
0 min

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

Information *Patsy Roseblade, Committee Chair/Independent Member*

Agenda Item Number: 2.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee held on the 16 August 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Jayne Sadgrove	Health Board Vice Chair
Geraint Hopkins	Independent Member (In part)

In Attendance:

Sara Utley	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Eifion Jones	NWSSP – Internal Audit & Assurance
Mark Thomas	Assistant Director of Finance
Owen James	Head of Corporate Finance (In part)
Cally Hamblyn	Assistant Director of Governance & Risk
Matthew Evans	Head of Local Counter Fraud
Gethin Hughes	Chief Operating Officer (In part)
Richard Hughes	Deputy Director of Nursing (In part)
Emma Walters	Head of Corporate Governance & Board Business (Secretariat)
Claire Brown	Head of Quality Assurance and Compliance (Observing)
Kelly Eddington	Quality Assurance and Compliance Officer (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 have been received from:

- Ian Wells, Independent Member
- Sally May, Executive Director of Finance

- Emma Samways, Internal Audit.

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 CONSENT AGENDA

G Hughes provided Members with a verbal update in relation to JAG accreditation and extended his apologies for not being able to provide a written report on this occasion.

Members noted that JAG is the national Endoscopy Accreditation Programme and is used to certify units across a range of domains, which included key quality metrics, physical layout of the department, waiting times and training needs and competencies. G Hughes advised that the programme was comprehensive and was a UK wide programme for accreditation.

G Hughes advised that there were three Endoscopy facilities within the Health Board, at Princess of Wales Hospital, Princes Charles Hospital and Royal Glamorgan Hospital. Members noted that the unit at the Princess of Wales Hospital was fully accredited by JAG, had achieved JAG compliance and was performing well.

In relation to Prince Charles Hospital, Members noted this unit would not achieve compliance at present given its physical layout and noted that as part of the ground and first floor works at Prince Charles Hospital, the Unit would be moving into a new endoscopy facility and into a physical space which would be compliant with JAG Accreditation. G Hughes advised that significant work was being undertaken to ensure that training needs and waiting times were compliant to enable the unit to go through the accreditation process.

In relation to Royal Glamorgan Hospital, Members noted that all aspects of compliance were being worked through, with the exception of the physical space which would not be addressed until the development of the Llantrisant Health Park facility was completed. G Hughes provided assurance that the Health Board wished to ensure that all units had a good level of JAG accreditation in place and were working hard to ensure this was achieved.

G Hughes advised that he would be looking to present a gap analysis to the next meeting for Prince Charles and Royal Glamorgan Hospitals which would outline the timeline for inviting JAG into the Health Board to undertake the accreditation process. G Hughes provided assurance that a written report would be presented to the October 2023 meeting.

J Sadgrove welcomed the verbal update and requested that as part of the written update being presented to the next meeting, a forward look be included, capturing an outline, timescale and plan which would provide the Committee with greater assurance.

The Committee Chair requested that this item was removed from the action log and included in the forward work programme given the timescales associated with this piece of work.

Actions: **Report to the October 2023 meeting to include a forward look (including an outline, timescale and plan.**

Item to be removed from the action log and included on the forward work programme given the timescales associated with this piece of work.

3.0.0 MAIN AGENDA

GOVERNANCE

3.1 Audit & Risk Committee Action Log

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

The Committee Chair advised that in relation to the action regarding the inclusion of hyperlinks within the audit recommendations trackers, this was to request that hyperlinks were included from the description in the cover paper to the recommendations contained within the audit tracker. C Hamblyn advised that it may not be possible to achieve this with the tracker in its current form and added that this could be explored further within the automated system the Quality Assurance and Compliance Team were looking to develop.

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 requested that consideration was given moving forwards to the structure of the agenda given that the consent agenda had now been moved, particularly in relation to the need to approve the minutes of the previous meeting prior to discussing matters arising.

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.

J Sadgrove commented that she found the report to be thorough and welcomed the discussions that had been held with the communications team in relation to awareness raising. J Sadgrove advised that she was pleased to see that a

healthy level of referrals were being received by the team which showed that people were thinking about fraud and were willing to report fraud directly or via the fraud line. J Sadgrove also advised that she was pleased to see progress being made in relation to Case reference WARO/20/00032

In response to a question raised by J Sadgrove as to whether a discussion would be held with the maternity team in relation to the new cases that had been reported regarding payroll errors relating to end dates, M Evans confirmed that a review of these cases would be undertaken and added that the position would be closely monitored to identify if any further cases are reported.

The Committee Chair made reference to participation in relation counter fraud awareness training and advised that the Health Board's compliance was below the Welsh average regarding this and sought clarity as to when an improvement in the position would be seen. M Evans advised that a programme of work was being developed leading up to Fraud Awareness week in November which should hopefully help to increase compliance in participation. Members noted that whilst staff were not attending specific awareness sessions, there appeared to be a good level of understanding amongst staff in relation to fraud awareness. Members noted that work would continue to ensure staff attend face to face learning/e-learning. The Committee Chair advised that she was pleased to hear that work was in train to address this leading up to Fraud Awareness week.

Resolution: The report was **NOTED.**

4.2 Procurements and Scheme of Delegation Report

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

J Sadgrove made reference to the retrospective Single Tender Actions that had been reported on page 4 of the report and questioned why this had been included given that retrospective cases had not previously been reported to the Committee. O James advised that this had been included as best practice following a review of reports that had been presented to other Audit & Risk Committees and advised this was a new reporting item as opposed to an issue that had recently been discovered. J Sadgrove welcomed the transparency in reporting and recognised the aim of not to have any retrospective orders.

The Committee Chair made reference to the single tender action waiver in relation to Honeywell Building Solutions and questioned whether this item had been missed off the original tender and if so, this was significant amount of money to have not been included. M Thomas advised that he would need to review the position outside the meeting and would provide a response to Members once he had chance to review the specific circumstances.

The Committee Chair made reference to the Charitable Funds Financial Control Procedure and made particular reference to Appendix F which related to VAT regulations. The Committee Chair advised that the document appeared to

indicate that the budget holder for the charitable fund was being asked to decide whether or not an item was VAT exempt and sought clarity as to whether the budget holders had support in place from Finance colleagues in relation to making a decision on the VAT position. O James confirmed that each form was submitted to the Senior Finance Officer who undertakes a review of the form and if it was felt that the item was VAT exempt then the form would be amended. O James added that he approves each form submitted and advised that the Health Board uses a company for VAT liaison recovery.

Resolution: The report was **NOTED** and the Updated Scheme of Delegation and the revised FP16 – Charitable Funds Financial Control Procedure was **APPROVED.**

Action: Review to be undertaken in relation to the specific circumstances regarding the single tender action waiver regarding Honeywell Building Solutions to determine whether this had been missed off the original tender

4.3 Losses & Special Payments Report

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

The Committee Chair extended her thanks for the inclusion of the various examples of the discounting rate and for demonstrating how much difference it makes to the total value of the claim. The Committee Chair added that if a claim was recoverable through the Welsh Risk Pool, then other than the initial 25k, this would affect NHS Wales and the total expenditure. M Thomas advised that it was difficult to predict how discount rates would move throughout the year and added that historically publication of the discount rates did not occur until November/December which was quite late in the year. M Thomas advised that Welsh Government had been asked as to what they expected the predicted position to be and added that a response had not yet been received regarding this. Members noted that this could potentially have a significant impact on the Health Board's financial position.

Resolution: The report was **NOTED**

4.4 Learning From Events Report

R Hughes presented Members with the report and highlighted the key matters for Members attention.

J Sadgrove extended her thanks to R Hughes for presenting the update and commented that the report highlighted the robust review of the process which had been undertaken. J Sadgrove advised that she felt assured from the report that the backlog was being addressed and that the team were continuing to deal with the new cases. In response to a question raised by J Sadgrove as to whether the learning was being implemented, R Hughes confirmed that each case was being scrutinised by Nurse Director colleagues and himself to ensure

actions identified were deliverable and measureable in order to confirm that learning had taken place.

The Committee Chair made reference to the backlog of LFER's and questioned whether the backlog included blank LFER's. R Hughes advised that 47 blank LFER's had been submitted last year and advised that the majority of these had now been re-submitted in more detail. R Hughes advised that he would confirm outside the meeting how many blank LFER's were still outstanding and advised that the numbers included in the report did include the blank LFER's.

The Committee Chair made reference to the 6 month extension period in addition to the four month period allowed for the completion of LFER's and sought clarity whether this extension had just been given to Cwm Taf Morgannwg and whether the extension was permanent or time limited. R Hughes advised that in relation to the extension, this was being described as a 12 month process. Four months had been given for the Health Board to consider and report on the learning prior to submission to the Welsh Risk Pool. The further six months was to enable the Health Board to work with the Welsh Risk Pool in relation to getting the learning points approved. Members noted that a review was in the process of being undertaken to determine what cases would likely breach the four months as a result of the revised process and noted that thresholds would be very different moving forwards.

Resolution: The report was **NOTED.**

Action: Confirmation to be provided outside the meeting as to how many blank LFER's were still outstanding

5.0.0 IMPROVING CARE

5.1 Organisational Risk Register

C Hamblyn presented the report and provided an update against the key matters for Members attention.

The Committee Chair made reference to the reduction of the fire safety risk which related to compartmentalisation at Prince Charles Hospital and advised that it was not quite clear whether the work required had been undertaken and added that she was unsure whether the Health Board was in a position to reduce this risk given that the enforcement notice was still in place at Prince Charles Hospital. C Hamblyn advised that she would seek a further update from the Executive Lead and Risk Lead outside the meeting.

J Sadgrove welcomed the report and sought clarity as to what approach was going to be taken in relation to the risk register as a result of the 10/20/30 work as the outputs of this should be available by the end of this month. C Hamblyn advised that this would be reflected in the next iteration of the report following discussions at the Operational Management Board and Executive Leadership Group. Members noted that discussion in relation to current financial challenges

were already taking place and noted that C Hamblyn would be placing focus on risk treatment once the new Director of Corporate Governance was in post. M Thomas added that the 10/20/30 plan had been submitted to Welsh Government and a response was awaited. Members noted that meetings had been held to discuss the low risk 'Just Do It' items that could be implemented immediately once a response had been received.

The Committee Chair extended her thanks to C Hamblyn for the continued improvement of the Organisational Risk Register.

Resolution: The report was **REVIEWED**.

Action: Update to be sought outside the meeting in relation to the reduction of the fire safety risk regarding compartmentalisation at Prince Charles Hospital.

5.2 Audit Recommendations Tracker

E Walters presented the report and highlighted the key matters for the attention of the Committee.

The Committee Chair made reference to the recommendations relating to the Patient Pathway Appointment Process, which was a Limited Assurance Follow Up Review and advised that no progress had been made since the initial date of December 2022. The Committee Chair requested an update on progress at the next meeting.

The Committee Chair made reference to the updates provided in relation to Princess of Wales Fire Safety recommendations which stated that recommendations would be addressed once the Business Case had been approved. The Committee Chair asked for clarity to be provided for the next meeting as to whether the funding for the Business Case was in the current plan, given the current financial situation. The Committee Chair advised that if funding had been assumed then false assurances were being provide.

Resolution: The report was **NOTED**.

Actions: Update to be included in the next iteration of the report in relation to recommendations relating to the Patient Pathway Appointment Process.

Confirmation to be provided as to whether funding for the Business Case referred to in relation to Princess of Wales Fire Safety had already been included in the current plan.

5.3 INTERNAL AUDIT

5.3.1 Internal Audit Progress Report

P Dalton presented the report and highlighted the key points for Members attention. P Dalton advised that there had been some delays being experienced between fieldwork stage and issuing of reports and added that the team were aware and mindful of the significant pressures within the system at present. Members noted that an alternative approach was being taken in relation to issuing of feedback questionnaires which should hopefully improve feedback rates.

Resolution: The report was **NOTED**.

5.3.2 Internal Audit Follow Up Review – Facilities Governance

Members noted that this item has been withdrawn and would now be presented to the October 2023 meeting.

5.3.3 Internal Audit Review – Prince Charles Hospital (PCH) Programme Redevelopment

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

J Sadgrove extended her thanks to the Team for encouraging the restarting of the community benefits work which fitted in really well with the Health Board strategy in relation to the local population and the Wellbeing of Future Generations Act activity. The Committee Chair also welcomed the report which highlighted positive outcomes.

Resolution The report was **NOTED**.

5.3.4 Internal Audit Review - Decontamination

P Dalton presented the report and highlighted the key points for Members attention. Members noted that a reasonable assurance rating had been allocated and noted the detailed responses that had been provided.

Resolution: The report was **NOTED**.

5.3.5 Internal Audit Review – National Incident Framework

P Dalton presented the report and highlighted the key points for Members attention. Members noted that a reasonable assurance rating had been allocated to this review.

Resolution: The report was **NOTED**.

5.3.6 Internal Audit Review – Performance Reporting: Integrated Performance Report

P Dalton presented the report and advised that an overall rating of reasonable assurance had been given.

J Sadgrove welcomed the point in relation to annual single data points which required updating and advised that this should be helpful with report production and presentation becoming more sustainable and reliable. P Dalton advised that the report was a large document at present with a significant amount of data contained within it.

The Committee Chair made reference to recommendation 2.2 and the agreed management actions and advised that there did not seem to be enough correlation between the recommendations, which had all been accepted, and the management actions and advised that the responses provided felt generic. P Dalton advised that there was good level of engagement with the Director of Digital in relation to this review and added that given this level of engagement and the significant amount of work being undertaken in this area, he felt that the matters identified would be addressed

Resolution: The report was **NOTED.**

5.3.7 Internal Audit Follow Up Review – Radiology Workforce

P Dalton presented the report which had been allocated a reasonable assurance rating following the limited assurance rating previously given.

J Sadgrove advised that from reading the report she could see the balance that had been made in relation to decision making in relation to the assurance rating and sought clarity as to whether Internal Audit planned to undertake any further work in this area or whether progress would be solely monitored via the Audit Tracker. P Dalton advised that normal process would be to monitor progress via the tracker and added that he would be happy to undertake a further review later in the year if Members would find this helpful.

The Committee Chair agreed that the balance was very fine and advised that Members would need to ensure they monitor progress closely in this area via the audit tracker, particularly the high level recommendations which remain outstanding. The Committee Chair advised that it was within the gift of Committee Members to request a further follow up if assurance was not being provided via the tracker.

J Sadgrove queried whether the discipline of further follow up would ensure that the changes required were being achieved and that the changes were being embedded sustainably across the whole of the Health Board. Following discussion, it was agreed that progress would be monitored over the next few months via the Audit Tracker, with an update to be added to the Forward Work Programme for February 2024 if Members felt that further follow up was required.

P Dalton provided assurance to Members that Internal Audit regularly undertake reviews of the audit tracker to test whether the information that is being presented to the Committee could be substantiated. The Committee Chair advised that it was helpful to know that this review was being undertaken by Internal Audit colleagues.

Resolution: The report was **NOTED.**

5.4 AUDIT WALES

5.4.1 Audit Wales Audit & Risk Committee Update

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

Resolution: The report was **NOTED.**

6.0.0 CONSENT AGENDA

6.1 FOR APPROVAL

6.1.1 Unconfirmed Minutes of the meeting held on 21 June 2023

Resolution: The Minutes were **APPROVED**

6.1.2 Unconfirmed Minutes of the In Committee meeting held on 21 June 2023

Resolution: The Minutes were **APPROVED.**

6.1.3 Unconfirmed Minutes of the Extra-Ordinary Audit & Risk Committee 26 July 2023

Resolution: The Minutes were **APPROVED.**

6.1.4 Audit & Risk Committee Annual Report

Resolution: The Annual Report was **APPROVED.**

6.1.5 Amendment to the Standing Orders

Resolution: The report was **APPROVED**

6.2 FOR NOTING

6.2.1 Audit & Risk Committee Annual Cycle of Business

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

6.2.2 Audit & Risk Committee Forward Work Programme

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

6.2.3 Declarations of Interest and Gifts & Hospitality Report

Resolution: The report was **NOTED.**

6.2.4 Standing Orders Breach Log

Resolution: The report was **NOTED.**

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

A verbal update was given against this item at the start of the agenda.

7.0.0 CLOSE OUT BUSINESS

7.1 ANY OTHER BUSINESS

The Committee Chair extended her thanks to J Sadgrove who was attending her last meeting of the Audit & Risk Committee. The Committee Chair advised that J Sadgrove would be missed by Committee Members and added that her professionalism and attention to detail had been exemplary. J Sadgrove extended her thanks to Committee Members for their support.

7.2 How Did we do in This meeting

The Committee Chair asked Members to share any feedback as to how they felt the Committee went today outside the meeting.

7.3 Committee Highlight Report to Board

Members noted that this would be drafted by the Committee Secretariat outside of this meeting.

Items Discussed at In Committee

8.0.0 Members noted that the following items would be discussed at the In Committee session being held following this meeting:

- Medical Variable Pay – Rates Agreed above Cap
- Organisational Risk Register – Cyber Security Risks

9.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Tuesday 24 October 2023 at 2:00pm

10.0.0 CLOSE

Agenda Item Number: 2.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk In Committee held on the 16 August 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Jayne Sadgrove	Vice Chair/Independent Member

In Attendance:

S Utley	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Mark Thomas	Assistant Director of Finance
Sallie Davies	Deputy Medical Director
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Head of Corporate Governance & Board Business

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

P Roseblade, Committee Chair welcomed everyone to the meeting. The format of the proceedings in its virtual form were also noted.

1.2 Apologies for Absence

Apologies were received from:

- Ian Wells, Independent Member;
- Geraint Hopkins, Independent Member;
- Sally May, Executive Director of Finance.

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 MAIN AGENDA

2.1 Medical Variable Pay - Rates Agreed Above Cap

S Davies presented Members with the report and highlighted the key matters for Members attention.

Members discussed the report in detail and were provided with responses to the queries raised.

Resolution: The report was **NOTED**.

2.2 Organisational Risk Register – Cyber Security Risk

C Hamblyn presented the report and highlighted the key matters for Members attention in relation to the business sensitive risks

In response to a comment made by the Committee Chair, C Hamblyn advised that she continued to ensure explanations were being provided when the risk consequence changes.

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 Tuesday 24 October 2023.

5.0.0 CLOSE

Agenda Item
2.1.3

CTM Health Board

AMENDMENT TO STANDING FINANCIAL INSTRUCTIONS: MODEL REVIEW 2023

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

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

Acronyms / Glossary of Terms	
WG	Welsh Government

1. Situation /Background

1.1 NHS bodies in Wales must agree Standing Orders (SOs). This, together with a set of Standing Financial Instructions (SFIs) and a scheme of decisions reserved to the Board; a scheme of delegations to officers and others; and a range of other framework documents set out the arrangements within which the Board, its Committees, Advisory Groups and NHS staff make decisions and carry out their activities. The Standing Orders should be based upon the model determined by the Welsh Government.

1.2 WG reviewed and revised the model Standing Financial Instructions and these changes are identified in this report. The amendments to the Standing Orders were received and endorsed by the Committee in August 2023.

1.3 All Health Board members and officers must be aware of the SO's and SFI's, and, where appropriate, should be familiar with their detailed content.

2. Specific Matters for Consideration

2.1 The changes to the SFI's are identified in red in Appendix 1. For ease of reference the amendments are on the following pages/sections:

- Section 3.4.7 – Page 15
- Section 3.5.2 - Page 16
- Section 4.1.2 – Page 18
- Section 6.2 – Page 27
- Section 11.6.4 V-Vi – Page 43
- Schedule 1 pages 80-85

2.2 These amendments supersede those issued in accordance with the Welsh Health Circulars (WHCs) numbered WHC 2020/011 and 2021/010 which have been superseded by WHC 2023/032. The WHC is available upon request.

2.3 The Board is required to incorporate and adopt this latest review into CTM's SFI's as appropriate.

3. Key Risks / Matters for Escalation

3.1 Once approved, the SFI's will be uploaded to SharePoint and the Health Board's Internet site.

3.2 The SFI's will be further strengthened in year as and when required.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service

		change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Audit & Risk Committee are requested to **ENDORSE APPROVAL** of the amendments to the Health Board's SFI's as outlined in section two of this report.

6. Next Steps

6.1 Once approved, the SFIs will be uploaded to SharePoint and the Health Board's Internet Site.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Scheme of decisions reserved to the Board and a scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the LHB. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

Cwm Taf Morgannwg University Health Board

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by **Cwm Taf Morgannwg University Health Board** (the LHB). They are designed to ensure that the LHB's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the LHB.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LHB and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the LHB's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non-compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of LHBs

1.3.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and LHB officers, and LHB committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees, sub-committees, joint committees or joint sub-committees that the LHB has established or to an officer of the LHB in accordance with the 'Scheme of delegation' document adopted by the LHB.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LHB's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility

for the LHB's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and LHB officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the LHB's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions, in order to disclose, with reasonable accuracy, the financial position of the LHB at any time; and

d) Without prejudice to any other functions of the LHB, and Board members and LHB officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and LHB officers, and LHB Committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to effect these SFIs.

2.4 Board members and LHB officers, and LHB Committees and Advisory Groups

2.4.1 All Board members and LHB officers, and LHB Committees and Advisory Groups, severally and collectively, are responsible for:

a) The security of the property of the LHB;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and LHB officers, and LHB Committees and Advisory Groups who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board, Committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,

- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the LHB;

c) Access at all reasonable times to Board members and LHB officers;

d) The production of any cash, stores or other property of the LHB under a Board member or a LHB official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the LHB.

The Auditor General may nominate his representative to represent him within the LHB and to undertake the required audit work. The cost of the audit is paid for by the LHB. The LHB's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative

[1] Note: The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs that relate to the exercise of many of his core functions, including his statutory audit of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the ~~Trust~~ LHB that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the LHB and its officers and staff, but also to, among others, suppliers to the LHB.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the LHB (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the LHB may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work

- Statutory report and opinion on the financial statements

- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the LHB and other public sector bodies. At LHBs he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the LHB Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The LHB shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).

https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the LHB Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the LHB.

3.5.5 The LHB must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The LHB should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the LHB Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.1.2 The details and requirements for the two duties are set out in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." Full details of the WHC can be obtained by contacting the HSSG Director of Finance at:

hywel.jones38@gov.wales

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Health Board has a statutory duty to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years, that is to breakeven over a 3-year rolling period.

4.2.2 Welsh Government will determine revenue and capital allocations prior to the start of each financial year and notify Health Boards.

4.2.3 Health Boards must ensure their boards approve balanced revenue and capital plans in line with their notified allocations before the start of each financial year.

4.2.4 The Director of Finance of the LHB will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year allocations and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial allocations and the application of such funds.

4.2.5 The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Health Board has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers**.**

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

https://gov.wales/sites/default/files/publications/2019-09/nhs-wales-planning-framework-2020-23%20.pdf

4.3.3 The NHS Planning Framework directs Local Health Boards to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context, including population health needs, within which the Health Board will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,
  - establishing preventative approaches across all care and services
- demonstrate how the Health Board will utilise its existing services and resources, and planned service changes, to deliver improvements in

population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plan should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the LHB's response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the LHB plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the LHB and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1. Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of improved population health, safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced, specified and non-recurring allocations and funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents)

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Identify available reserves;

j) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

k) Identify potential risks and opportunities.

5.2. Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the

management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3. Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to LHB Board as soon as they

come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management, performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:

- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports, and as a minimum the reports will cover:
    - Current and forecast year end position on statutory financial duties
    - Actual income and expenditure to date compared to budget and showing trends and run rates
    - Forecast year end positions
    - A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
    - Explanations of material variances from plan
    - Capital expenditure and projected outturn against plan
    - Investigations and reporting of variances from financial, activity and workforce budgets.
    - Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
    - Statement of performance against savings targets
    - Key workforce and other cost drivers
    - Income and expenditure run rates, historic trends, extrapolation and explanations
    - Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4. Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

https://gov.wales/health-boards-and-trusts-financial-monitoring-guidance-2019-2020-whc-2019013

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the LHB's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the LHB. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.

6.3 The Director of Finance, on behalf of the LHB, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The LHB's annual accounts must be audited by the Auditor General for Wales. The LHB's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The LHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the Welsh Ministers. LHBs are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Health Board business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the LHB's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the LHB's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the LHB. No officer other than the Director of Finance shall open any account in the name of the LHB or for the purposes of furthering LHB activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the LHB and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the LHB's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the LHB's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled

stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Director of Finance will review banking arrangements of the LHB at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LHB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LHB from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in

writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The LHB shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The LHB can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The LHB should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Director of

Finance when overpayment of salary or expenses have been made, in order that recovery can be made.

9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1 The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2 The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation.

10.9.1 The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice

(whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the LHB's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Health Boards must consult with NWSSP Procurement Services, Director of Finance and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Health Board Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the LHB, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;

- In line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LHB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Health Board. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Revised General Consent to enter Individual Contracts. included as **Schedule 1** of these SFIs**.**

11.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic law. The Welsh Government policy framework and the Wales Procurement Policy

Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations (2015 No. 102)) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the LHB and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the LHB is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the LHB shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies

e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the LHB's delegation arrangements and approval processes.

11.6 Procurement Consent

11.6.1 Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on LHBs to obtain the consent of the Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust, either for the general or any specific purposes of the LHB or for any purposes relating to the health service).

The provision allows the Welsh Ministers to give consent, which may be given in general terms covering one or more descriptions of case.

11.6.2 General Consent has been granted to LHBs by the Welsh Ministers for individual contracts up to the value of £1 million in each case with the exception of those contracts specified in SFI 11.6.4 All contracts exceeding this delegated limit, all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being entered into. In addition, 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. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales. Further detailed guidance is incorporated within the Procurement Procedures.

11.6.3 **Schedule 1** details the requirement and process for LHBs to obtain consent to enter into contracts exceeding £1m and monitoring arrangements for contracts below £1m.

11.6.4 The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and/or Welsh Ministers direction, and therefore does not apply to:

i) Contracts of employment between LHBs and their staff;
ii) Transfers of land or contracts effected by Statutory Instrument following the creation of the LHBs;

iii) Out of Hours contracts; and
iv) All NHS contracts, that is where one health service body contracts with another health service body.
v) Contracts entered into by Health Education and Improvement Wales (HEIW) for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning also do not require further Ministerial notification or consent.

To ensure consistency with guidance issued by NWSSP Procurement Services, further exceptions highlighted below should also be applied:

vi) Contracts over £500k - £1 million (for noting) and £1 million + (for approval);
  i) Wales Public Sector Framework Agreements e.g. Frameworks established by National Procurement Services (NPS) or NWSSP (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award or mini competition.

  ii) Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

11.6.5 The Revised General Consent does not remove the requirement for LHBs to comply with SOs, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Health Boards must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being and Future Generations Act (Wales) 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are

- a prosperous Wales
- a resilient Wales
- a healthier Wales
- a more equal Wales
- a Wales of cohesive communities
- a Wales of vibrant culture and thriving Welsh language
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales

11.7.4 Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The LHB is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on ethical employment in supply chains which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The LHB shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The LHB shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the LHB shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement the LHB shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Health Boards must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

11.9.4 Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer term commitment. Regular reports on free of charge services provided to the Health Board should be submitted by Board Secretary to Audit Committee.

11.9.5 Health Boards are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Health Board's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Health Boards must ensure the value of their requirement considers cumulative spend across the Health Board for like requirements and opportunity for collaboration with other Health Boards and Trusts:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SFI 11.6.3.

11.11.2 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks.

- include robust performance measures to effectively measure and manage supplier performance; and
- consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes

and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;
- An acceptable level of assurance is available before presentation for approval in line with the Health Board Scheme of Delegation; and
- An “or equivalent” test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Health Board has already entered into an arrangement directly.

11.13.5 As SQA or STA are only used in exceptional circumstances the Health Board, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent recurrence by the Health Board.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Health Board to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training or
- Take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA

where competition not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA's not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Health Board making use of any agreements covering the disposal of such items.

11.14.3 The Health Board must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Health Board. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties

to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder, shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records
- Monitoring contract performance measures
- Engaging suppliers to ensure performance delivery
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Health Board budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Health Boards compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Health Board will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed

for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the LHB's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Health Board by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Health Board will commission healthcare services for its resident population both internally, from its own LHB provided services, and externally, from other LHBs, Trusts and other providers. The Chief Executive is responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for the provision of health care services from external providers.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the LHB by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables Health Boards to commission certain healthcare services. The relevant sections under the Act are as follows:

- Section 7 sets out the definition of an NHS contract, being an

arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body;

- Section 9 sets out arrangements to be treated as NHS contracts for ophthalmic and pharmaceutical services;
- Section 32 makes provision in relation to services which can be provided to Health Boards by local authorities;
- Section 33 enables the Welsh Ministers to make provision which enables Health Boards and Local Authorities to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Part 4 enables Health Boards to make arrangements for the provision of primary medical services;
- Part 5 enables Health Boards to make arrangements for the provision of primary dental services;
- Part 6 enables Health Boards to make arrangements for the provision of general ophthalmic services;
- Part 7 enables Health Boards to make arrangements for the provision of pharmaceutical services;
- Section 188 enables the Welsh Ministers to make provision which enables Health Boards and the prison service to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Section 194 sets out the Health Boards powers to make payments towards expenditure on community services; and
- Section 195 sets out the conditions for payment where expenditure proposed under section 194 is in connection with services to be provided by a voluntary organisation.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements with external providers. These reports will be linked to, and consistent with, other Board reports on commissioning and financial performance.

13 GRANT FUNDING

It is a matter for LHBs to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the LHBs functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the LHB has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The LHB shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Welsh Government's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members

and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, LHBs should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money .The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on LHBs or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and

effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;

- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

13.4.1 It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, LHBs should ensure principles of good practice available from a number of external sources are considered and reflected in grant programmes. Information on grants management is available on the Audit Wales website at:

https://www.audit.wales/good-practice/grants-management-miniguides

13.4.2 Health Boards must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.3 For grant programmes that span a number of financial years, the LHB is responsible for evaluating the programmes to ensure they are fit for purpose, achieving required outcomes and continue to provide value for money.

13.4.4 LHBs are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.5 LHBs are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the LHB to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.6 The LHB must enter into legally binding funding agreements with all

delivery organisations. When developing funding agreements, the LHB should ensure principles of good practice available from a number of external sources are considered and reflected.

13.4.7 The LHB is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The LHB will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e., the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without

the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development, has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development is responsible for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
   - reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation;

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records, and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within Welsh Government capital finance resource limits.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the capital allocations, as set out in the Welsh Government (WG) Capital Resource Limit for the year, and the LHB must not exceed the allocation resource limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance
- Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework

15.2.2 The Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Health Board's Scheme of

Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that formal confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual

Capital Programme, is approved by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate LHB personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme by the Health Board shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs.

15.4.7 The Director of Planning and Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital

schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The LHB must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The LHB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the LHB's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the LHB, it is the responsibility of Board members and senior LHB officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the LHB's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and LHB officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as LHB property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements for receipt, issues, and returns of goods to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals

and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a LHB asset and goods, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;

b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and goods are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either

immediately inform their head of department, who must immediately inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The LHB must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the LHB for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology.

18.1.2 The LHB shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the LHB that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the LHB digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the LHB's digital systems and data, for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information System Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information System Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial data and systems, and amendments to current financial data and systems, are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the LHB arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 LHB Responsibility

19.1.1 The LHB has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Health Board will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 Paragraph (x) of Section A to the SOs refers to the LHB having specified powers to act as corporate trustee for the management of funds it holds on trust (charitable funds). SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the LHB's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The LHB shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the LHB's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and LHB officers must take account of that guidance before taking action.

20.2.3 The LHB shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

Schedule 1

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales, HEIW and DHCW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All,

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

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LHBs and HEIW

Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts

Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts

Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;

- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

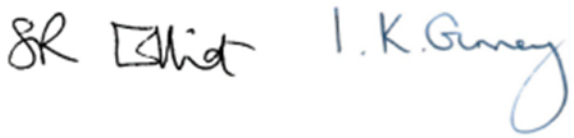
The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,



Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
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Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

7 November 2022

Chief Executives of Local Health Boards and NHS Trusts

Dear All

ADDENDUM TO STANDING FINANCIAL INSTRUCTIONS

PROCEDURES FOR CONSENT FOR LOCAL HEALTH BOARDS TO ENTER INTO CONTRACTS EXCEEDING £1 MILLION

Some confusion has arisen in relation to the procedures for the consent to enter contracts over £ 1 million. The latest version of the Standing Financial Instructions issued in April 2021 state in paragraph 11.6.2 :

General Consent has been granted to LHBs by the Welsh Ministers for individual contracts up to the value of £1 million in each case with the exception of those contracts specified in SFI 11.6.4 All contracts exceeding this delegated limit, all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being into. In addition, Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being entered 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. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales. Further detailed guidance is incorporated within the Procurement Procedures.

Paragraph 11.6.4 states that the exceptions mentioned above are as follows :

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and/or Welsh Ministers direction, and therefore does not apply to:

i) Contracts of employment between LHBs and their staff;

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ii) Transfers of land or contracts effected by Statutory Instrument Model Standing Orders, Reservation and Delegation of Powers for LHBs Schedule 2.1: Standing Financial Instructions Status: Update – March 2021;
iii) Out of Hours contracts;
iv) All NHS contracts, that is where one health service body contracts with another health service body.

To ensure consistency with guidance issued to NWSSP Procurement Services, further exceptions highlighted below should be applied;

v) Contracts over £ 500k - £1 million (for noting) and £ 1 million + (for approval);

i) Wales Public Sector Framework Agreements e.g. Frameworks established by National Procurement Services (NPS) or NWSSSP (not exhaustive) - no further approval required to award contracts under these Frameworks through a direct award or mini competition.

ii) Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

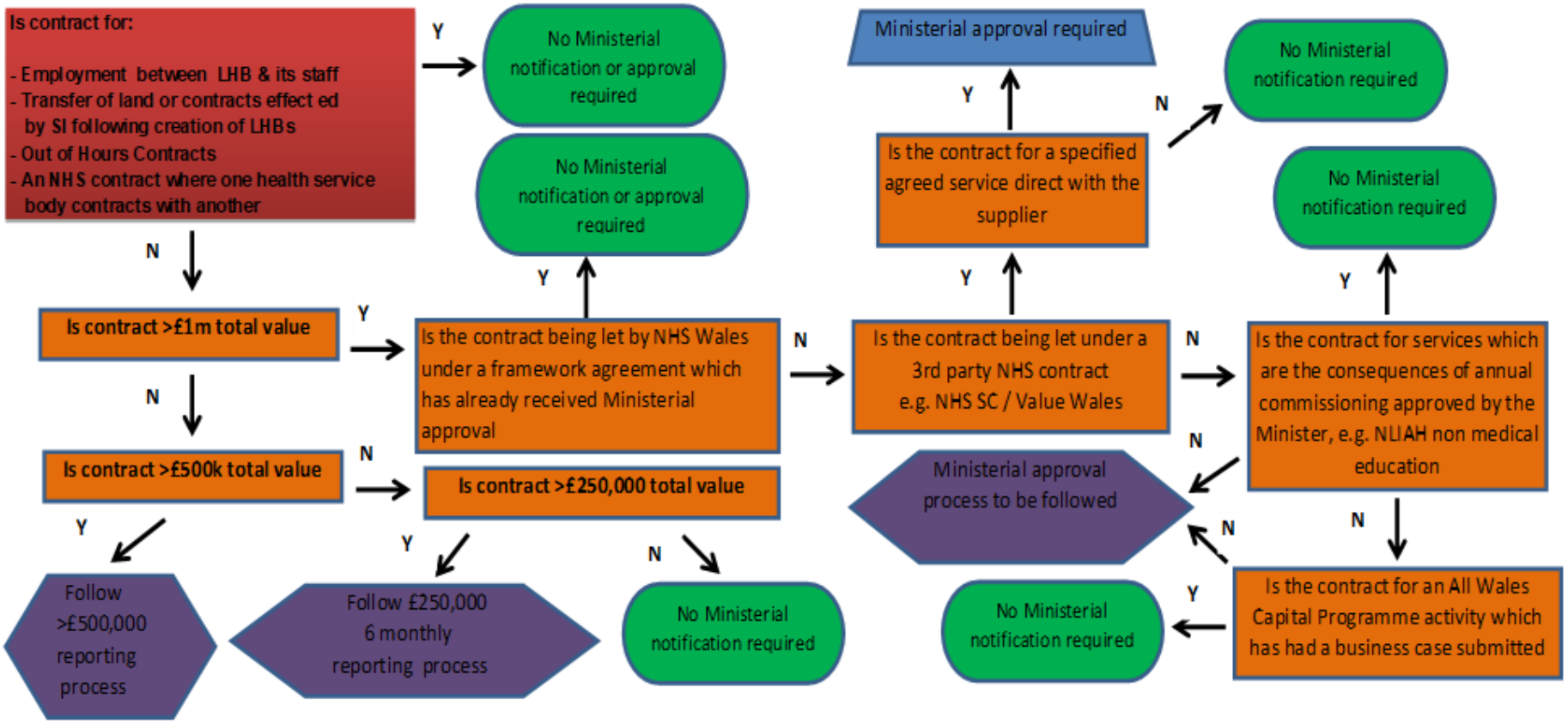
All Health Boards in Wales and Special Health Authorities bodies should apply these exceptions from the date of this letter.

The revision introduced in point v) above will be included formally in the next version of the Standing Financial Instructions.

Yours sincerely

Steve Elliot

Cyfarwyddwr Cyllid dros dro | Interim Director of Finance


Is contract for:
- Employment between LHB & its staff
- Transfer of land or contracts effect ed by SI following creation of LHBs
- Out of Hours Contracts
- An NHS contract where one health service body contracts with another
Y
No Ministerial notification or approval required
N
Is contract >£1m total value
Y
No Ministerial notification or approval required
Y
Is the contract being let by NHS Wales under a framework agreement which has already received Ministerial approval
N
Is the contract being let under a 3rd party NHS contract e.g. NHS SC / Value Wales
N
Is the contract for a specified agreed service direct with the supplier
Y
Ministerial approval required
Y
N
No Ministerial notification required
N
Is contract >£500k total value
N
Is contract >£250,000 total value
Y
Follow >£500,000 reporting process
Y
Follow £250,000 6 monthly reporting process
N
No Ministerial notification required
N
Ministerial approval process to be followed
N
Is the contract for services which are the consequences of annual commissioning approved by the Minister, e.g. NLIAH non medical education
Y
No Ministerial notification required
N
Is the contract for an All Wales Capital Programme activity which has had a business case submitted
Y
No Ministerial notification required

Agenda Item
2.2.1

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

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

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

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

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

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

4. Assessment

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

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

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

5. Recommendation

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

6. Next Steps

6.1 There are no next steps required.

Audit & Risk Committee

Cycle of Business

(1st January 2023 – 31st December 2023)

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

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

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

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

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

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

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

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

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

Item of Business	Executive Lead	Reporting period	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Local Counter Fraud Report	Director of Finance	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				⚑								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				⚑								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				⚑								
National Fraud Initiative Progress and Outcomes	Head of Local Counter Fraud	Bi-Annually from June 2023 onwards						⚑						
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				⚑								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										⚑		
Medical Variable Pay Reports (for In Committee discussion)	Medical Director	All Regular In Committee Meetings								⚑		⚑		⚑
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Organisational Risk Register	Director of Corporate Governance	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Consultant Job Planning	Medical Director	Bi-Annually				⚑						⚑		
Medical Rostering	Medical Director	Bi-Annually				⚑						⚑ Defer to Dec 2023		⚑
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				⚑								
Internal Audit Reviews	Head of Internal Audit	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
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually							Extra ordinary meeting					
Audit & Risk Committee Update	Audit Wales	All regular meetings												
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings												
Audit Wales Annual Audit Report	Audit Wales	Annually												
Audit Wales Audit Plan 2022	Audit Wales	Annually												
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually							Extra ordinary meeting					
Structured Assessment	Audit Wales	Annually												
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually								Defer to Oct		Defer to Dec		
Hosted Bodies														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings												
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings												
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually						(draft report)	Extra ordinary meeting					
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings							Extra ordinary meeting					
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually						(draft report)	Extra ordinary meeting					
WHSSC & EASC Annual Accounts	WHSSC/EASC	Annually						(draft accounts)	Extra ordinary meeting					
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						(draft report)	Extra ordinary meeting					
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually												

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 2.2.2

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	13 February 2023 – Deferred to 19 April 2023 as per action log update. Deferred to August 2023 as per action log update. Verbal Update received at the August 2023 meeting. Written progress report to be presented to the meeting being held on **24 October 2023.** Date for receipt of final closure report to be confirmed.
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. Now Deferred to the October 2023 meeting following presentation to the September 2023 Quality & Safety Committee – **On agenda**

Email Request from the Assistant Director of Governance & Risk	Additional Item	Audit Wales/Healthcare Inspectorate Wales Joint Review Follow Up Report	Director of Corporate Governance	24 October 2023 – **On agenda**
Email Request from the Deputy Director of Finance	Additional Item	Changes to the Welsh Risk Pool Agreement	Director of Nursing	24 October 2023 – **On agenda**
Email Request from the Assistant Director of Governance & Risk	Additional Item	Amendment to the Standing Financial Instructions	Director of Corporate Governance/Director of Finance	24 October 2023 – **On agenda**

Completed				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Request received from the Assistant Director of Governance & Risk	Additional Item	Standing Orders Breach Log	Assistant Director of Governance & Risk	**Completed** Received at the meeting held on 16 August 2023. Added to the annual cycle of business.
Request made at the June Audit & Risk Committee for a report to come forward	Additional Item	Learning From Events Report – Impact, process in place to monitor, assessment of impact on Financial Plan in terms of any other penalties likely	Deputy Director of Nursing	**Completed** Received and discussed at the meeting held on 16 August 2023.
Email request received from the Assistant Director of Governance & Risk	Additional Item	Amendment to the Standing Orders	Assistant Director of Governance & Risk	**Completed** Received and discussed at the meeting held on 16 August 2023.

Email Request from the Assistant Director of Governance & Risk	Additional Item	Non Consultant Medical Staff Rate Card	Medical Director	**Completed** It was agreed that this is no longer required to be presented to Audit & Risk Committee given that it has been presented and approved at ELG.

Agenda Item
2.2.3

Audit & Risk Committee

A National Review of Consent to Examination & Treatment Standards in NHS Wales – Final Welsh Risk Pool Report

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kevin Conway, Consent Lead
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Quality & Safety Committee	21/09/2023	Noted

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PSCF	Procedure Specific Consent Form
ESR	Electronic Staff Record

1. Situation /Background

1.1 A National Review of Consent to Examination & Treatment Standards in NHS Wales has taken place and the report was published in March 2023. (Appendix 1 – available on request)

1.2 The clinical areas selected for the focus of the assessment were Unscheduled Orthopaedics, Elective Endoscopy, and Elective Gynaecology.

1.3 The purpose of this report is to provide assurance to the committee that the Health Board is taking action to improve on the areas with partial compliance.

2. Specific Matters for Consideration

2.1 CTMUHB were found to be **compliant** for the following standards:

- Policy Content
- Consent Process for Adults
- Consent Process for Children & Young People

2.2 CTMUHB were found to be **partially compliant** for the following standards:

- Consent forms
- Training in Consent
- Patient Information
- Monitoring of the Consent Process

3. Key Risks / Matters for Escalation

3.1 A Peer Review Audit of the Consent to Examination and Treatment Processes was carried out in April 2023, as instructed by Welsh Risk Pool. Plans are in place to repeat this on a recurring annual basis. (Appendix 2 – available on request)

3.2 The CTMUHB Consent Working Group has developed a formal documented Governance process for the development and approval of Procedure Specific Consent Forms. (Appendix 3 – available on request)

3.3 The CTMUHB Consent Working Group are developing a repository of Procedure Specific Consent Forms on SharePoint. The CTMUB Consent Working Group have approved three Health Board PSCFs based on advice from the All Wales Consent to Examination & Treatment Group.

3.4 The CTMUHB Consent Working Group continues to provide training to all appropriate staff groups. (Appendix 4 – available on request)

3.5 The CTMUHB Consent Working Group has disseminated links for Consent to Treatment information and training, including the new All-Wales E-Learning for Consent to Examination and Treatment on ESR.

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Equality *Have you undertaken an Equality Impact Assessment Screening?*		This is an overarching update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Audit & Risk Committee are asked to **NOTE** the contents of this report and the activity underway to improve compliance with NHS Wales Consent to Examination & Treatment Standards.

6. Next Steps

6.1 In line with the direction from Welsh Risk Pool and the All Wales Consent to Examination & Treatment Group, the CTMUHB Consent Working Group are redrafting the Health Board's consent policy.

6.2 The CTMUHB Consent Working Group are collaborating with the CTMUHB Safeguarding team to host a joint Consent/Capacity Assessment resource on SharePoint.

7. Appendices (available on request)

Links

- Launch of NHS Wales E-learning for Consent to Examination and Treatment
- WRP E-learning and Webinars on Consent
- GMC Decision Making & Consent
- ESR login
- CTM Intranet Safeguarding and Capacity Resources
- All Wales Consent to Treatment Policy

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.1

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

5.2	21/06/2023	Audit Recommendations Tracker - Lead officers to be asked for rationale to be provided as to why they were proposing a change to the implementation date.	Head of Corporate Governance & Board Business	16 August 2023 Now October 2023 **Now December 2023**	**In Progress** Rationale for changes to implementation dates has been captured against some updates provided. Work will continue to ensure rationale is provided for all future updates.
4.2	16/08/2023	Procurement and Scheme of Delegation Report – Review to be undertaken in relation to the specific circumstances regarding the single tender action waiver regarding Honeywell Building Solutions to determine whether this had been missed off the original tender	Deputy Director of Finance	24 October 2023	**Completed** Review undertaken and response shared with Members by email on 18 October 2023
4.4	16/08/2023	Learning From Events Reports – Confirmation to be provided outside the meeting as to how many blank LFER's were still outstanding	Deputy Director of Nursing	24 October 2023	**Completed** As of the 9 October 2023, the Assistant Director of Quality & Safety has confirmed that there are five blank LFER's that are in the process of being addressed.
5.1	16/08/2023	Organisational Risk Register – Update to be sought outside the meeting in relation to the reduction of the fire safety risk regarding	Assistant Director of Governance & Risk	24 October 2023	**Completed** Update against this risk was received from the Assistant Director of Health, Safety & Fire and

		compartmentalisation at Prince Charles Hospital			was circulated to members by email on 8 September 2023
5.2	16/08/2023	Audit Recommendations Tracker – Update to be included in the next iteration of the report in relation to recommendations relating to the Patient Pathway Appointment Process. Confirmation to be provided as to whether funding for the Business Case referred to in relation to Princess of Wales Fire Safety had already been included in the current plan	Head of Corporate Governance & Board Business	24 October 2023	**Completed** Updates have been provided against the recommendations relating to the Patient Pathway Appointment Process. **In progress** Fees funding has already been provided to develop the business case and the Welsh Government capital team are receiving regular updates on progress. Funding cannot be confirmed until a business case is submitted and appropriately scrutinised however Welsh Government are aware of the consequences of not addressing the fire enforcement notice and that this requires capital investment.

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)
5.3	19/04/2023	Audit Recommendations Tracker - 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 Now 16 August 2023	**Completed** Audit Tracker improvements made. Further work required to include hyperlinks to audit reports within the audit recommendations trackers which will be considered when exploring an automated system.
4.2	21/06/2023	Procurements & Scheme of Delegation Report – Director of Finance to clarify the position in relation the statement made within the Capital Monitoring Financial Control Procedure that any changes over 500k go to the Chief Executive and any changes between 500k and 1m go to the Board.	Executive Director of Finance	16 August 2023	**Completed.** Action Sent to Sally May 26/7/2023
4.3	21/06/2023	Losses and Special Payments Report - Worked example to be included in the next iteration of the report to explain the discounting rate and what this was used	Head of Corporate Finance	16 August 2023	**Completed** Action Sent to Owen James 26/7/2023 and on agenda for August.

		Progress report to be presented to the next meeting outlining the steps being taken to address the backlog in Learning From Events reports	Deputy Director of Nursing		On agenda at item 4.4.
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	**Completed and Ongoing** Report presented to the August 2023 In Committee meeting. Has been added to the annual cycle of business as a routine item for discussion at future meetings.
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	**Completed and Ongoing** Verbal update on progress provided by the Chief Operating Officer at the August 2023 meeting. Members requested a written progress report to be presented to the October 2023 meeting. Members also requested that this is removed as an action from the action log given the timescales associated with this piece of work and requested that this is added to the forward work programme instead.

Agenda Item
4.1

Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

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

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

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

4. Assessment

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

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

5. Recommendation

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

6. Next Steps

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

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 24 October 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	32
Ensuring that anti-crime measures are embedded at all levels across the organisation		
Inform and Involve	118	47
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	95
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.		
Hold to Account	320	125
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.		
TOTAL	616	299

4. STRATEGIC GOVERNANCE

The Head of Counter Fraud Services has engaged with a consultation process currently being undertaken in relation to counter fraud arrangements in NHS Wales. This follows presentation of a paper to the November 2022 Directors of Finance Forum, which was also reviewed at the Counter Fraud Steering Group. The paper was prepared at the request of Directors of Finance and as well as setting out the current arrangements, it also included some initial considerations regarding the future provision of the services. The consultation meeting centred around discussion of 3 options developed in this Forum paper:

Option 1	**No change –** continue with the current three tier service provided via CFS Wales, LCFS and NHSCFA. Smaller health bodies continue to buy in their LCFS service from the larger health bodies, for example, DHCW and HEIW buy in their LCFS services from C&V UHB.
Option 2	**Hybrid system** – all health bodies have the **option** to opt into a NWSSP led service. LCFS services provided by NWSSP would retain a local presence at the health bodies they represent, maintaining a strong operational relationship with the relevant Finance Directors. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.
Option 3	**Centralised Model** – CFS Wales and **all** LCFSs move across to an NHS Wales Shared Service Model which retains a strong local presence at the relevant health bodies, similar to the current NWSSP procurement provision. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.

Key stakeholders have been engaged to determine views on the current arrangements and the relative merits of the options included in the DoF Forum paper. A consultation report will now be compiled for presentation and consideration at Counter Fraud Steering Group and DoF Forum.

5. INFORM AND INVOLVE

The Counter Fraud Team have engaged around a review of fraud awareness training and visibility of that offering. The following matters were discussed:

- Mandating the e-learning package – a business case will be developed and submitted for consideration of mandating the Counter Fraud eLearning package. The case will be made to align to other NHS Wales bodies who have already mandated package. This will likely be a 3 year mandatory cycle for staff with supplemented targeted bespoke training for groups of staff at higher risk of exposure to fraud.
- Promotion in L&D Update - the e-learning package will be promoted for completion in the L&D update that is issued monthly. The L&D update is issued to all Supervisors and Managers, roughly 1,500 staff, for onward dissemination.
- Corporate Welcome – The Counter Fraud Team have worked with L&D to review Counter Fraud input into the Corporate Welcome that is given to new starters but with existing staff also having access to package. A fraud section is being added to the package to provide basic fraud awareness information along with counter fraud contact points.
- Classroom Sessions – the Counter Fraud classroom training sessions will be established as a course on ESR. As well as allowing for recording completion of counter fraud awareness training on individual staff records this will allow for easier promotion and increased visibility of the course in existing communications routes via L&D.

In preparation for fraud awareness month taking place in November the Counter Fraud Team have arranged for a fraud awareness screensaver to run on Health Board computers.

6. PREVENT AND DETER

NHS Counter Fraud Authority (NHSCFA) have identified a growing trend of fraud offences relating to impersonating a medical professional and have issued a Fraud Prevention Notice (FPN) for action.

The operation of this type of fraud relates to bank/agency staff where a person registers with an agency, meets all the identification and qualification requirements, and books on to several shifts. However, a completely different person arrives to work the shift.

The NHSCFA has also seen an increase in cases involving substantive posts where someone is interviewed, satisfies the NHS employers requirements but another unknown person undertakes the role.

In response to this FPN the Counter Fraud Team are undertaking a proactive exercise centred around measuring compliance with pre-employment checks and ward/department level controls. Compliance testing with pre-employment checks will involve review of previous proactive exercise in this area and review of fraud risk assessment. The Counter Fraud Team will also conduct physical ward spot checks around to test the completion of agency worker induction forms and ID checks carried out at ward level.

Alongside this all-roster information for a 6 month period is being requested from other NHS Wales bodies to enable a data matching exercise to be carried out to identify overlapping shifts from same individual.

A findings report will be brought to the next Audit Committee meeting.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in the Appendix 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.

Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Item 4.1 – Appendix

Counter Fraud Investigations Update Report

24 October 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
5	0	26

Case Rates

Referrals Received 2023/24	Cases Under Investigation for Over 12 Months
17	1

Sanctions/Outcomes

Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	3	1

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	The subject in this case has entered a not guilty plea to 9 counts of dishonesty offences relating to deceit around gaining employment in the NHS. Trial preparation hears have been set and trial is expected to be in June 2024. There has been press interest in this case with TV and print media coverage. Further interest anticipated at trial. A communication plan was in place and continues to be maintained with support from the Health Board's Communications Dept and NHS CFA Communications Team. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are awaiting outcome of criminal case.
INV/23/01232	27/06/2023	False Overtime	Allegation received that staff are not completing overtime hours or not attending at all and claiming full day overtime payments. Allegation states that supervisors are aware of this. Enquiries are ongoing but made more difficult by allegation that managers are aware and allow conduct.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/01588	01/08/2023	Timesheet Fraud	Information received following concerns established during disciplinary process. Allegation that staff member has not been completing contracted hours and is in deficit. Enquiries have sought data of Outlook account, IT logins, system logins, and ESR. This has been measured against fob data to established working hours. Enquiries have established a small deficit which would not be proportionate to seek prosecution. Findings have been shared with disciplinary process which is proceeding.
INV/23/02008	18/09/2023	Procurement Fraud	Allegation received that the person providing contracted services to other public sector organisation is related to the staff member responsible for the decision making in procuring these services. Case allocated to CFS Wales due to potential corruption / bribery aspect.
INV/23/02142	29/09/2023	Recruitment Fraud	Allegation received via Fraud and Corruption Reporting Line that an applicant failed to declare an ongoing investigaiton at employer at point of application. Subject is being traced and appears to now work for another NHS organisation. Confirmation is being sought.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/02207	05/10/2023	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Allegation received via Fraud and Corruption Reporting Line that staff member has been working for a private healthcare provider whilst absent due to sickness from substantive role. Initial enquiries have been unable to identify the subject as a Health Board Employee. Enquires with neighbouring Health Boards is being considered in attempt to trace subject.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/22/01138	18/08/2022	Non-completion of contracted hours and leave fraud	Evidence collated via ESR, Health Board systems data, documentary evidence, and engagement with witnesses was assessed against the Full Code Test which concluded that the evidence available did not meet the required threshold to give a realistic prospect of conviction. The investigation found discrepancies with account provided by reporting person and that dates alleged to have been inappropriately taken where actually signed off by management.
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.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			Assessment of case concluded that subject lacked dishonesty. A civil recovery was agreed and full recovery has now been received of the overpaid amount.
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.
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

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			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. Full repayment has been received.
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. Enquiries established that the subject had contacted Payroll at first discovery of overpayment. This was disclosed to Ward Manager upon return to work. A new digital process is currently being launched by Payroll Overpayments Team which includes verifying contact into Payroll by overpaid staff before referral.
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

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			Police led the investigation and ultimately took no further action against the subject. This was influenced by Pharmacists not wanting to give witness statements. Counter Fraud Team have engaged with Police and the Drugs Liaison Officer and provided clarity that the NHS is victim in cases such as these and should be engaged before closure decided. Subject resigned position immediately upon allegation being made. Safeguarding has been undertaken with information shared with subject's GP and MASH Team.
INV/23/01231	27/06/2023	Bullying/Harassment	Allegation received via Fraud and Corruption Reporting Line that staff member is bullying, intimidating, and oppressing other staff and agency staff. Information was assessed as not in the remit of Counter Fraud Team. Subject was traced and information shared with Workforce colleagues.
INV/23/01298	04/07/2023	Sickness Fraud	Information received that a staff member has been absent due to sickness but has been working in their own business due sick period. Enquiries found that this allegation was known by management and had previously challenged the subject around this. Subject left employment with the Health Board at beginning of July.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			This case was assessed as having no realistic prospect of conviction given low level value and previous addressing of same conduct by Health Board.
INV/23/01339	14/07/2023	Recruitment Fraud	Information received that staff member had employed their child and the child's friends to work at the Health Board. Enquiries established that the staff member had been involved in short listing of the vacancies of concern but had not been part of deciding panel. Recruitment processes had been followed and no fraud established.
INV/23/01345	10/07/2023	Recruitment Fraud	A registered nurse staff member was found to have an expired PIN registration. Enquiries established that the staff member did not have an active PIN registration with NMC. It was established that the staff member had come to Health Board employment via a TUPE process. That process did not examine the registration of registered professionals. This has now been addressed with all details of staff in this TUPE process verified and a revision of policy and procedure to include this check in future TUPE processes. No legal duty was established for the subject to declare the lack of PIN to the Health Board and as this hadn't been requested no false representation was complete. No Fraud Act offence had actually been committed as a result.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/23/01440	27/07/2023	Sickness Fraud	Allegation received that staff member currently absent through sickness of long covid was seen to be working on their own property on social media posts. Enquiries established that the subject had a genuine fitness for work certificate stating them not fit for work. No fraud offence could be established in this instance and information was shared with Workforce for review.
INV/23/01875	05/09/2023	Agency Worker Identity	Concerns received around identification of agency worker working shift. Enquiries were undertaken with supplying agency who supplied documentary evidence that person working shift was in fact the person witnessed on ward. No fraud established in this case.

Agenda Item
4.2

Audit & Risk Committee

PROCUREMENT & SCHEME OF DELEGATION REPORT

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James, Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
OJEU	Official Journal of the European Union
FCPs	Financial Control Procedures
SoD	Scheme of Delegation

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 01.08.23 to 30.09.23.

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 2023-24.

1.3 Scheme of Delegation and Financial Control Procedures

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

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

2. SPECIFIC MATTERS FOR CONSIDERATION 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 01.08.23 to 30.09.23.

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

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

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Tables A and B** below provides details of such actions during the period 01.08.23 to 30.09.23

Table A – Single Tender Actions 01.08.23 to 30.09.23

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1683	Cap	Capital Estates	Repair and upgrading works on CHP unit Flues	Rung Heating Supplies Ltd	£27,192	(b)	10/09/23
1677	Rev	Estates	Dishwasher Maintenance contract	Meiko	£47,152	(a)	01/08/23
1680	Cap	Capital Estates	Upgrades to life critical alarm systems RGH, PCG and Glanrhyd	Morris Churchfield	£378,441	(c)	10/09/23

Reasons for approval:

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

b) Compatibility issue

c) Genuine 1 provider

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

Table B - Single Tender Actions- Retrospective

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1680	Rev	Primary Care	Specialist security provision for the Alternative Treatment Service (ATS) provided at Oak Tree Surgery Bridgend and Pont Newydd in Porth.	Specialist Security Company Ltd	£45,360	(c)	21/08/23
1682	Rev	Estates	Baby Tagging System	Active Tagging Solutions Ltd	£60,264	(c)	13/09/23
1684	Rev	Maintenance	Maintenance and support contract for the Dental R4 Software Package used as the patient management system in Porth Dental Teaching Unit	CareStream Dental	£25,142	(b)	03//10/23
1678	Rev	Estates	Emergency work for collapsed Sewer and drain POW	F P Hurley	£26,157	(a)	11/08/23

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

Reference	Title	Supplier	Value	Date Approval Received
T897	Psychological Substance Misuse Service - Parc Prison	G4s Care and Justice Services (UK) Ltd	£1,884,653	21/08/2023

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 01.08.23 to 30.09.23:

Reference	Title	Supplier	Value	Date Approval Received
N/A				

e) **Single quotation actions (below £25k)** 01.04.23 to 30.09.23
The single quotation actions are shown below for noting, as a catch up from 1st April 2023 to 30th September 2023.

SQA	Rev /Cap	Division	Contract description	Supplier	Contract value	Reason for approval	Date returned
1660	Rev	Value in Health	Person centered care in Catering	Sprink	£10,000	(c)	N/a
1668	Rev	Facilities	Unit lease for equipment	Elite supported employment	£14,401	(a)	N/a
1669	Rev	NCCU	Connects mental Health leaders to spread innovation and best practice	International initiative for MH leadership	$25,000 (USD)	(c)	28/07/2023
1672	Rev	Estates	Maintenance and On Call for High voltage switchgear	National grid – formally Western power	£11,920	(c)	04/07/2023
1675	Rev	WHSSC	Accessible reader for traumatic stress Wales website	Recite me	£8,700	(c)	N/a
1679	Rev	Imaging academy	Licences to access STAdx, diagnostic tool for radiologists	Elsevier Clinical solutions	£11,489	(c)	N/a

2.2 Purchase to Pay (P2P)

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

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 6 2023-24 achieving 96.9% (value 95.1%). This compares to 94.6% (value 94.0%) to Month 6 2022-23.

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-23	15,571	38,586,322	16,298	43,991,964	95.5	96.0
May-23	23,465	69,816,166	23,924	76,960,512	98.1	97.9
Jun-23	22,974	35,244,677	23,533	39,126,216	97.6	95.2
Jul-23	31,044	54,058,760	31,830	56,526,210	97.5	95.6
Aug-23	18,381	34,149,207	18,973	36,983,288	96.9	92.3
Sep-23	19,722	46,960,932	20,740	51,217,771	95.1	91.7
YTD	**131,208**	**278,868,305**	**135,349**	**293,396,569**	**96.9**	**95.1**

The NHS invoice position continues to be challenging and shows that 79.3% (number) and 93.0% (value) of invoices were paid within 30 days to month 6 2023-24. (79.9% (number) and 86.6% (value) for the same period in 2022-23).

An escalation process has now been established where the financial accounting team are going to target areas where regular non-payment of NHS invoices within timescales is noticed. If there continues to be delay in payment of invoices this will be escalated to the appropriate Director and Director of Finance.

Scheme of Delegation and Financial Control Procedures (FCPs)

There are no updates to Scheme of Delegation or FCPs for this report.

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. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol –	Not Applicable

Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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

5. Recommendation

The Audit & Risk Committee is asked to:

a) **NOTE** the position on procurement matters for the period 01.08.23 to 30.09.23;

b) **NOTE** the position on the Single quotation actions 01.04.23 to 30.09.23;

c) **NOTE** the update regarding Purchase to Pay and achievement of PSPP target for the first quarter of 2023/24

Agenda Item
4.3

Audit & Risk Committee

Post Payment Verification Mid-Year Report 1st April 2023 - 30th September 2023

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Amanda Legge – All Wales Post Payment Verification Manager
Cyflwynydd yr Adroddiad / Report Presenter	Amanda Legge – All Wales Post Payment Verification Manager
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

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

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

In mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. It also compares the overall performance of the Health Board against the national PPV visits.

The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

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

2. Specific Matters for Consideration

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

The following key points should be noted:

2.1 General Medical Services (GMS): Following communications that went out on 20th December, regarding the inability to undertake the entirety of the visits on the visit plan for 2022/2023, we are planning to condense all remaining visits from the 3-year visit plan into a 2-year period of 2023/24 and 2024/25. We also experienced some transitional points with the introduction of the new payment system, so a separate assurance exercise is being undertaken by our payment colleagues in SSP for the data range January 2022 to September 2022. As a result, we began by checking the data submitted from practices from October 2022. The length and period of data will extend as time moves forward as it has done historically as part of the PPV assurance.

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

2.2 General Ophthalmic Services (GOS): The visit plan for GOS 2022-2023 was agreed by Health Boards after explaining that these visits were subject to change due to beginning a new way of working. PPV began remote access options having full support from Optometry Wales and begun to carry out virtual visits via Microsoft TEAMS which proved successful. Future visits will now be included in the 2023-2024 visit plan, and although we are hoping to increase the number of remote visits, we are also incorporating physical visits to carry us through this transition period of electronic claiming which is being encouraged by Welsh Government. We also continue to undertake the GOS patient letter programme across Wales to provide additional elements of assurance to our Health Boards.

2.3 Pharmacy Services (GPS): Due to COVID-19, the Medicines Use Review (MUR) service was stopped in March 2020. In 2022/23 NWSSP introduced a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and the Collaborative Working Scheme. In April 2023 we went 'Live' with the Quality and Safety scheme and will begin the Collaborative Working Scheme in April 2024.

2.4 Additional Services: As requested by Welsh Government in 2022/2023 we verified the PPV declaration for additional community pharmacy payments that were paid in 2022/2023 which has now been completed.

We are providing a new service check for incorrect dispensing data and after a successful pilot we rolled this out nationally in August 2022 using the quarterly data from April-June 2022. This is continued as a quarterly service for all Health boards across Wales.

Clinical Waste Self Assessments have been piloted for GMS and are now being rolled out to ensure compliance with legislation. We are planning to conduct a pilot with the Self Assessments for Pharmacies in the next few months.

Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks.

There is a bi-monthly National GMS Working Group with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. PPV are planning to commence a National GPS and GOS Working Group to align with the above which has proved successful.

PPV training events and roadshows to Practice Managers have been delivered locally and we are now recording these in advance, based on our trend data analysis. In addition to facilitating one-on-one training requirements, particularly for new practice managers where we created a video recorded guide to assist with this.

3. Key Risks / Matters for Escalation

The reports provide the PPV overall progress of visits and narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving throughout the claiming process.

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A

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

5. Recommendation

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

6. Next Steps

Produce the end of year report.

CTMHB Audit Report - 1st April 2023 to 30th September 2023

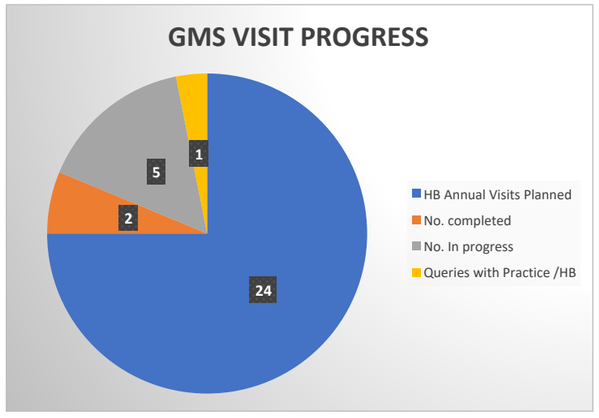
To Notes

Above planned numbers were sent to HB for 23/24 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise
Training/support is provided to practices after visit where necessary

GMS	Visit Type	HB Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	24	2	5	1	19	£745,11	20	49	173	£9 290,89
	Revisit	22	1	0	0	269	£2 769,16	0	0	114	£22,26
	Total	**46**									

Summary of themes/findings/issues

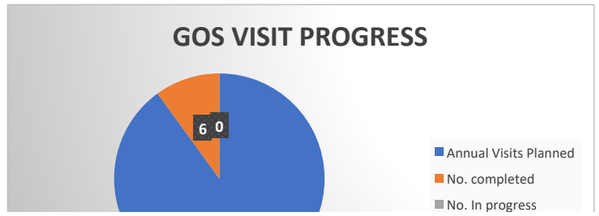
Due to the new payment system, all Revisits across Wales are on hold until Dec 2023



GOS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	54	6	0	0	12	£518,92	15	20	301	£1 498,10
	Revisit	0	0	0	0	0	0	0	0	6	£0,00
	Total										

Summary of themes/findings/issues

As contractors are transistioning to electronic records, remote access visits are slow in progressing.



GPS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
Q&S Scheme	Routine	29	5	24		0	£0,00	43	144	239	£0,00
	Total	29									

Summary of themes/findings/issues

Nothing to report at this stage

Agenda Item
4.4

Audit & Risk Committee

WELSH RISK POOL RISK SHARING AGREEMENT 2023/24

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Nigel Downes, Assistant Director of Quality & Safety
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
DEL	Departmental Expenditure Limit
HCHS	Hospital and Community Health Services
NHSLA	NHS Litigation Authority
PPO	Periodical Payment Orders
PTR	Putting Things Right
RSA	Risk Share Agreement
WRP	Welsh Risk Pool

1. Situation /Background

1.1 As set out in the Welsh Risk Pool (WRP) Committee report, dated 20th September 2023, there has been an increase in CTMUHB's 'NHS Wales Risk Share' charges for 2023/24. These charges are shared across NHS Wales and arise from excess expenditure above the Welsh Government annual allocation for Clinical Negligence and Personal Injury claims.

2. Specific Matters for Consideration

2.1 WRP receives an annual funding stream to meet in year costs associated with settled claims, the Departmental Expenditure Limit (DEL). When expenditure rises above the DEL allocation, the excess is recouped from Health Boards and Trusts, via a Risk Sharing Agreement approved by the Shared Services Partnership Committee.

2.2 WRP notes that, due to the continuous pressure on the DEL budget, year-on-year, the Risk Share Agreement apportionments has increased since 2019/20. The increases to the Risk Share Agreement charges across NHS Wales have been:

2019/20 £3.974m
2020/21 £13.779m
2021/22 £16.495m
2022/23 £25.345m
2023/24 £26.494m

2.3 The current risk share methodology encompasses principles based on the English NHS Litigation Authority (NHSLA) model, and the WRP model determines each Health Board's apportionment based on:

- Hospital and Community Health Services (HCHS) and Prescribing Allocation
- Claims History
- New Claims <£25k Transferred from the Service to Legal & Risk Services (NHS Shared Services).
- Claims Potentially Affecting Next Year's Spend
- Management of Concerns & Learning from Events

2.4 Assessment

2.5 **The financial movement for CTMUHB amounts to an increase of £522,612 to £4,005,958:**

	Planned RSA 2023/24 – IMTP	RSA 2023/24 Updated %	RSA 2023/24 Updated £	Movement from forecast
CTMUHB	£3,483,346	15.12%	£4,005,958	£522,612

2.6 The overall % position for CTMUHB is an increase from 13.15% to 15.12% of the overall NHS Wales Risk Share Agreement:

Year	Health Board/Trust	TOTAL	HCHS Allocation A	Claims History B	PTR C	Cashflow < 1 year D (i)	PPO D (ii)	Audits / Lessons Learned E
Risk Weightings			30%	20%	10%	15%	10%	15%
2023/24	Cwm Taf Health Board	15.12%	4.55%	4.08%	2.35%	1.82%	0.99%	1.33%
2022/23	Cwm Taf Health Board	13.15%	4.47%	3.19%	1.41%	1.88%	0.87%	1.33%

The increase for CTMUHB mostly relates to the 'Claims History' and Putting Things Right (PTR) elements with smaller increases in the Periodical Payment Orders (PPO) and HCHS allocation. The only cost driver with a decrease in % is for the Cashflow.

2.7 In relation to the increase in the apportionment of CTMUHB's contribution to the NHS Wales Risk Share Agreement, WRP note the following:

- **HCHS Allocation** – CTMUHB's core revenue allocation in absolute terms has reduced by 14.22% compared to last year. Previous years' core funding from 2020/21 included additional Covid-19 funding for each organisation. However, as a proportion of the total NHS Wales allocation, CTMUHB's share has risen to 15.17% compared to 14.86% last year.

- **Claims History %** - relates to the value of reimbursements approved via the WRP committee over the past three years as a proportion of the total for reimbursements across NHS Wales over the same period. Within the 20% weighting for the Claims History element, CTMUHB's proportion has increased from 3.19% in the previous 3 year rolling period (2019/20 to 2021/22) to 4.08% for 2020/21 to 2022/23.

  The total value of reimbursements paid to CTMUHB for the 3-year rolling period to 2022/23 was £24m or 65% higher than for the previous 3-year period to 2021/22. This follows a catch up of reimbursements following a backlog of submitted claims for reimbursement in 2021/22 and 2022/23. Total reimbursements to NHS Wales increased by 29% over the same period from £234m to £302m.

- **PTR** – this element is based on the number of claims with damages estimated at less than £25K passed to Legal & Risk Services (NHS Shared Services) in the previous financial year instead of being managed locally under the PTR scheme. CTMUHB have passed more claims proportionately and numerically, to Legal & Risk Services (NHS Shared Services) compared to last year.

- Cashflow < 1 Year – refers to the value of 2023/24 forecast cashflows for case settlements on the Legal & Risk Services' (NHS Shared Services) database. A lower proportion of forecast expenditure on the Legal & Risk Services' (NHS Shared Services) database relates to CTMUHB than in 2022/23, although in absolute terms, the total forecast for CTMUHB is £4m higher.

3. Key Risks / Matters for Escalation

3.1 As noted within the report, the financial movement for CTMUHB amounts to an increase of £522,612 to £4,005,958.

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Please refer to the contents of this paper – there is an increase in the contribution to WRP of **£522,612** from £3,483,346 to **£4,005,958**.	

5. Recommendation

5.1 The Committee are requested to NOTE the report.

6. Next Steps

6.1 Ongoing monitoring of NHS Wales' Risk Share Agreement contribution and update the Audit & Risk Committee of any further amendments to CTMUHB's contribution.

Agenda Item
5.1

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	August / September 2023	RISKS REVIEWED
Operational Management Board	Via Email 12.9.2023	ENDORSED FOR ELG
Executive Leadership Group	18th September 2023	*REVIEW AND MANAGEMENT SIGN OFF RECEIVED*
Quality & Safety Committee (Public Session)	21st September 2023	*REVIEW OF ASSIGNED RISKS*
Audit & Risk Committee	24th October 2023	*PENDING*

Acronyms / Glossary of Terms	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

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

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

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

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams) continue. **476** members of staff trained to date. Focussed sessions to discuss risk has also been undertaken with Care Group Leads during June 2023.

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

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Central Function – Facilities

- Datix Risk ID 4348 - Compliance to the PUWER (Provision and Use of Work Equipment) Regulations 1998, MHRA compliance, Wales Duty of Quality Statutory 2023. Risk scored at a 20.

Diagnostics, Therapies, Pharmacy and Specialties

- Datix Risk ID 2713 - Backlog of Reporting Radiology Examinations. Risk scored at a 20.

3.2 CHANGES TO RISKs

a) Risks where the risk rating INCREASED during the period

Nil in terms of risks currently escalated to the organisational risk register. There have been new risks escalated to the organisational risk register following an increase in scoring at the latest risk review.

b) Risks where the risk rating DECREASED during the period

Care Group – Diagnostics, Therapies, Pharmacy and Specialties

- Datix Risk ID 5036 – Pathology Services unable to meet current workload demands. Risk score reduced from a 16 to a 15.

Care Group – Unscheduled Care

- Datix Risk ID 1133 - Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). Risk score reduced from a 16 to a 12.

Care Group – Children and Families

- Datix Risk ID 4928 - Special care baby unit infrastructure does not comply with recommendations. Risk score reduced from a 15 to a 9.
- Datix Risk ID 4650 - Ensuring correct establishment for Special Care Baby Unit. Risk score reduced from a 15 to an 8.

Central Function – Infection, Prevention & Control

- Datix Risk ID 4217 – No IPC resource for primary care. Risk score reduced from a 15 to a 12.
- Datix Risk ID 4479 - No Centralised decontamination facility in Princess of Wales Hospital (POWH). Risk score reduced from a 16 to a 12.

Central Function – Patient, Care & Safety

- Datix Risk ID 4148 - Non-compliance with Deprivation of Liberty Safeguards (DoLS) legislation and resulting authorisation breaches. Risk score reduced from a 16 to a 12.
- Datix Risk ID 4907 - Failure to manage Redress cases efficiently and effectively. Risk score reduced from a 20 to a 16.
- Datix Risk ID 5267 - There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses on acute hospital sites. Risk score reduced from a 20 to a 12. There is a residual risk remaining in relation to retaining and recruiting nursing staff in the community and mental health services, and a new risk is being developed by the Deputy Nurse Director and relevant Care Group Nurse Directors which will come forward in the next iteration of the Organisational Risk Register.

Central Function – Digital and Data

- Datix Risk ID 5437 – Dual Deployment at CTM of both RISP and LINC Programme systems. Risk score reduced from a 16 to an 8.

Central Function Risks – Health, Safety & Fire

- Datix Risk ID – 2987 - 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. Risk score reduced from a 15 to a 12. This risk was proposed for de-escalation in July 2023, however, further assurance was sought from Audit & Risk Committee members as to the rationale for closure and therefore de-escalation was placed on hold. A further update is captured in Appendix 1 and if Members are assured this risk will now be de-escalated from the Organisational Risk Register.

Rationale for changes captured in Appendix 1.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

No risks have been closed this period.

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

Consequence						
	5			4253 3337 4768 3993 4887 4080	4664 5276	
	4				4337 3008 4906 4809 4753 3131 4671 5364 5477 4908 5462 5404 4152 3133 4752 4922 4417 5374 5254 4798 3826 5304 4348 4907	4491 4632 4071 4103 4841 4827 4780 4922 5427 5425 2713
	3					3638 4691 4732 4699 4928 4650 4672 4691 2808 5040 5036
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. MATTERS TO NOTE

4.1 The Diagnostics, Therapies, Pharmacy and Specialties Care Group are currently developing the following risk for escalation which has been drafted by the RISP Programme team following agreement on the deployment order for the national programme:

"As CTMUHB will be the last organisation in the RISP Programme national deployment if there are delays with other organisations then there is a risk that the CTM deployment date is pushed back resulting in a delay in realising benefits and the requirement to extend the current supplier (Fuji) contract beyond August 2026."

The programme team with executive support are currently discussing with suppliers and Digital Healthcare Wales the mitigation of this risk and will closely monitor progress with other organisations and currently consider the risk as moderate but will review on at least a monthly basis and assess accordingly.

4.2 Diagnostics, Therapies, Pharmacy and Specialties: There is an emerging risk to the regional (South East Wales) ability to produce systemic anticancer therapy. The Chief Pharmacists in each of the Health Boards have developed a paper to articulate the risks if the Transforming Access to Medicines (TrAMs) project does not go ahead on schedule. This paper was presented to the Operational Management Board in September 2023 and the associated risk will be added to the organisational risk register as a collective and consistent report once fully developed.

5. IMPACT ASSESSMENT

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

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

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

6. Recommendation

6.1 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

7. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	IF there is consistent backlog of Radiology reports THEN there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes RESULTING IN deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Review allocation of reporting and productivity. All further mitigations would require financial resource. WLIs options being considered. Mitigating actions have been discussed through Operational Management Board, Planned care recovery Operational group and have discussed some further options with the Assistant Director of Transformation, Strategic and Operational Planning, Executive Director of Strategy and Transformation and the Chief Operating Officer. Risk score increased and therefore this risk has now been escalated to the Organisational Risk Register due to the current increase in reports outstanding, particularly for MR, USC and concerns raised from internal colleagues and patients. The score is now 20 based on risk being held within the service.	Quality & Safety Committee Planning Performance & Finance Committee	20	C4xL5	4 C4xL1	New risk escalated to the Organisational Risk Register September 2023	08.02.2017	21.08.2023	30.09.2023
3	4348	Chief Operating Officer	Central Support - Facilities Function	Assistant Director of Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Compliance to the PUWER (Provision and Use of Work Equipment) Regs 1998, MHRA compliance, Wales Duty Of Quality Statutory 2023	IF: The Health Board fails to deliver a robust and sustainable Clinical Engineering function. Then: Due to the quantity and complexity of medical devices being purchased the Health Board would not be able to provide a full service in terms of advice, maintenance & repair and compliance with relevant legislation and regulations. Resulting In: Non-compliance with the legislation / regulation such as PUWER, MHRA (Medicines and Healthcare Products Regulatory Agency) Managing Medical Devices 2021 guidance and Wales Duty Of Quality Statutory Guidance 2023.	All calls and responses are being prioritised according to service risk and need. Some overtime is being utilised to cover some planned maintenance. Service contracts in place for life support Anaesthetics Equipment (a cost pressure) as a result of vacant B6 Technologist post.	A situation report (SBAR) has been completed by Head of Clinical Engineering and submitted to Deputy COO/COO with more detail regarding budget deficit and vacancy status. Dated 5/05/2023. Three substantive band 5 vacancies have now been approved and undergoing recruitment. Interview process completed with likely start dates of end of September and October 2023. A period of training/induction to bring up to speed will be in place. Advised a specific department to place CTG equipment on service contract (cost pressure) to mitigate possible issues while CE staff are not trained and/or not in post to support equipment fully and safely. The management of a number of service contracts which are the responsibility of the user departments have been handed back to the users to manage as is their responsibility and budget. Update 4.9.2023 - will review in October following recruitment and that at this point score will be reduced.	Planning, Performance & Finance Committee	20	C4xL5	4 C4xL1	New risk escalated to the Organisational Risk Register September 2023	23.07.2010	10.8.2023	31.10.2023
4	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.	Updated September 2023 - On the 13th June 2023, NHS Wales and the software company jointly agreed to end the contract for the implementation of a Laboratory Information Management System. This decision was made on the basis of the current and future requirements of the pathology service in Wales. Both parties remain committed to managing the transition out of this project in the best interests of patient outcomes in Wales. CTM Local Deployment Project Group have reassumed meeting once a month to ensure any Programme actions can be progressed. Review end of October.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	8.9.2023	31.10.2023
5	5425 (Replacing 5153)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2023/24. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 23/24 Context: The context is that the draft financial plan for 22/23, . This planned deficit is also dependent on the delivery of efficiency savings of £27.3m which is a significant step up in savings compared to recent years.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper was submitted to WG on 31 May but the forecast deficit for 23/24 remains at £79.6m. Update August 2023 - Given the significant financial challenge facing NHS Wales, all Health Boards were asked on 31 July to submit potential savings options to improve their forecast deficits by 10%,20% and 30% . The CTM response was submitted on 11 August and we are awaiting a response.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	↔	28.04.2023	29.8.2023	31.10.2023
6	5427 (Replacing 5154)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper was submitted to WG on 31 May but the forecast deficit for 23/24 remains at £79.6m. Update August 2023 - Given the significant financial challenge facing NHS Wales, all Health Boards were asked on 31 July to submit potential savings options to improve their forecast deficits by 10%,20% and 30% . The CTM response was submitted on 11 August and we are awaiting a response.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	↔	28.04.2023	29.8.2023	31.10.2023
7	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~~ Statutory Duty, Regulation, Mandatory Requirements	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 Inquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update August 2023 - Timeline including World Health Organisation (WHO), Welsh Government (WG) and Public Health Wales (PHW) Guidance is in place. The Covid-19 Information Manager is prioritising mapping CTMUHB response and catalogue of information against that timeline . Approach from other Health Boards has been shared. Next review October 2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	17.8.2023	31.10.2023
8	4780	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training Then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to Incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at 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 September 2023 - Further discussion underway with the Executive Leadership Group and Finance to release the funding for additional posts. Timeframe for review 31.10.2023	Health Safety & Fire Sub Committee	20	C4 x L5	4 C2xL2	↔	06.08.2021	6.9.2023	31.10.2023

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9	4827	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses e.g. Covid, flu, etc.; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	SBAR completed outlining the requirements regarding Fit Testing. Update September 2023 - Original Business case will need to be updated and presented back to Executive Leadership Group for final sign off/approval. Timeframe for review 31.10.2023	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	6.9.2023	31.10.2023
10	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update July 2023 - The financial Planned Care Recovery package agreed in June 2023 and the schemes are now in motion which is resulting in a positive impact on backlogs and ongoing demand. The Health Board has trajectories in place for planned and cancer targets which is monitored weekly by the Planned Care Director and their wider team. Clinical strategy work is ongoing which will serve to strengthen the Health Boards ability to create more capacity within the system. The Health Board is also starting to look at a Demand Management Plan as currently referrals to CTM are higher than pre-Covid levels. In order to sustain performance the Health Board needs to tackle this issue along with Primary Care colleagues and in this regard have produced a heat map to identify those practices that the Health Board needs to work collaboratively with as a priority. In addition the Six Goals Plan was agreed in June 2023 and the plans to increase Same Day Emergency Care (SDEC) plans across CTM are in motion. The Health Board is now focussing on its outcome matrices to ensure it captures investment return effectively. Reviewed 12th September no change to mitigation as reported in July (above) - no change to risk score. Review 31.10.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	12.9.2023	31.10.2023
11	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 June 2023 - Action plan in response to Welsh cancer patient experience survey finalised. Roll out of Canisc replacement piloting with the Breast MDT. Implementation of weekly performance meetings with highlight report to COO weekly. Action plans developed for high risk challenged areas - Gynaecology, Lower GI, & endoscopy with support from the DU to implement required changes. Update September 2023 - risk score reviewed and no changes made to scoring or mitigation as detailed in the July update. Next review October 2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	11.09.2023	31.10.2023
12	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF:** The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews Next review 31.8.2023 Update September 2023 - risk score reviewed and no changes made to scoring or mitigation as detailed in the July update. Next review October 2023.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	11.09.2023	31.10.2023
13	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 4th September 2023: It is the expectation that the new governance arrangements will give a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • 1st Board meeting held and monthly meetings to follow from September onwards. • Operational Group being established with 1st meeting in September with a focus on the performance and actions for improvement. • Consultant recruitment still problematic and as such alternative options being explored re SAS doctors to provide an increased level of robustness. • Brainomix implementation continues. • The risk level will need to remain high as Medical and CNS staffing levels at PCH continue to be a challenge relating to maintaining services however also relating to service improvement i.e providing services outside 8-4 during the working week. Review date 31/10/23	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	4.9.2023	31.10.2023
14	5462	Executive Director of Therapies and Health Sciences.	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	AWMS Monitor Capacity and Demand: Update 30.8.23 - Monitoring and reporting within current structures. Current WL for L3 as of 31/7/23 was 998. with expected capacity of 150/year waiting list currently standards at 6.6 years. Team reviewing interventions and working towards group interventions due to be piloted in September 2023. Should see capacity increase to at least 250/year. Timeframe 29.9.2023. AWMS - Pathway Design - Update 30.8.23 - first group trial likely September. Working with research department to support evaluation. Timeframe 31.10.2023.	Quality & Safety Committee People & Culture Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	30.08.2023	31.10.2023

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15	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.	Redacted due to business sensitive infomration - will be received in Private Session.	Redacted due to business sensitive infomration - will be received in Private Session.	Digital & Data Committee	20	C5 x L4	15 (C5xL3)	↔	26/05/2021	01.09.2023	31.10.2023
16	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	~~Patient / Staff /Public Safety~~ ~~Impact on the safety – Physical and/or Psychological harm~~ Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update September 2023 - This risk has been reviewed and re-assessed against the domain matrix Statutory Duty, Regulation, Mandatory Requirements and the risk score re-evaluated to a 16. Mitigations previously documented have not all come to fruition. In response, the Legal Services Team are currently developing a new invest to save bid to support this area of risk focussing upon the backlog. Moving forward consideration will also need to be afforded to the compliance with the Duty of Candour statutory requirements, with an expected increase in cases and current workforce challenges. The next review of this risk will include a robust review of the detailed narrative and what this risk is measuring.	Quality & Safety Committee	20 ↓ 16	C4xL4	8 (C4xL2)	↔	02.11.2021	04.09.2023	31.10.2023
17	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:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update 31.8.2023 - Senior Management Team improvement plans in place as part of the 6 goals improvement programme however this programme is not yet in implementation stage. Targeted improvement trajectories in place for the Unscheduled Care Group relating to 4 hour ambulance delays and patients waiting over 12 hours within the department which will improve overcrowding. This remains an ongoing risk for all 3 sites and will be reviewed regularly as implementation of targeted improvement takes place. SMT reviewed and mitigating actions remains and new review date of 31/10/23	Quality & Safety Committee	16	C4xL4	12 (C4xL3)	↔	24.09.2019	31.8.2023	31.10.2023
18	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	~~Patient / Staff /Public Safety~~ ~~Impact on the safety – Physical and/or Psychological harm~~ Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update September 2023 : Post Covid the number and complexity of inquests has become more challenging owing to an increasing number, with backlogs being experienced both within the Coroners Office as well as the Health Board. Mitigations previously documented have not all come to fruition. In response, the Legal Services Team are currently developing a new invest to save bid to support this area of risk focussing upon the backlog. The next review of this risk will include a robust review of the detailed narrative and what this risk is measuring.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	04.09.2023	31.10.2023
19	5304	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU is over 20 years old and is at risk of malfunction. If: the air handling unit malfunctions Then: the aseptic unit will not be able to function Resulting in: patients not being able to receive certain drug therapies.	The room pressures are being monitored on a daily basis. The estates department maintain the AHU regularly. Monthly in-house QC testing of air quality provided by AHU. 6 monthly external testing of air quality provided by AHU. Contingency plan in place if the AHU does malfunction.	Update September 2023: NWSSP Audit has been carried out with a number of recommendations identified that are being considered by the DTPS Care Group and specifically the Chief Pharmacist. The recommendations will now be considered in terms of a management response and timeframes for completion that will be monitored via the Audit & Risk Committee.	Quality & Safety Committee	16	C4xL4	4 (C4xL1)	↔	29.11.2022	11.09.2023	31.10.2023
20	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	IF: the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. THEN: There will be delays in performing and reporting autopsies. RESULTING IN: * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update 30.08.2023 - Awaiting feedback form paper submitted outlining challenges in Post Mortem service/after death service flows. Conversations for winter planning arranged with MES. Additional concern around impact of proposed introduction of MES into the community, leading to increase in referrals of deceased to Hospital Mortuaries.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	30.08.2023	30.09.2023
21	4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	**If** the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), **Then:** the critical service will be unable to meet the need of patients requiring therapy, **Resulting in:** significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response.	Update September 2023: Successfully recruited to 3 x part time Speech and Language Therapy roles to provide specialist services to all 3 ITUs in CTM. This is great news and will have a significant impact on MDT morale, patient safety and patient care. POW role has commenced the other 2 are awaiting pre-employment checks and subsequent start dates. Gaps in other AHP provision remain. Next review date 1.11.2023.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	20.08.2021	1.9.2023	1.11.2023

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
22	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update June 2023: - Submit paper to HTA board regarding releasing deceased on MES certificate. By releasing deceased following MES certificate this will improve flow of deceased. Reviewed following further scrutinisation of relevant guidance, which suggests this might be appropriate for urgent releases recognizing risk. Timeframe 31.7.2023. - Review processes to encourage collection by Funeral Directors. Explore options to reduce length of stay of the deceased and engagement with stakeholders. Timeframe 31.7.2023. Update 30.8.2023 Awaiting feedback form Paper submitted outlining challenges in Post Mortem service/after death service flows. Conversations for winter planning arranged with MES. Additional concern around impact of proposed introduction of MES into the community, leading to increase in referrals of deceased to Hospital Mortuaries.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	30.08.2023	30.09.2023
23	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update September 2023 - Mitigations previously documented have not all come to fruition. In response, the Legal Services Team are currently developing a new invest to save bid to support this area of risk focussing upon the backlog. Moving forward consideration will also need to be afforded to the compliance with the Duty of Candour statutory requirements, with an expected increase in cases and current workforce challenges. The next review of this risk will include a robust review of the detailed narrative and what this risk is measuring.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	04.09.2023	31.10.2023
24	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	Update June 2023 - No change to mitigation or risk score. 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 - Mitigation Timeframe June 2024. August 2023 - No review this month as not due until 31/10/23 due to nature of the risk	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	21.6.2023	31.10.2023
25	3008	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 6. Ask other HB`s their MH requirements SBUHB online training package to be shared. 7. Directorate will Seek out any opportunities for online updating to support current practice 8. 2 registered nurses to undertake train the trainer and initially cascade to community midwifery staff, commencing Sept 2022. 9. Staff member identified to action monthly module B training to facilitate improvement in knowledge and skills- agreed 11.10.22 10. In agreement with MH team 2 midwives to undertaken 5 day TTT course for manual handling in July. Meeting arranged with MH team to arrange bespoke 3 hour course for all midwives to be implemented 2023/2024 for 100% compliance in 12 months.	Organisational plan for compliance training. Update April 2023 - Risk reviewed. Bespoke training module in development and ready for roll out 2023. Risk score will be adjusted once numbers trained increases. Update June 2023 - risk reviewed by AD Health, Safety & Fire 27.6.2023 - No Changes made.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	27.6.2023	31.08.2023
26	3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	August 2023 - update: the Health Board compliance percentage has increased to 29% based on a 3 year compliance (change to previous reporting). Whilst this is a slight improvement in overall compliance, this increase is not considered sufficient to reduce the severity of this risk. In addition, there has been no progress with developing an E Learning package. Next review 3 months.	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	22.8.2023	31.10.2023
27	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. PCR funding bid for 2 biochemists - FITT testing - new vetting criteria Update July 2023 - The referral pathway for lower gastrointestinal (GI) investigations has been modified following national guidance and FIT testing. This is ensuring the patients are receiving the correct investigation at the start of the pathway. Referral criteria for non-obstetric ultrasound scans have been updated to include national guidance. This ensures scanning only when clinically indicated. Next review due 31.8.2023.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	21.08.2023	18.09.2023

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
28	4337	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	**If:** The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers **Then:** The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	**Key Controls** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems, the ABHB Clinical Workstation or Local Authority system Numerous delays in NHS Wales progressing open architectural approach which results in CTM UHB being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Integrate Bridgend ICT Systems within CTM - 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. Update September 2023 - No change to mitigation risk or risk score. Next review due 28.10.2023.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	05.09.2023	28.10.2023
29	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Module D PMVA Training Provision / Programme Delivery - Timeframe 28.07.2023. Addition training needs to be acquired to meet the increasing demand as highlighted in the Training Needs Analysis. The present training programme will not meet specified compliance targets. Timeframe 31.08.2023 Update September 2023 - Risk reviewed and position has not changed since last update. Review timeframe 31.12.2023.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	06.09.2023	31.12.2023
30	4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	Update August 2023 - The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams, with Patient Safety Improvement Managers taking a lead of facilitation. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. The business intelligence team have developed reports and dashboards. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs. Penalties have recently been realised. Letter from Medical Director outlining the importance of engagement in the quality and safety agenda has been distributed. However, LFERs still remain a difficult area to manage. Weekly meeting with AD Claims & Complaints, Head of Legal Services and Heads of Quality & Safety to review all deferred LFERs. Actions are taken to assist service areas to produce learning. Penalties have been received over the past few months and are set to continue for anything deferred for more than 6 months. New procedures come into place from 1st September 2023 and all LFERs triggered before this date will have to be submitted and approved before 31st January 2024	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	04.09.2023	31.10.2023
31	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 from MHLD Care Group - September 2023 - For Mental Health inpatient areas a further review has been completed which identifies some limited challenges, for example with outward opening doors . These have been reported through estates. Next review 30.9.2023.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	6.9.2023	31.10.2023
32	5364	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage	IF we are unable to recruit SCPHN School Nurses into vacant caseloads. THEN there will not be enough SCPHN's to deliver the School Nursing Framework and Welsh Government priorities. In addition increased pressure on existing staff. RESULTING IN – the school nursing service being unable to fulfil all of its statutory obligations to safeguarding, optimise immunisation uptake rates, support CYP with their emotional health and compliance with the CMP. It is also predicted that there will be increased levels of staff sickness and impact on recruitment and retention of staff.	Vacancies to be advertised as required. Development of a SCPHN SN bank Team Leader and CNS safeguarding to support staff to ensure safeguarding statutory duties are met. Plan in place to prioritise, Immunisations, CMP, SEHS. Where possible, Team Leader to protect SCPHN time to hold drop in sessions within schools. Vacant caseload policy has been activated. Letter send to Directors of Education and Head Teachers regards reduced SN service capacity. Development plan in place for junior staff to complete SCPHN training and ensure succession planning of future SCPHN workforce. Cross cover support from School Nursing staff across the HB. Extra hours have been offered throughout the team. Team leader review workforce capacity as required and escalate to Senior Nurse when required. Skill mix approach by MC team to deliver school nursing service Senior Nurse to escalate to senior management as required	Due to a national shortage of SCPHN students qualifying across Wales, all vacant SCPHN posts will be recruited into at every opportunity. Band 5 development plan, to support succession planning and future of SCPHN workforce Timeframe: 21.7.2023 Reviewed by Children and Families Care Group on the 30.08.2023 - proposed for closure. Rationale for closure being sought prior to de-escalation / closure from the Organisational Risk Register.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	03.02.2023	30.08.2023	30.09.2023
33	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	Redacted due to business sensitive infomration - will be received in Private Session.	Redacted due to business sensitive infomration - will be received in Private Session.	Digital & Data Committee	16	C4 x L4	9 (C3xL3)	↔	03.05.2021	05.09.2023	30.09.2023

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
34	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	Update August 2023: Medical Workforce Productivity Programme is fully established. Within this programme are a range of initiatives which are interrelated and mitigate each associated risk one part at a time. Within the initiatives/workstreams, financial aspects are fully considered. Collaborative discussions have been ongoing for CTMUHB to align rates with Aneurin Bevan UHB's rate card. This has been discussed at Executive level and financial controls have been considered. An updated paper is due to be received at Executive Leadership Group in September for formal approval.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	21.08.2023	31.10.2023
35	5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Service Director - Diagnostics, Therapies, Pharmacy 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 30.9.2023 Demand & capacity review Due Date 30.9.2023 Workforce redesign Due date 30.09.2023 Dedicated Pathology IT resource Due Date 30.09.2023 Accommodation review Due Date 30.09.2023 Novation of Equipment to the Managed Service Contract Due date 30.09.2023 Update August 2023 - The current control measures are ongoing. Care Group have reduced the current score slightly to 15 to more accurately the current consequence and likelihood. Risk score likelihood remains as a 5 in light of current staffing capacity and Administrative and Clerical / Managerial vacancy restrictions within the Health Board. There will be particular challenges within the Cell Path Consultant teams as a result of a staff member leaving later in the year which could result in a potential need to increase outsourcing. Current Planned Care Recovery funding is forecast to be exhausted by November 2023 based on current activity levels and this risk has been escalated via the Planned Care Recovery Board and through Operational Management Board.	Quality & Safety Committee	15 ↓ 16	C3 x L5 Risk scoring reviewed August 2023.	6 (C3xL2)	↓ Decreased from a 16 in September 2023	02.03.2022	09.08.2023	31.10.2023
36	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 1.0 wte Psychiatrist (clinical lead role, Uplift from 8a to 8b 0.6 wte Pharmacist, 1.0 wte Band 3 admin & 0.6 wte Band 3 HCSW - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred. Meetings scheduled to bid for funding via Regional Partnership Board. Timeframe 29.9.2023	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	05.07.2023	31.07.2023
37	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	Update June 2023 -options for decant remains under strategic review and is proposed for discussion at Improving Care Board on 27th June. If this is the agreed way forward this will be discussed at a formal review with Welsh Government, likely to be late July. If approved then the contractor can be re-engaged and works commence on procuring the decant solution and developing the design for the theatre department works for inclusion in a business case. Further funding will need to be applied for to develop the business case. Once approved then the decant will need to be installed. Likely to require a further extension on the Fire enforcement notice which is due to expire on 31st December 2023. Update September 2023 - Project board established and at the July meeting discussed all options for earliest decant from POW theatres, including some that have not previously been considered. Full options appraisal is under development for presentation at a future meeting. Review end of October.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	20.06.2023	31.08.2023
38	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 2023 - Day forward scanning has been maintained to be within the agreed 48 hour turn around due to a focus by our external provider (GBS) moving from legacy note scanning to day forward. Current contract only funded until Sep 2023 and business case currently being developed for the continuation of the project past this point. Significant risk if no further funding is awarded/ business case approved from Sep 23 to maintaining the 48 hour turnaround due to insufficient capacity of the in-house CTM scanning department. Risk is supplemented by the cessation of any scanning of the legacy paper records and decision to minimise the creation of any new digital patient notes. Clinical coding improvement programme delivering 95% of episodes being coded within the month, with main constraint being availability of the record. Clinical resource and Admin support levels to maintain and record the record being cited as challenging Digital dictation programme being refreshed Integration architecture for eforms under consideration	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	01.09.2023	30.09.2023
39	4732	Chief Operating Officer	Unscheduled Care Group Proposed change to Planned 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	Update August 2023 - Orthogeriatrician service model is being reviewed and CTM as part of the trauma and orthopaedic reconfiguration of service. New review date 31.10.2023. Senior Management Team reviewed and has requested that this risk is transferred to planned care Directors for management.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	31.10.2023	30.09.2023

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
40	5040	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	**IF:** The Health Board can not integrate new applications into its digital architecture in a timely fashion **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered **Resulting in:** delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	Update August 2023 - SLA discussions with key providers have articulated a requirement for APIs to be made available far more rapidly. Whilst there is a commitment of all partners towards opening up the architecture and ability for data to flow across the NHS there appears to be fundamental constraints within NHS Wales in having the capacity and capabilities to do so.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	01.09.2023	01.12.2023
41	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update September 2023: See control measures which also include mitigating action being taken. New WCCIS Programme Board and Operational Group established for CTM.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	6.9.2023	31.10.2023
42	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case to be prepared and submitted to Welsh Government Inpatient Improvement Programme has been established - April 2023.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. SON completed to support strategic and systematic review of inpatient development opportunities. 3. Develop a strategic outline business case following no.2 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Update September 2023 - Statement of Need (SON) completed to support strategic and systematic review of inpatient development opportunities. Develop a strategic outline business case following SON completion. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Review 31.10.2023.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	5.9.2023	31.10.2023
43	4699	Director of Digital	Central Support Function - Digital & Data (Information Governance)	Chief Information Officer	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	**IF:** The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care **Then:** There will be a loss of trust and confidence in the Health Board from its patients, population, staff and 'care providing partners' and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. **Resulting in**: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	**Key Controls:** - Adoption and implementation of All Wales IG and Data protection policies, - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc) - Mandatory training in Information Governance with auditing functionality (such as NIIAS) built in to monitor compliance, - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI -Professional (clinical) training and approach to maintain an accurate and timely medical record **Gaps in Controls:** 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom if Information and Subject Access Requests	Cyber and Data Protection Improvement Plans being taken forward. - Timeframe: Quarterly updates Response to ICO audit recommendations being managed on a prioritised and smart basis (aligned to other improvement areas) Benchmarking with other organisations in Wales undertaken. Procedures and requirement to initiate all programmes being enhanced to meet legal requirement of privacy by design Update August 2023 - Letter received from the ICO advising that UHB has a deadline of January 2024 to complete the actions they identified in their audit in January 2022 Head of Information Governance has confirmed start date of 18th September 2023 with task of delivering on these requirement Ongoing challenges in meeting minimal operating requirements in IG, with numerous members of staff acting down to maintain an operational service, and an inability to make inroads into the improvement plan Recruitment process for 3 additional IG posts at job description development phase. Risk score currently remains unchanged and will be reviewed at the end of September.	Digital & Data Committee	15	C3xL5	12 C3xL4	↔	18.06.2021	05.09.2023	30.09.2023

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
2987	Executive Director of Strategy & Transformation	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. 04/07/2023 - Updated by Assistant Director Health, Safety & Fire . Risk scoring has been amended appropriately (reduced from a 15 to a 12) as this risk is in the process of reducing as further works on the site are completed.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	12 ↓ 15	6	04/07/2023 - Updated by Assistant Director Health, Safety & Fire . Risk scoring has been amended appropriately as this risk is in the process of reducing as further works on the site are completed. On Hold due to query at Audit & Risk Committee, further assurance sought which is included below: In relation to this risk, the programme of works in PCH to address the fire issues has been ongoing for over 10 years. Each year completion of the works undertaken is enabling the health board to demonstrate improved compliance with current fire legislation. Each year the HB has to provide SWF&RS with an update on the completion of works on the site to address the notice. It was felt at the last review with SWEF&RS that due to the amount of works now undertaken against the original notice that the risk is now reducing. At some point in the next few years the risk will be totally eliminated. Propose to de-escalate.
4217	Executive Director of Nursing & Midwifery Infection Control	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.	A strategic review is planned to determine what is required to provide an integrated whole system approach for IPC. Update August 2023 - Reduced to 12 following discussion and risk appraisal with Deputy Executive Director of Nursing and Lead IPC Nurse. The risk consequence remains major with current partial mitigations, however, based on evidence (number of recorded preventable cases), the likelihood has been adjusted to monthly.	Quality & Safety Committee	12 ↓ 15	9	Update August 2023 - Reduced to 12 following discussion and risk appraisal with Deputy Executive Director of Nursing and Lead IPC Nurse. The risk consequence remains major with current partial mitigations, however, based on evidence (number of recorded preventable cases), the likelihood has been adjusted to monthly.
4479	Executive Nurse Director / Deputy Chief Executive	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Centralised decontaminatio n 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.	The planning application for the centralised decontamination unit has been approved by Bridgend County Borough Council and the tender has been shared with 5 companies. Update 30/6/23 - Capital planning are in a position to develop the business case for WG however, awaiting Executive steer on future plans for decontamination. Ongoing concerns with Urology decontamination equipment in POW, care delivery group informed and awaiting a response. Review 31.8.2023. Update August 2023 -risk reviewed and score reduced to 12 (4x3). Incidents due to aging equipment are reported monthly rather than weekly.	Quality & Safety Committee	16 ↓ 12	8	Likelihood of the risk reduced. IPC have received confirmation that the failures associated with aging decontamination equipment in POW are reported monthly rather than weekly. In view of this information, the risk score has been reduced to 12 (4x3).

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
1133	Chief Operating Officer	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	Update September 2023: Senior Management Team reviewed and there was an agreement for funding to be approved for two substantive posts for Royal Glamorgan Hospital. Currently within the recruitment phase, 1 has commenced role as Locum. Nursing workforce vacancies are currently being filled with use of bank an agency with an invest to save in progress. With these mitigating actions this will reduce the risk score to 12, with C4 & L3. Target date 8. Next review date 31/10/23	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16 ↓ 12	8	Update September 2023: Senior Management Team reviewed and there was an agreement for funding to be approved for two substantive posts for Royal Glamorgan Hospital. Currently within the recruitment phase, 1 has commenced role as Locum. Nursing workforce vacancies are currently being filled with use of bank an agency with an invest to save in progress. With these mitigating actions this will reduce the risk score to 12, with C4 & L3. Target date 8. Next review date 31/10/23
5437	Director of Digital	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.	Update September 2023- All Wales agreement on timescales for RISP agreed. CTM looking at April 2026. MSA for NHS Wales being signed on 6/9/23, with CTM deployment order scheduled to be signed before the end of September. Workshop for in-depth deployment arrangements within CTM planned for 20/9. As LINC is now scheduled for July 2025 this has mitigated the dual deployment risk.	Digital & Data Committee	16 ↓ 8	4	Update September 2023- All Wales agreement on timescales for RISP agreed. CTM looking at April 2026. MSA for NHS Wales being signed on 6/9/23, with CTM deployment order scheduled to be signed before the end of September. Workshop for in-depth deployment arrangements within CTM planned for 20/9. As LINC is now scheduled for July 2025 this has mitigated the dual deployment risk.
4148	Executive Nurse Director / Deputy Chief Executive	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.	Recurrent Welsh Government funding has been approved to continue to reduce the DoLS backlog and further strengthen Mental Capacity Act awareness. Procurement are sourcing an agency to complete authorisations through tender. Once an agency is agreed and contracts confirmed they will be utilised to address the backlog. The backlog has already been reduced through the appointment of two further BIA and performance management. Review 31.8.2023.	Quality & Safety Committee	16 ↓ 12	9	Update August 2023 - Risk reviewed with Head of Safeguarding and Deputy Nurse Director, owing to the consequence being affected (reduced) with the backlog being attended to, the risk has been reduced to 12. It is anticipated that with the clearance of the backlog, the likelihood will also reduce, bringing the risk down to the target range of 9 and therefore tolerated and suitable for closure. This will be reviewed again in mid-October.
4928	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Special care baby unit infrastructure does not comply with recommendations.	The current neonatal unit infrastructure is based on a dated footprint that does not comply with current recommendations. (Health Building Note 09-03:Neonatal Units, DoH, 2013) IF the unit remains the same as it is now the ability to provide safe patient care will be compromised. THEN as well as patient care being effected we will continue to fail IPC audits and medicines management audits. We will not be able to provide the best possible care for the families on the unit and staff morale will continue to suffer. RESULTING IN long term damage to the patient	In order to mitigate the ongoing situation all available areas of the ward have been utilised to support patient safety. An extra cubicle has been created by moving the ward managers office to a family room. Storage for equipment has been temporarily sought in the parent accommodation. The patient areas have been moved around to try to ensure space between cots is optimised.	Update June 2023:Meetings to be convened with capital colleagues. Latest IPC audits to be highlighted. Risk score reduced as there has been refurbishment following Infection Prevention Control recommendations and Public Health Wales audit. Footprint remains the same regarding spacing in some areas.	Quality & Safety Committee	15 ↓ 9	6	Risk score reduced as there has been refurbishment following Infection Prevention Control recommendations and Public Health Wales audit. Footprint remains the same regarding spacing in some areas.

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
4650	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ensuring correct establishment for Special Care Baby Unit	IF: the current staffing levels are maintained as minimum BAPM level of staffing requirement THEN: safe staffing of the unit will not comply with WTE directive. Also there will be an increase in the use of overtime/ bank/ agency to cover shift patterns. RESULTING IN: a core staffing deficit of 2.45 wte NNEB, as per BAPM requirements.	Care Group are currently running a roster that aims to maintain 4 staff (3 registered and 1 nursery nurse)on each shift by utilising bank and overtime when available. Ward manager/Practice development Nurse also steps in to cover short fall when needed. Shifts are managed depending on patient acuity and skill mix.	Continue to utilise bank and overtime shifts when needed. Continue to work collaboratively with paediatric staff if support is needed. Acknowledging the shortfall and filling the vacancy will ensure the use of overtime and bank is reduced and give staff confidence in the staffing levels.	Quality & Safety Committee	15 ↓ 8	6	Risk score reduced as update as at 05/09/23 Band 4 and Band 5 posts now filled and awaiting start date. One band 5 vacancy currently due to investigation in process. Sickness remains a challenge however, lower levels noted.
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Nurse Director / Deputy Chief Executive	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 on acute hospital sites.	**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.	LOCAL MITIGATION: 1. Safe to start is in operation daily across all three acute hospital sites, giving an overview of staffing numbers, acuity and dependency to enable team decision-making. 2. Utilisation of the monthly dashboard on areas such as sickness, vacancies, safe-to-start information and other quality/safety measures. 3. Improving level in the utilisation of data to support analysis and associated actions across the clinical areas. 4. All acute hospital sites now using safe care to report staffing levels, acuity and dependency to support decision-making and data transparency. 5. Wards and clinical areas now working to the agreed rostering policy which is in turn monitored through the care group leadership teams and corporate nursing.	Update August 2023. CTM WIDE APPROACHES: 1. Corporate nursing and local nursing representatives are working with HEIW on the implementation and translation of the 'Retention Toolkit'. 2. International nursing recruitment continues for 2023/24 and is being managed as a workstream through the Nursing Productivity Group which in turn reports to the Value and Effectiveness Group monthly. 3. The Advanced Practice Board is now substantiated and is reforming the governance to support the progression of nursing and allied clinical staff whilst ensuring a consistent and measured approach to ensure stability in general and specialist ward nursing levels where advancement is occurring. 4. Advancement of the bank utilisation programme, establishing set KPIs for the recruitment and sourcing of bank nurses and HCSWs is being coordinated and overseen via the Nursing Productivity Group.	Quality & Safety Committee	12 ↓ 20	9	Based on the local mitigation being undertaken as outlined under controls in place the likelihood of this risk being realised has been reduced. There is a residual risk remaining in relation to retaining and recruiting nursing staff in the community and mental health services and a new risk is being developed by the Deputy Nurse Director and relevant Care Group Nurse Directors which will come forward in the next iteration of the Organisational Risk Register.

	A	B	C	D	E	F	G	H	I	J	K
1	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
2	Nil this period										
3											
4											

Agenda Item
5.2

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Emma Walters, Head of Corporate Governance & Board Business
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

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

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

2. Specific Matters for Consideration

2.1 Internal Audit (NWSSP)

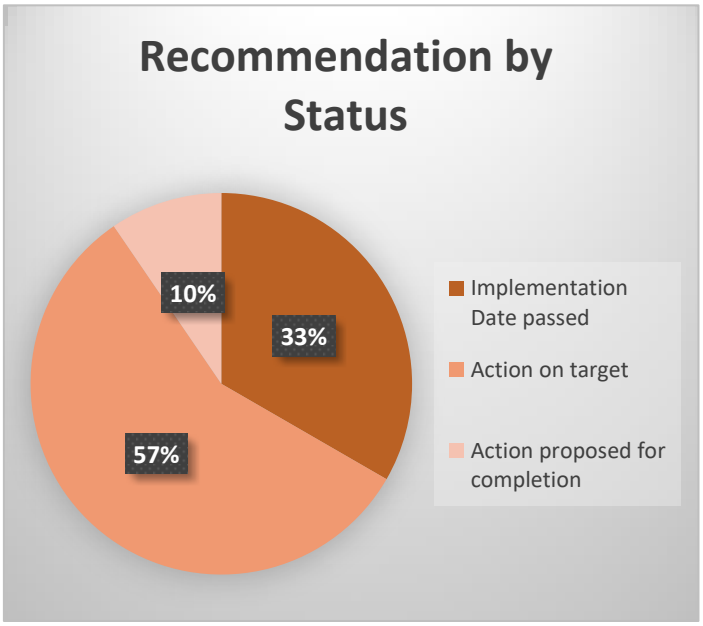
2.1.1 Since the last meeting the following changes and updates are noted:

- **5 NEW** Internal Audit Reviews have been added to the Audit Recommendations Tracker:
  - Prince Charles Hospital Programme Redevelopment – Five recommendations;
  - Decontamination – Five recommendations;
  - National Incident Framework – Eight recommendations;
  - Performance Reporting – Integrated Performance Report – Seven Recommendations;
  - Follow Up Review – Radiology Workforce – Eight recommendations.

- **32** Internal Audit recommendations have been completed and are proposed for **CLOSURE**, these are:
  - Princess of Wales Fire Safety Works 1.1;
  - Digital Operating Model 1.1, 4.1
  - Radiology Service Review 9.1, 10.1, 10.2;
  - Medical Variable Pay 1.1;
  - Reasonable Offer Process 4.1, 2.1, 2.2
  - Overtime and Additional Hours 5.0, 1.1b, 1.2, 2.1, 2.2, 3.0, 4.0,
  - Performance Reporting – Integrated Performance Report 2.2, 2.3. 3.1, 3.2, 3.3
  - Radiology Workforce Follow Up Review 1.1, 1.2, 2.1, 2.2
  - CAMHS Workforce Follow Up Review 2.1,
  - Board Awareness of Digital 1.1;
  - Prince Charles Hospital Programme Redevelopment 2.2, 3.1, 4.1;
  - Board Assurance Framework 1.1.

2.1.2 **Current Position**

The tables below provide a summary of the current position in relation to Internal Audit Recommendations, noting that the proportion of red status recommendations has improved slightly to 54% compared to the August position which was at 58%.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High	**34**	14	9	11
Medium	**87**	49	19	19
Low	**13**	10	1	2

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**1**	0	0	1
Director of Finance	**24**	15	6	3
Chief Operating Officer	**36**	20	5	11
Director of Nursing	**23**	20	3	0
Director of Digital	**12**	1	3	8
Director for People	**11**	3	1	7

Director of Strategy & Transformation	**19**	11	7	1
Medical Director	**8**	3	4	1

Implementation Date Extended by					
Priority	**TOTAL**	More than 24 Months	18-24 Months	12-18 Months	6-12 Months
High	**10**	1	1	8	0
Medium	**39**	4	12	11	12
Low	**6**	2	1	2	1

2.2 External Audit (Audit Wales)

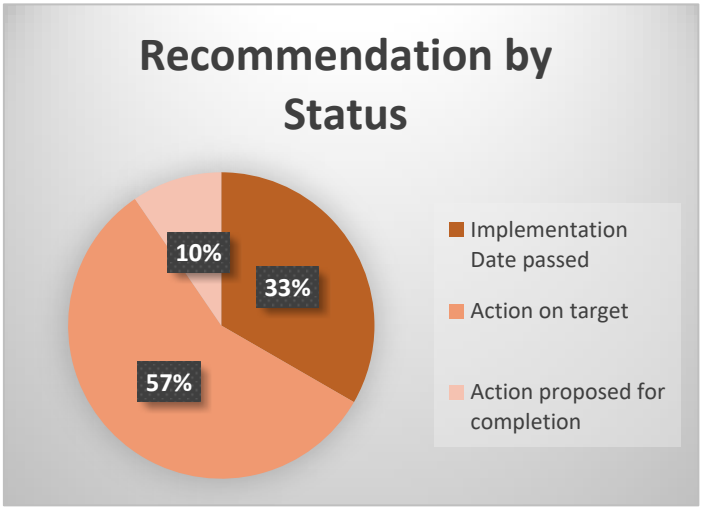
2.2.1 Since the last meeting the following changes and updates are noted:

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

- **2** external audit recommendations have been completed and are proposed for **CLOSURE**, these are:
- Cwm Taf Morgannwg/Swansea Bay Service Level Agreement Review R4;
- Structured Assessment 2022 R5.

2.1.3 Current Position

The tables below provide a summary of the current position in relation to External Audit Recommendations. You will note that the percentage of recommendations whereby the implementation date has now passed has improved to 33% compared to the 41% reported to the August 2023 meeting.



Recommendations by Priority & Status				
Priority	**TOTAL**	Implementation Date passed	Action on target	Actions Completed
High/Medium/Low	**21**	7	12	2

Recommendations by Executive Lead & Status				
Executive Lead	**Total**	Implementation Date passed	Action on target	Actions Completed
Director of Corporate Governance	**1**	1	0	0
Director of Strategy & Transformation	**10**	3	5	2
Chief Operating Officer	**3**	0	3	0
Director of Digital	**1**	0	1	0
Director of Nursing	**3**	1	2	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	**12**	2	2	5	3

3. Key Risks / Matters for Escalation

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

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

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb	Yes: ☐	No: ☒

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

5. RECOMMENDATION

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

CTM Interna [date]

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

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

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Patient Pathway Appointment Management Process Follow Up 2.4	Jun-22	Limited	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	High	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	Chief Operating Officer	ILG Acute Services General Managers / Head of Information	Sep-22	Now February 2023 Now June 2023 Now October 2023 Now December 2023 as a consequence of further focused work needed.		In progress	October 2023 update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.
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 Now September 2023		Completed	October 2023 Update - First Meeting of the Project Board happened on the 21st August with a further meeting arranged for the 21st September, and subsequent monthly meetings set up.	August 2023 Update - Draft TORs have been created and membership developed. Currently a meeting date is being confirmed and it is expected that invites will be sent imminently for a date in Late August/ early September. During this time information on a final option is being developed for a discussion on the decant options which will be the focal point of the first project Board meeting.
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		Completed	October 2023 Update - Propose to Close A new Strategic Leadership team has been created for Digital & Data and now meets every Monday (since September 2023) This has overall control for decision making regarding digital plans and resources The Leadership Group interfaces with the Care Group Senior Leadership Meetings, Strategic Group Meetings, the new Design Authority and Executive Leadership Group	August 2023 Update - This recommendation is on track for completion by Quarter 2 2023/2024
Radiology Service Review 9.1	Dec-22	Limited	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. We acknowledge that the service will always need to prioritise clinical activity, but in order to achieve set targets, the service should develop an action plan outlining a realistic approach to tackle the backlog, prioritising those with future increment dates. Consideration must also be given to developing a sustainable way of maintaining PDR compliance rates once the backlog has been cleared. As part of addressing the backlog, staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	High	An action plan will be developed to address the backlog of PDRs and establishing a sustainable system of maintaining PDR compliance in line 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 Now October 2023		Completed	October 2023 Update - Propose to close as superseded by Follow Up Review undertaken and new recommendations identified	August 2023 Update - significant improvement noted at PCH with increased compliance from 39% up to 66%. The team have booked and planned PDRs around incremental dates. All managers have been asked to review and ensure all dates are reflected accurately on ESR. It has been noted that some staff are lacking confidence in completing the new PDR document prior to the planned PDR. Staff are encouraged to engage in the process and work through the document with their line manage during the PDR or seek support prior to the PDR. Ongoing
Radiology Service Review 10.1	Dec-22	Limited	Work should be undertaken to ensure the training requirements and achievements captured in ESR are accurate: • Management should identify if there are staff that have completed higher levels of training yet are not showing as compliant at the lower levels and inform the Learning & Development team, as that may indicate an issue with the set up in ESR that will need resolving. • Management should identify staff that they believe do not need to undertake training at the higher levels identified (or any additional modules). They should follow the appeals process and work with the subject matter leads to determine what is the right level for that role, so that ESR can be amended for the individual and where necessary the wider staffing group. • If management feel staff are professionally qualified above the requirements of any of the ESR modules	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 Now October 2023		Completed	October 2023 Update - Propose to close as superseded by Follow Up Review undertaken and new recommendations identified	August 2023 Update - Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development. Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.
Radiology Service Review 10.2	Dec-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 Now October 2023		Completed	October 2023 Update - Propose to close as superseded by Follow Up Review undertaken and new recommendations identified	August 2023 Update - Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development. Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.

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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	Now October 2023		Completed	October 2023 Update - Completed. To be set in line with the Non Consultant Rate Card	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card
Medical Variable Pay 3.1	Feb-23	Limited	3.1a The process for authorising payments that exceed the WG cap rates should be reviewed, with suitable authorisation taking place to approve higher value payments. 3.1b The FCP and SOP should be updated to reflect the correct process to be followed and should provide greater clarity on the cost elements that need to be included when determining if a rate exceeds guidance rates. There should be consistent use of terminology across the FCP, SOP and Retinue system.	High	3.1a The process for payments exceeding the WG cap rates will be fully reviewed as part of the development of the new FCP and SOP. The recommendations of this audit will be incorporated into the FCP and SOP. 3.1b The new FCP and SOP will fully address and unify the inconsistent terminology used currently, to reduce any confusion going forwards. The documents will also clearly set out the authorisation process required for rates that exceed WG cap rates. The process for requesting above WG cap rates will also be included in the refresher training to all areas using agency workers.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23	Now October 2023		In progress	October 2023 Update - A new Non Consultant Rate Card has been agreed with Execs. This will be launched on 19th October. There will be a new governance / reporting system for any breaches of these rates. These rates are more than those set by the WG cap of 2019.	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card
Medical Variable Pay 3.2	Feb-23	Limited	Approval of higher rate payments should be retained in a suitable format that allows future reference if needed.	High	All authorisation of higher rates payments will be recorded fully and provided on request. The way this is captured and accessible for audit will be included in the FCP and SOP for future reference.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23	Now October 2023		In progress	October 2023 Update - Non Consultant Rate Card has been agreed by Execs. Launch is 19th October. There will be a new governance and reporting system led by both DMDs that the care groups MUST report into if there are any breaches of the rate card.	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card
Medical Variable Pay 6.1	Feb-23	Limited	6.1a The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate. 6.1b The FCP and SOP should be updated to reflect the correct process to be followed.	High	6.1a A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff. 6.1b The recommendations and subsequent processes developed will be included in the FCP and SOP.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Aug-23	Now October 2023		In progress	October 2023 Update - Non Consultant Rate Card has been agreed by Execs. Launch is 19th October. There will be a new governance and reporting system led by both DMDs that the care groups MUST report into if there are any breaches of the rate card. The Care Groups can breach up to 10% of the rate however this must be done in extreme circumstances only. The EMD can only authorise over 10% of the rate.	July 2023 update - FCP agreed, now awaiting Executive Leadership Group sign off for rate card
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	Now December 2023		Completed	October 2023 Update - Compliance reporting of application to RTT compliance relating to individual staff due to complexity of RTT rules with no single report available on application of rules. All training documentation/ RTT applications has been reviewed and updated, this is available on sharepoint and has been shared at weekly RTT meetings and with all clinical service group managers to make team aware. Training is available from PAS team on request, there has been uptake from teams in POW over the summer period.	August 2023 Update - Training is available to all staff from the PAS team and RTT manager with recent training sessions held with speciality staff in POW. Online training material available to all staff via sharepoint.
Reasonable Offer Process 5.1	Apr-23	Limited	A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	High	5.1.1 - Identification of WPAS reports to allow for identification of compliance. 5.1.2 - Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements	Chief Operating Officer	Director of Operations Planned Care & Head of Clinical Administration Transformation	July 2023 August 2023	Now December 2023,		In progress	October 2023 Update - In terms of reports this has not changed since previous update as one report on application of RTT rule is not available. In mitigation to this we have agreed that an escalation route through weekly RTT meetings of any identified areas of noncompliance with RTT rules which are identified by performance and reporting team where actions on patients pathways are not inline with guidance.	August 2023 Update - 5.1.1 identification of compliance reports have not yet been identified as RTT rules are numerous and reporting on individuals and their application of the rules is complex. 5.1.2 Where examples of non RTT compliance are identified (recent example of patients ROTT process) these are escalated through the CSG management functions for action and training needs assessments.

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SLA Arrangements 1.0	Jun-23	Limited	To aid the Health Board in achieving more efficient use of resources, a consistent approach for entering into SLA agreements should be adopted. Guidance should be in place to provide clarity on the roles and responsibilities of the central commissioning team in supporting service managers when SLAs are set up. The development of procedures, guidance and templates should be completed, approved and made available to all staff. Communication with staff should take place, to ensure staff are aware of the Health Board's desired approach and prevent the use of localised procedures and approaches that may not comply with the Scheme of Delegation or allow value for money to be achieved.	High	A project team has been set up to develop the guidance required for development of SLAs. This includes Strategy and Transformation, Finance (Commissioning) leads and will include Procurement and Care Group representatives as the work progresses. This group will: • Develop guidance for the development of SLAs. • Provide templates for SLAs and service specifications. • Ensure all SLAs currently in place are recorded on the register of agreements and have Strategy, Commissioning and Care Group (service) leads. This guidance will be supported by a clear structure of governance supported by meetings with each Care Group to manage and monitor SLAs. Progress already made includes: • A checklist for the development and changes to SLAs has been drafted. • A revised SLA template is being tested for a current SLA development	Director of Strategy & Transformation	Assistant Director of Transformation and project team	Sep-23			In progress	October 2023 - Update has not been provided on this occasion	August 2023 Update - no update has been provided on this occasion
SLA Arrangements 2.0	Jun-23	Limited	Data in the register of agreements should be checked to confirm its accuracy and completeness. • Once the current completeness and accuracy of the register of agreements has been confirmed, procedures will need to be put in place to ensure that changes are promptly notified so that it remains accurate and up to date. • The register of agreements should be checked before setting up an SLA agreement with a provider to ensure that multiple SLAs are not set up with the same provider for the same service and that no issues have been identified which would suggest that setting up the SLA agreement should not proceed. The columns for end date and review date in the register of agreements should be regularly used to identify when periodic reviews are due and whether they have been completed on schedule.	High	The register of agreements will be reviewed by a process of sharing with all corporate and service (Care Groups) teams for review and supported by a structure of meetings between the Strategy and Transformation Team (Commissioning leads) and the Care Groups to manage and monitor SLAs. All third sector SLAs have been reviewed and the register will be updated to reflect the latest status.	Director of Strategy & Transformation	Assistant Director of Transformation supported by the Commissioning Manager and Planning Assistant	Aug-23			In progress	October 2023 - Update has not been provided on this occasion	August 2023 Update - no update has been provided on this occasion
SLA Arrangements 5.0	Jun-23	Limited	Adequate data should be obtained in line with SLA requirements to allow effective performance, quality and financial monitoring of the SLA to take place. The supporting data should be provided in sufficient time before SLA reviews are scheduled to occur so that it can be properly considered at the review. Evidence and supporting data should be retained of the SLA review process.	High	Please refer to action four above, which confirms that information requirements and review frequency will be determined with Care Groups. The capacity of the Strategy and Transformation team's commissioning function has been a limiting factor in the robust development of processes. A Commissioning Support Officer vacancy is being considered by the organisation's scrutiny panel. This post will lead on organisation of the administration of the register of agreements and the meetings with Care Groups. A Head of Commissioning job description has been developed and has been sent for Agenda for Change banding. This post will be recruited to on a fixed-term basis while the Head of Planning post is vacant due to secondment. Should this role provide successful, every effort will be made to structure the team to retain this function, however this will be dependent upon the team budget.	Director of Strategy & Transformation	Assistant Director of Transformation and Commissioning Manager	Sep-23			In progress	October 2023 - Update has not been provided on this occasion	August 2023 Update - no update has been provided on this occasion
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	October 2023 Update - Work continues within the Fire Team to update the Site Specific Documents where site changes have taken place. Completion should have taken place by the June 2024 deadline.	August 2023 Update - Due to staff absence it has not been possible to obtain an update for this submission
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	October 2023 Update - This recommendation is difficult to achieve due to the changing political and financial position within Welsh Government. Each year the Fire Team bid for Capital Monies to support Fire Management initiatives across the Health Board. As Capital funding has reduced, so has the ability to address the risks that have been requested through the Capital allocation. The Fire Team have received £50k of Capital funding for the current year.	August 2023 Update - Due to staff absence it has not been possible to obtain an update for this submission
Patient Pathway Appointment Management Process Follow Up 3.1	Jun-22	Limited	Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members	Medium	This will be addressed by the ILG with colleagues from Performance	Chief Operating Officer	ILG Directors of Operations / Head of Information	Sep-22	Now February 2023 Now June 2023 Now October 2023 Now December 2023 as focus has been on validation aspect of this work		In progress	October 2023 - opinion sought from Performance colleagues.	August 2023 Update - limited progress has taken place. There will be a further update at the next meeting.

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POW Theatres Fire Safety Works 3.1	Aug-22	Limited	The Health Board should ensure timely completion of contacts.	Medium	Agreed – though in this case, due to the bespoke nature of the contract – a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Director of Strategy & Transformation	Project Director	At future contracts	Now January 2023 Now March 2023 Now June 2023 Now March 2024		In progress	October 2023 Update - Work to identify the preferred decant option is ongoing, a further option was considered at the August project Board to be reported on in the November Board. Once this has been confirmed then work can commence on the business case	August 2023 Update - Once the business case is approved, updated contracts will be required for the SCP, Project Manager and Supervisor - all governed by Designed for Life principles. Also a contract for the Cost advisor will be required. It is anticipated that these will be standard Stage 4 construction contracts and therefore can be issued and signed immediately. Until this point the current bespoke contract arrangements remain in place. In terms of timing, the case remains under strategic review for discussion at the Project Board. Once a preferred option is internally approved this can be discussed with WG and the business case work recommenced. It is anticipated that a business case will be at least 16 weeks in development as costs must be tendered and therefore unlikely to be completed until at least February 2024. It is hoped that this will have a swift approval and turnaround by WG
POW Theatres Fire Safety Works 4.1	Aug-22	Limited	The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Medium	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Director of Strategy & Transformation	Project Director	At future contract awards	Now January 2023 Now March 2023 Now June 2023 Now March 2024		In progress	October 2023 Update - Please see note above this action will be addressed once there is an approved business case in place	August 2023 Update - Project remains under strategic review - options to be discussed at Project Board which is being scheduled for the end of August/beginning of September, once this has happened this can be discussed with WG. Currently there are no contracts to enter it, this recommendation is noted as a future requirement when the construction phase becomes live and contracts are entered into. As this is a D&L scheme then most contracts are prescribed under that framework, including Project manager so this would only refer to contracting for a cost advisor for the balance of the scheme which will be undertaken once the business case is approved.
POW Theatres Fire Safety Works 4.2	Aug-22	Limited	The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now March 2024		In progress	October 2023 Update - As above action remains open pending business case preparation and approval. Only then will a construction contract be let and this can be actioned.	August 2023 Update - As mentioned above the cost advisor in post is contracted until Business case approval. A planned competitive process is planned for the stage of business case scrutiny to let the contract for the cost advisor without delay once the business case is approved
POW Theatres Fire Safety Works 4.3	Aug-22	Limited	The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now March 2024		In progress	October 2023 Update - As above this will be required on the next phase of the development	August 2023 Update - This links into the response and timeline for the above and will be addressed when the contract falls to be renewed with a competitive process.
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	October 2023 Update - It is proposed that the SCP contract be ended and this will be discussed on the 21st September 2023 Project Board. If this action is taken then this will be closed if the scheme continues outside of the current framework.	August 2023 Update - As mentioned above post an agreed strategic review and way forward with WG, the SCP and PM will be re-engaged and the formal performance review mechanisms will be re-enacted under the contract
POW Theatres Fire Safety Works 8.1	Aug-22	Limited	Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: • contacted sums; • cash flow budgeted to date; • expenditure to date; • forecast out-turn; and • associated variance commentary.	Medium	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now September 2023		In progress	October 2023 Update - This will be part pf the formal project Board update - expected to be agreed as a template in September Board and implemented for October Board.	August 2023 Update - Formal cost reporting templates have been developed and agreed for utilisation upon commencement of work by the SCP and PM. These will be formally reported at Project Board as well as reported via ECMG in terms of in year CRL performance and risks to the total capital allocation.

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POW Theatres Fire Safety Works 9.1	Aug-22	Limited	Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Medium	Agreed. This will be undertaken at the future procurement.	Director of Strategy & Transformation	Project Director	At confirmation of the preferred option	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now October - December 2023		In progress	October 2023 Update - In the light of the LHP outcome this is not a likely outcome. However it does remain important that value for money is evidenced in any solution as part of the option appraisal.	August 2023 Update - The business case process will ensure value for money - once recommenced this will be an integral part of the case once the preferred option is developed for the single stage business case
POW Theatres Fire Safety Works 10.1	Aug-22	Limited	A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023 Now June 2023 Now September 2023		In progress	October 2023 Update - This is part of the Project Board remit and will be a standing item on the Project Board	August 2023 Update - As above this will be developed in a risk workshop once the preferred option is confirmed both internally and with WG for the single business case
POW Theatres Fire Safety Works 10.2	Aug-22	Limited	Management should actively monitor and report the value of residual risk v remaining contingency.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now December 2023		In progress	October 2023 Update - This will not be a requirement until we have a revised and funded project allocation. As the preferred option is not yet identified this can not be reviewed.	August 2023 Update - no update has been provided on this occasion
POW Theatres Fire Safety Works 10.3	Aug-22	Limited	Risks should be individually assigned to those best placed to control them, with time parameters for action.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now November 2022 Now January 2023 Now March 2023 Now June 2023 Now September 2023		In progress	October 2023 Update - The Project Board will oversee the risk register, updates and risk allocation	August 2023 Update - As detailed above, this will be undertaken on re-commencement of the project in conjunction with the review and update of the risk register
POW Theatres Fire Safety Works 10.4	Aug-22	Limited	An exception report should be published of targeted risk mitigations not achieved.	Medium	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now September 2023		In progress	October 2023 Update - This will be actioned as part of the Project Board Agenda	August 2023 Update - As detailed above, this will be undertaken on re-commencement of the project in conjunction with the review and update of the risk register
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			Completed	October 2023 Update - Propose to Close Structures have been and continue to be reviewed by the new Strategic Leadership Group for Digital & Data This is now a core activity that will be undertaken by this group	August 2023 Update - This recommendation is on track for completion by Quarter 2 2023/2024

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Medical Variable Pay 2.1	Feb-23	Limited	2.1a The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. 2.1b The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	Medium	2.1a The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. 2.1b Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23	Now August 2023 Now November 2023		In progress	October 2023 Update - Planned Care, Primary and Community and DT+S have DE rates of over 98%. The Care Groups that have the most non engaged Doctors are Unscheduled Care and Mental Health. The Unscheduled Care group sent a letter to all agency workers giving them a 6 week period to establish engagement.	July 2023 update - DE document written and shared with Care Groups
Medical Variable Pay 2.2	Feb-23	Limited	The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.	Medium	All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health board, which will allow the organisation to target and reduce DE use.	Medical Director	Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23	Now August 2023 Now November 2023		In progress	October 2023 Update - Planned Care, Primary and Community and DT+S have DE rates of over 98%. The Care Groups that have the most non engaged Doctors are Unscheduled Care and Mental Health. The Unscheduled Care group sent a letter to all agency workers giving them a 6 week period to establish engagement.	July 2023 update - DE document written and shared with Care Groups
Medical Variable Pay 5.1	Feb-23	Limited	Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.	Medium	Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	Medical Director	Assistant Director of Finance/ Assistant Medical Director/Head of Workforce Productivity & eSystems	Jun-23	Now October 2023		In progress	October 2023 Update - Care Groups given monthly spend broken down into DE rates, ADH and locum agency spend. Divided into specialities and Doctor grades so target areas can be then addressed in Medical Productivity Group. Will need to include once rate card is implemented on number of breaches of the rate card and where specific problems are.	July 2023 update - Plan to discuss breaches at Medical Productivity Board. FCP has been updated but awaiting rate card approval at Executive Leadership Group
Reasonable Offer Process 1.1	Apr-23	Limited	As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.	Medium	Standard Operating Procedures to be reviewed and updated with approval at OMB and Executive Leadership Group. Once approved, the SOP will be published and issued to all booking teams. Previous versions of the SOP will be removed from the intranet and kept in a historical record.	Chief Operating Officer	Director of Operations Planned Care/Head of Clinical Administration Transformation	End April 2023	Now August 2023 Now October 2023 Now December 2023 given additions to process and need to revisit policy.		In progress	October 2023 update - Following feedback received by the Director of Planned Care and updated guidance from WG on the management of RTT patients this SOP will need to be presented at the next OMB for approval.	August 2023 Update - WL SOP previous version has been requested to be removed via E Business Team. Awaiting outcome of OMB decision.
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 Now October 2023		Completed	October 2023 Update - The recommendation is complete - processes have been reviewed and have shown to be similar to wider HB, direct booking and partial booking where service is allowing	August 2023 Update - There are a mix of direct and partial booking being utilised across the site with more direct booking due to the nature of patient referrals, Urgent/ USC. Not all services are booked from within core team and the services outside of main function have been identified to ensure consistent access to training material when approved. Weekly stakeholder meeting established with SME from Information and operational booking managers to review current training materials and implementation of audit recommendations
Reasonable Offer Process 2.3	Apr-23	Limited	Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	Medium	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Chief Operating Officer	Director of Operations Planned Care/Head of Clinical Administration Transformation	End June 2023	Now August 2023 Now October 2023 Now December 2023 as a consequence of OCP Phase 2		In progress	October 2023 Update - This will be completed when Phase 2 of the OCP is complete in December 2023.	August 2023 Update - Future consideration following organisational change through summer 23/autumn 2023

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Reasonable Offer Process 3.1	Apr-23	Limited	The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Medium	A training needs assessment and compliance sign off will take place post implementation of the agreed SOP. Refresher training to be organised where required for staff identified.	Chief Operating Officer	CSGMs & for all operational/booking team managers/Head of Clinical Administration Transformation	Aug-23	Now October 2023 Now December 2023 given need for update on SOP		In progress	October 2023 Update - additional work has been required and an update on the SOP Is imminent.	August 2023 Update - An update will be available when the status of the SOP has been confirmed.
SLA Arrangements 3.0	Jun-23	Limited	When SLAs are agreed the documentation should be completed to include the details of the lead contact for the Health Board. SLAs should be signed on behalf of the Health Board as the commissioning body and by the provider before the start of the period to which it applies to confirm agreement with its terms and conditions.	Medium	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Director of Strategy & Transformation	Assistant Director of Transformation and project team	Sep-23			In progress	October 2023 - An update has not been provided on this occasion	August 2023 Update - no update has been provided on this occasion
SLA Arrangements 4.0	Jun-23	Limited	SLAs should be reviewed in line with timeframes set out within them and the spreadsheet register kept up to date with renewal dates.	Medium	The meetings to be initiated with Care Groups as described in the actions above and the updating of the register of agreements will include the required performance information for each agreement and frequency of reporting, with the officers responsible for review to be identified.	Director of Strategy & Transformation	Assistant Director of Transformation and Commissioning Manager	Sep-23			In progress	October 2023 - An update has not been provided on this occasion	August 2023 Update - no update has been provided on this occasion
POW Theatres Fire Safety Works 2.1	Aug-22	Limited	The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Low	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Director of Strategy & Transformation	Project Director	At the business case	Now 2023 Now January 2023 Now March 2023 Now September 2023 Now December 2023		In progress	October 2023 Update - Delays in the identification of the preferred option will further delay the preparation of the business case and preparation of appropriate resource schedules. This is a future recommendation based on a specific event and the date needs to tie in with the latest proposed business case date	August 2023 Update - This will be included in the business case scheduled for completion over the autumn once the preferred option is defined
POW Theatres Fire Safety Works 7.1	Aug-22	Limited	The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works	Low	Agreed	Director of Strategy & Transformation	Project Director	Aug-22	Now 2023 Now January 2023 Now March 2023 Now June 2023 Now September 2023		In progress	October 2023 Update - Please see note above this will be part of the business case process	August 2023 Update - as previously noted this will be undertaken once the options paper is approved at executive level
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 Now October 2023		Completed	October 2023 Update - Recommendation completed	August 2023 Update - All material has recently been reviewed and updated with this being made available on sharepoint to all staff. This has also been communicated via RTT meetings.
Directorate Review Acute Medicine & A&E 13	Aug-20	Reasonable	An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	High	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Chief Operating Officer	General Manager	Apr-21	01/05/2021 August 2021/April 2022 Now September 2022 Now March 2023 Now June 2023 Now December 2023		In progress	October 2023 Update - no further progress to report. Until the vacancies that exist as a consequence of phase 2 of the OCP are filled there will not be the management capacity to undertake this piece of work.	August 2023 Update - position remains unchanged while being reviewed by Care Group.

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Overtime & Additional Hours 5.0	May-22	Reasonable	The functionality available in Health Roster to monitor compliance with the various Working Time Regulations requirements should be used to ensure staff are not in breach of regulations. For those areas not using Health Roster, managers should routinely monitor the hours and working patterns of staff to ensure they are not in breach of WTRs. To do this effectively, they should be aware which staff have opted out of the WTRs and therefore know the upper limit of hours to be worked in a week.	High	The UHB will turn on the Health Roster functionality to block book bank / agency workers to work any non-WTR compliant shifts. The revised Overtime Policy will set out the line manager's responsibility to routinely monitor the hours and working patterns of their staff, to ensure compliance with WTRs, when Health Roster is not used. The Policy will also require the manager to check whether their staff who regularly work overtime have completed a WTR Opt-Out Form. The Overtime Policy will be cross referenced with the WTR Policy	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023 Now August 2023		Completed	October 2023 update - The Overtime Policy was approved by People and Culture Committee on 9th August 2023 and published and distributed across CTM. This audit recommendation can now be closed.	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.
Financial Systems 8.1	Jun-22	Reasonable	Management should ensure that staff responsible for approving requisitions and processing purchase orders are aware of the correct procurement process as stated in the Requisition of Goods and Services FCPO and the All-Wales No PO No Pay policy.	High	Procurement will increase the training and cascade information relating to the No PO No Pay policy. We will identify the areas of retrospective ordering, implement a plan and ensure bespoke training to these areas.	Director of Finance	Head of Procurement	Jul-22	Now August 2022 Now November 2022 Now January 2023 Now March 2023 Now September 2023 Now End of March 2024		In progress	October 2023 update - No PO Policy , Communication plan and exemption list on hold, as AW Finance academy have stood down the AW P2P group. As part of monthly P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). What does good Procurement session held with Care groups within Operational Management Board 12th July 2023. Further sessions held in Sept with Pharmacy, Pathology and Primary Care. October sessions booked with Planning and Communication teams, trying to finalise sessions with other Care groups. AW P2P governance group disbanded by Finance Academy. No governance exists, discussions ongoing with NWSSP and Finance academy.	August 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). What does good Procurement session held with Care groups within Operational Management board 12th July 2023. Further lunch and learn sessions being scheduled from Sept 2023 as part of Procurement Engagement plan to target Non compliant areas.
Radiology Service Review 3.1	Dec-22	Reasonable	a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.	High	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via SharePoint underway.	Chief Operating Officer	Senior Superintendents Clinical Leads Superintendent Radiographers Clinical Leads Health & Safety Leads	June 30th 2023	Now August 2023 Now October 2023 Now December 2023 (as structure is under review)		In progress	October 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this workstream. A management structure including support for the governance role has been submitted to the Executive Board for approval. This post has not been reflected in the OCP document as it cannot be fully funded at present.	August 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this workstream. A management structure including support for the governance role has been submitted to the Executive Board for approval.
Radiology Service Review 12.1	Dec-22	Reasonable	A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.	High	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Chief Operating Officer	Care Group Service Director Care Group Medical Director	30th November 2022	Now August 2023 Now December 2023		In progress	October 2023 Update - Initial scoping meeting took place on 13/09/23 with People's Services. An identified sponsor and leads to take this forward established. The leads are currently establishing a ToR and will arrange the T&F working group on completion of ToR.	August 2023 Update - Second Phase of planning ongoing and will not be operational until August 2023. HEIW will be supporting the workforce planning going forward to inform next IMTP.
Welsh Risk Pool 2.1	Jun-23	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes, appropriately recorded on Datix Cymru, and monitoring takes place to ensure compliance with this requirement.	High	In respect of LFER's a new process and SOP is being drafted to ensure timely submission of LFER's. In respect of CMR's there is a process that currently picks up on upcoming CMR's. The process around monitoring CMR's will be solidified by the new dashboard which will allow a more robust monitoring process. Individuals who have missed deadlines will be reminded of importance of CMR deadlines and provided with additional training & support.	Director of Nursing	Head of Claims & Inquest	Jun-23	Now September 2023 Now December 2023		In progress	October 2023 Update Standard Operating Procedure for LFERs drafted and re-circulated for final comments. The SOP now includes an escalation process. CMRs and LFERs are already monitored via the weekly reporting process. LFER dashboard has been completed. Further developments are in process to ensure information is available to service areas. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs. Working to improve the CMR monitoring is underway. Rationale for Revised Implementation date: from September to December 2023-New Welsh Risk Pool Procedures came into force in September 2023 and therefore SOP had to be revised. This is now out for review. Audit programme is being developed for the Legal Services function by the BI team. Long term sickness of staff within the team resulted in a delay in progressing all actions	August 2023 Update Standard Operating Procedure for LFERs drafted. Whilst escalation is taking place this needs formalising to ensure a consistent approach. SOP is out for consultation and will be ratified imminently. CMRs and LFERs are already monitored via the weekly reporting process. Further development of dashboard will ensure that appropriate staff have easy access to this data. Dashboard development forms part of the work plan for Business Intelligence Team, which is well underway. Staff remained of work deadlines and prioritisation. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs.
Bridgend Transfer of Informatics Services Follow Up 1.1	Apr-23	Reasonable	Consideration should be given to requesting that services fully quantify the impact of the lack of integration on the delivery of services and service change, with monitoring with reporting at an appropriate committee.	High	Bridgend disaggregation is reported to every Digital & Data Committee. This reporting will be reviewed to ensure it covers integration, service delivery and service change. The programme is currently developing a template which will assess the impact of any of the repatriation. The template is planned to be completed by June 2023.	Director of Digital	Director of Digital / Assistant Director of ICT	Qtr. 2 2023/2024	Now end of Qtr. 3 2023/2024		In progress	October 2023 Update - Further work required to complete this activity - propose to close end of Qtr. 3 2023/2024	August 2023 Update - This recommendation is on track for completion by Quarter 2 2023/2024

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National Incident Framework 5.1	Aug-23	Reasonable	Management should ensure that incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. Management should review the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce the delays. There should be an agreed mechanism in place for ongoing monitoring and reporting of the key stages within the incident life cycle.	High	A process for providing and monitoring data in relation to the timescales for reviewing, investigating and closing of incidents on a weekly basis to be established. Information in relation to Incident Management Timescales to be included as part of the Care Group dashboard development work currently being undertaken. The information will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	Director of Nursing	Head of Concerns & Business Intelligence	01.09.23	Now November 2023		In progress	October 2023 Update A baseline review of incident management is currently being undertaken. This will inform the scope and metrics to be included in the weekly reporting programme. A thematic review of incident management across the DGH sites has been completed. A 12 month programme for the development of dashboards has been developed. Incident management dashboards have been developed for ward managers providing information on the incident status for incidents within their area. Rationale for revised implementation date: From Sept to Nov 23 the plan for development will be finalised by the 01.11.23. Once the plan has been finalised, this action will be complete and the ongoing work required will continue. The information will be presented to the relevant groups from the 01.11.23.	
Performance Reporting Integrated Performance Report 2.1	Aug-23	Reasonable	The Standard Operating Procedure for preparing the performance report should be enhanced to fully set out the process for preparing the report. It should include more comprehensive information on how it is determined, which performance measures are to be reported on, how data should be checked for accuracy and completeness and a detailed monthly timetable for production that allows sufficient time for Executive review.	High	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	Director of Digital	Director of Digital	QTR 3 2023/2024			In progress	October 2023 Update - Ongoing - work incomplete	
Performance Reporting Integrated Performance Report 2.2	Aug-23	Reasonable	A review of the process for compiling the performance report should be undertaken in an attempt to move away from a manual, resource intensive approach to a more automated one, that will allow more time for interrogation and validation of the data.	High	A review of the process for compiling the report will be undertaken to ensure all opportunities have been taken to minimise manual burden.	Director of Digital	Director of Digital	QTR 3 2023/2024			Completed	October 2023 Update - Propose to close Review undertaken and improvements have been applied to the performance report. Board have agreed an iterative approach to the final report presentation, especially in light of additional measures being added from Welsh Government	
Performance Reporting Integrated Performance Report 2.3	Aug-23	Reasonable	It should be ensured that a number of staff are proficient in preparing the performance report to avoid over reliance on one individual.	High	A number of the team are already included in the preparation of the performance report. A review of the existing capacity to support the performance report will be undertaken.	Director of Digital	Director of Digital	QTR 3 2023/2024			Completed	October 2023 Update - Propose to close Current personnel involved in the report preparation has been reviewed.	
Radiology Workforce Follow Up Review 1.1	Aug-23	Reasonable	Training in relation to the Managing Attendance Policy should be re-arranged for PCH staff, in order for those staff who are responsible for absence management to fully understand the policy and apply the correct processes when managing the absence of staff.	High	06/07/2023 – Sickness Absence training in person was delivered by People's Services. 16 staff attended the bespoke training which discussed the policy, recording of dates and information as well as when to move staff through stages of sickness and navigation through the resources. 2 from PCH, 11 from RGH and 3 from POW attended. Register obtained for audit purposes. Two Superintendents at PCH has been assigned sickness management responsibility for the whole department. The full episode of sickness will be quality checked for compliance by the Senior Superintendent who covers RGH/PCH.	Chief Operating Officer	Radiology Clinical Service Group Manager	06/07/2023			Completed		
Radiology Workforce Follow Up Review 3.0	Aug-23	Reasonable	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. Staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	High	Current compliance as at 10/07/23: • POW 82.5% • RGH 60.8% • PCH 66% Significant improvement noted at PCH with increased compliance from 39%. The team have booked and planned PDRs around incremental dates. All managers have been asked to review and ensure all dates are reflected accurately on ESR. It has been noted that some staff are lacking confidence in completing the new PDR document prior to the planned PDR. Staff are encouraged to engage in the process and work through the document with their line manage during the PDR or seek support prior to the PDR.	Chief Operating Officer	Site Superintendent Radiographers Radiographer Radiology Admin Manager	Ongoing			In progress	October 2023 update - Current compliance for September 2023 71.93%. Previous compliance for August 2023 71.02%. The team continue to drive performance compliance with site plans.	

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Medical Equipment and Devices Follow Up 03	Feb-20	Reasonable	While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Medium	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required	Chief Operating Officer	Assistant Director of Facilities	Apr-20	September 2020 April 2021 July 2021 Now March 2022 Now September 2022 Now January 2023 Now July 2023 Now November 2023		Part Completed	October 2023 Update: Capital bid logged on SON system indicating costs for POW and RGH as described previously. Issues experienced with server access for Kinsetsu RF-ID data migration, ICT working on resolution to enable completion and test of data migration. ICT de-segregation work still on-going and therefore no further progress on POW access for cross site systems previously mentioned. Due to these issues, target date now for RF-ID data migration 30/11/2023	August 2023 Update - no update has been provided 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 reviewing and updating the policy.	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Chief Operating Officer	ILG Directors/ General Manager	September 2020/December 2020	01/04/2021 Now April 2022 Now December 2022 Now February 2023 Now June 2023 Now December 2023 as a consequence of management capacity and vacancies.		Part Completed	October 2023 - no further progress to report. Until the vacancies that exist as a consequence of phase 2 of the OCP are filled there will not be the management capacity to undertake this piece of work.	August 2023 Update - no update has been provided on this occasion
Sunnyside Health & Wellbeing Centre 01	Aug-21	Reasonable	Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	Medium	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Director of Finance	Head of Capital	Sep-21	Now January 2022 Now 31 March 2022 Now May 2022 Now August 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023		In progress	October 2023 Update - An addendum to the approved FBC has been prepared and is due to be submitted to Welsh Government by the 21st September. If this is approved at the October scrutiny panel then the project can be re-started and all documentation and the full meeting structure will restart, this includes steering groups, financial reporting, risk registers etc.	August 2023 Update - As per the June update, the Tender process has concluded with only one return and the tender evaluation report is expected imminently. Once received this will need to form the basis of an updated Full Business Case to be submitted to WG by September. Once this is approved, the contract can be entered into and the PEP updated for this information
Sunnyside Health & Wellbeing Centre 04	Aug-21	Reasonable	Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	Medium	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023 Now November 2023		In progress	October 2023 Update - The date has been revised from September to November as there was a delay in the receipt of the final tender and then the tender report. This means that the revised business case can not be submitted until 21st September and earliest approval is going to be mid - late October. The new contract sum as the outcome of the tender process will confirm the provisional sums and contingency values and once these are part of the Welsh Government approved funding sumen they can be reported through the project Board structure. If approval is late October it is expected that this reporting can start for the November project Board	August 2023 Update - As noted above, the tender has just closed and the report is awaited. Once received and the business case completed this level of reporting and oversight can commence.
Sunnyside Health & Wellbeing Centre 05	Aug-21	Reasonable	Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	Medium	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Director of Finance	Senior Project Manager	Jan-22	Now March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now December 2023		In progress	October 2023 Update - This is on track as long as the business case is approved by late October 2023 and will be part of the new contract expected to be let by December 23 subject to approvals.	August 2023 Update - The re-commencement of actual works is likely to not take place before the winter due to the need for an updated business case and WG approval process
Sunnyside Health & Wellbeing Centre 07	Aug-21	Reasonable	Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	Medium	These are available and will be supplied by the developer.	Director of Finance	Senior Project Manager	Sep-21	Now November 2021 Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Review July 2023 but could be later depending on timings of approvals Now November 2023		In progress	October 2023 Update - As above if funding is approved then by November the contrctor will have to supply all required documentation under the contract	August 2023 Update - Once the contract can be let then this will be made available to the HB but due to the need for a revised business case this is not expected to be until the end of the year
Sunnyside Health & Wellbeing Centre 10	Aug-21	Reasonable	Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	Medium	This will be provided when the project restarts and all design works are completed.	Director of Finance	Senior Project Manager	No Date Identified	01/03/2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023		In progress	October 2023 Update - Again on entering into contract for the completion of the health centre the new contractor will agree the form of contract variations toand the HB will implement the arrangements for sign off of varaitions outlined in the updated PEP	August 2023 Update - As mentioned above this can not be made available until the contract for the construction is let and this is agreed with the new contractor
Sunnyside Health & Wellbeing Centre 11	Aug-21	Reasonable	The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	Medium	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Director of Finance	Senior Project Manager	Mar-22	Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023		In progress	October 2023 Update - Once funding is approved and the contractor appointed these reminders will be made	August 2023 Update - As above, this will be raised with the new contractor once appointed
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	October 2023 Update - This will be updated monthly as part of the Project Board and steering group reporting on approval of the business case alongside contingency monitoring and reporting referenced above	August 2023 Update - This will be updated on submission of the revised FBC and then will be subject to monthly review and udpates therefore in conjunction with the main contractor once appointed

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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	October 2023 Update - See above point	August 2023 Update - As noted above, this can not be applied until the contractor is appointed
Sunnyside Health & Wellbeing Centre 15	Aug-21	Reasonable	The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	Medium	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Director of Finance	Project Leader	Sep-21	Now January 2022 Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023		In progress	October 2023 Update - This needs to be deferred to November as can not be implemented until the new contract is entered into. At the moment, subject to WG approval timeframes this is expected to be in late October / early November.	August 2023 Update - As above, with the need for a revised business case this wont be until later in the year once a formal appointment can take place
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	October 2023 Update - Once the business case is agreed and costs known then Shared Services can re-commence lease discussions with the GP practices and work towards production of signed lease documents.	August 2023 Update - Once the development timeline is known, and costs are understood these discussions can be refreshed with the primary care contractors and negotiations and drafting undertaken
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	October 2023 Update - This will now be led by the Primary and Community Care Group and the relevant steering group will be re-started as soon as business case approval is given.	August 2023 Update - This remains Ongoing
Sunnyside Health & Wellbeing Centre 20	Aug-21	Reasonable	Objectives at the business case should be measurable.	Medium	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023		In progress	October 2023 Update - This will be part of the Project Board agenda alongside review of the risk register	August 2023 Update - This will be refreshed for the revised FBC
Sunnyside Health & Wellbeing Centre 21	Aug-21	Reasonable	Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	Medium	Please see response above .	Director of Finance	Head of Capital	Jan-22	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now July 2023 Now September 2023		In progress	October 2023 - Please see above	August 2023 Update - As noted above, to form part of the revised FBC
CHC and FNC 1.3	Feb-22	Reasonable	1.3 The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board.	Medium	1.3 The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed.	Chief Operating Officer	Finance Manager CHC/Finance Manager Commissioning and Contracting	May-22	Now August 2022 Now October 2022 Now December 2022 Now April 2023 Now June 2023 Now December 2023 - as no response received, has now been chased specifically with Finance colleagues.		In progress	October 2023 Update Sian Lewis liaised with Finance on 03.10.23 to advise this is the only outstanding item left from our Audit. Finance will look into this and provide us with an update of a completion date.	August 2023 Update - no update has been provided on this occasion
Overtime & Additional Hours 1.1b	May-22	Reasonable	Given the time and events that have passed, a reminder should be issued to all senior managers in relation to the Overtime and Additional Hours Policy, including the authorisation process to follow if payments outside of 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		Completed	October 2023 update - The Overtime Policy was approved by People and Culture Committee on 9th August 2023 and published and distributed across CTM. This audit recommendation can now be closed.	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.

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Overtime & Additional Hours 1.2	May-22	Reasonable	Procedure documents in relation to overtime should be developed and made available to those areas that do not currently use 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		Completed	October 2023 update - The Overtime Policy was approved by People and Culture Committee on 9th August 2023 and published and distributed across CTM. This audit recommendation can now be closed.	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.
Overtime & Additional Hours 2.1	May-22	Reasonable	The value and practicality of using the overtime authorisation checklist should be reviewed. Consideration should be given to alternative approaches for capturing the justification and authorisation of overtime in advance of it being worked. For example, in some instances, it may be more efficient to have one justification checklist completed and approved per department but reviewed periodically.	Medium	The Overtime Policy review will be undertaken by the Workforce Policy Review Group (WPRG), in partnership with local trade union colleagues and key stakeholders. The revised Overtime Policy will set out the new, more practical approach for capturing the justification and authorisation of overtime in advance of it being worked in accordance with the Audit recommendation. Provision will be made within the revised Overtime Policy to address both circumstances i.e. consistent use of overtime and occasional use, ensuring that clear guidance is provided on how to manage both in Health Roster and outside of Health Roster.	Director for People	Assistant Director of Policy, Governance and Compliance	Nov-22	Now January 2023 Now March 2023 Now August 2023		Completed	October 2023 update - The Overtime Policy was approved by People and Culture Committee on 9th August 2023 and published and distributed across CTM. This audit recommendation can now be closed.	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.
Overtime & Additional Hours 2.2	May-22	Reasonable	If the approach to using the overtime authorisation and justification checklist is to be consistently used in the future, then the information being captured should be reviewed and scrutinised in order to understand the underlying reasons for use of overtime and to aid the development of plans to address those issues.	Medium	The revised Overtime Policy will outline the responsibility of the Workforce Efficiency Team to regularly review and analyse the overtime authorisation and justification checklist data to provide the UHB with intelligence on the reasons for overtime, which will assist the organisation to review and 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		Completed	October 2023 update - The Overtime Policy was approved by People and Culture Committee on 9th August 2023 and published and distributed across CTM. This audit recommendation can now be closed.	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.
Overtime & Additional Hours 3.0	May-22	Reasonable	A standardised claim form for capturing overtime and additional hours should be in place, that incorporates the requirement for individuals to confirm the hours they have worked, and for management to authorise the claim ahead of input on pay return. Claim forms also need to be clear about the need to capture time net of breaks.	Medium	A single standardised claim form, for the use in all non-health roster areas will be developed by the WPRG and contained within the Overtime Policy, for all areas of the UHB to access and use. The form will be based on the standardised NWSSP Payroll form for overtime and additional hours claims, which will contain information on the shift worked, the date, time, rate of pay and who has approved and authorised the payment. Once the Overtime Policy is reviewed and ratified all former UHB overtime forms in circulation and use will be withdrawn (removed from SharePoint etc.) and Payroll instructed to only accept and process the new standard form for payment.	Director for People	Head of Workforce Productivity and E-Systems	Nov-22	Now January 2023 Now March 2023 Now August 2023		Completed	October 2023 update - The Overtime Policy was approved by People and Culture Committee on 9th August 2023 and published and distributed across CTM. This audit recommendation can now be closed.	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.
Overtime & Additional Hours 4.0	May-22	Reasonable	Now that all Covid related agreements for payment of higher overtime rates have concluded, a review of payroll data should be carried out to identify departments that are continuing to pay staff outside of the AfC terms and conditions. Payroll codes set up specifically for such payments should be closed to prevent usage. Where it identified that payments outside AfC remain, discussions should be held with the departments to ascertain the reasons why. If necessary, the appropriate procedure should be followed to obtain authorisation in line with the scheme of delegation to continue with such payments.	Medium	Review of Payroll Overtime enhancement codes undertaken by Head of Workforce Productivity and e Systems with an NWSSP Payroll manager to ensure all non AfC payroll codes are closed immediately. The revised overtime policy will set out that all overtime and enhanced payments will be paid only in accordance with AfC. Should a department wish to deviate from these arrangements a discussion must take place with Executive Director for People.	Director for People	Head of Workforce Productivity and E-Systems Assistant Director of Policy, Governance and Compliance	July 2022 November 2022	Now January 2023 Now March 2023 Now August 2023		Completed	October 2023 update - The Overtime Policy was approved by People and Culture Committee on 9th August 2023 and published and distributed across CTM. Any payroll codes that were set up to specifically pay staff outside of the A4C terms and conditions have been closed. Payroll will not process any payments outside of A4C unless prior approval has been given by the UHB.	August 2023. - The Overtime Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.
Consultant Job Planning Follow Up 5.1	May-22	Reasonable	Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	Medium	A paper discussing the principles on which a rate card will be developed has been submitted to Director of People. Agreement of these principles will then result in the engagement of interested parties to develop the rate card.	Director for People	Director for People	Dec-22	Now April 2023 Now August 2023 Now October 2023 Now January 2024		In progress	Update October 2023 - Following approval by the Executive Leadership Group the non-consultant rate card will be launched on the 19th October 2023. Work is now underway to develop a comparable proposal regarding a Consultant Rate Card. This will require the development of a proposal, Executive approval and engagement with key stakeholders.	August 2023 - 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 August 2023 with a proposed October 2023 implementation date.

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Welsh Risk Pool Claims 1.1	Jun-22	Reasonable	Management should ensure that required documentation is submitted to the WRP within the specified timeframes and monitoring takes place to ensure compliance with this requirement.	Medium	1.1a Legal Services SOPs to be reviewed and updated. 1.1b Monitoring process to be implemented in respect of deadlines for various paperwork submissions. 1.1c Spot check audit to be undertaken bi-monthly on paperwork submissions against deadlines i.e. CMRs, LFERs etc.	Director of Nursing	Legal Services Manager	1.1a Dec 2022 1.1b June 2022 1.1c August 2022	Now February 2023 Now May 2023 Now July 2023 Now September 2023 Now December 2023		In progress	October 2023 Update Staff are aware of the importance of completing all required fields in Datix Cymru during the weekly team meeting. An audit tool is in draft form. Baseline validation exercise of open claims currently being undertaken. Spot check audit planned for the end of the year. Rationale for revised implementation date from Sept to Dec 23: Audit programme is being developed for the Legal Services function by the BI team Long term sickness of staff within the team resulted in a delay in progressing all actions	August 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. A draft checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. A SOP to support the training has been developed, further guidance regarding stages is in the process of being completed. Monthly audits will commence when guidance and training has been completed. An audit tool is being drafted. Baseline validation exercise of open claims currently being undertaken. Feedback being provided to the Claims Team Manager.
Welsh Risk Pool Claims 2.1	Jun-22	Reasonable	Procedures should be in place that provide staff with clear guidance on how to process claims, especially the dates that are to be used in relation to the 'Decision to Settle' and 'Final Payment', and the circumstances of when these dates should be updated in Datix. Guidance should also cover the other issues we identified including the correct process for capturing financial transactions in Datix and the process that should be followed if a claim is dismissed when taken to court.	Medium	2.1 Legal Services SOPs to be reviewed and updated and staff to be retrained where appropriate. 2.2 SOP to be devised to assist staff through the financial process if a claim is dismissed.	Director of Nursing	Legal Services Manager	Dec-22	Now January 2023 Now February 2023 Now May 2023 Now July 2023 Now September 2023 Now December 2023		In progress	October 2023 Update Standard Operating Procedure for LFERs drafted, consultation with staff, with changes made and out for final comment. Deep dive review being undertaken facilitated by the BI Team, to ensure that CMRs have been approrpiately triggered. Thus providing further assurance for the monitoring process. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs	August 2023 Update - Standard Operating Procedure for LFERs drafted. Whilst escalation is taking place this needs formalising to ensure a consistent approach. SOP is out for consultation and will be ratified imminently. CMRs and LFERs are already monitored via the weekly reporting process. Further development of dashboard will ensure that appropriate staff have easy access to this data. Dashboard development forms part of the work plan for Business Intelligence Team, which is well underway. Staff remined of work deadlines and prioritisation. Heads of Quality & Safety meet regularly with the Legal and Claims team to review progress against outstanding and deferred LFERs.
Financial Systems 8.2	Jun-22	Reasonable	In cases where it is appropriate, management should explore the use of alternative mechanisms for raising orders and paying invoices, for example the use of 'call off' orders.	Medium	As above, we will identify the areas where retrospective orders are raised and review alternative mechanisms for order or payment.	Director of Finance	Head of Procurement	Mar-23	01/09/2023 (aligned to AW T&F exemption list review) Now November 2023 pending AW P2P group		In progress	October 2023 update - Alternative methods of payments being reviewed as part of AW PO exemption list T&F group. First meeting held 15th September 2023. AW T&F group being led by Head of Corporate finance and Head of Procurement, good output from initial group actions being agreed virtually but no overaching Governance group as AW finance academy disbanded the group.	August 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 Now November 2023		In progress	October 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly	August 2023 Update - Refer to the update provided for 7.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local P2P group monthly
Financial Systems 8.4	Jun-22	Reasonable	Documentation to support all orders should be retained made available if required	Medium	Documentation will be made available via SharePoint.	Director of Finance	Head of Procurement	Mar-23	Now May 2023 Now June 2023 Now September 2023 Now November 2023		In progress	October 2023 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides by November 2023. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB.	August 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 Sept 2023. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB.
Medical & Dental Rostering Follow Up Review 3.1	Aug-22	Reasonable	The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff.	Medium	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	Medical Director & Director for People	Head of workforce productivity and E-Systems	Nov-22	Now February 2023 Now March 2023 Now June 2023 Now September 2023 Now December 2023		In progress	October 2023 Update - The paper went to LNC and returned with some feedback in which we are working with and amending the policy. This will be discussed at the December LNC for further review with said amendments.	July 2023 - Delays due to ensuring formatting was correct. Now scheduled for discussion at LNC meeting scheduled to take place on Tuesday 12th September 2023

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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		Completed	October 23 - Implementation plan has commenced and as highlighted in last report all therapies files are stored electronically and since the last report electronical files have been requested from IT. Approach to commence with all new staff having electronic files. As highlighted in previous reports there is a robust and agreed process around where staff paper files are held and how they can be accessed if required when line managers are not in work, which addresses the initial concern from the audit.	August 2023 Update - SOP has been signed off and an implementation plan has been developed to move files to electronic system. All therapies files are now stored electronically with the other areas being progressed in the next few months. As highlighted in the previous report, there is an agreed process around where staff paper files are held and how they can be accesses if line managers 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	October 2023 Update - Work Ongoing New Assistant Diretcor of Digital Transformation - with responsibility for the Medical Records team has now commenced in post. Core part of their role will be to take this work forward	August 2023 Update - This recommendation is on track for completion by Quarter 2 2024/2025
Radiology Service Review 2.1	Dec-22	Reasonable	a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	Medium	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancelation the members will review the agenda to assess whether there are any urgent matters that require action and re arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	Chief Operating Officer	Clinical Service Manager Clinical Lead for Quality and Governance Senior Superintendents Health and Safety Leads	30-Nov-22	Now March 2023 Now April 2023 Now August 2023 Now October 2023 Now December 2023 (as a consequence of Phase 2 and decisions to be taken).		In progress	October 2023 update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager. A management structure including the governance role has been submitted to the executive board for approval. This is not reflected in new structure in OCP document as it cannot be fully funded at present. ToR established and Vice Chair appointed.	August 2023 update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager. A management structure including the governance role has been submitted to the executive board for approval. Changes to current monthly Radiology Performance meetings discussed and new structure. Executive team to update.
Radiology Service Review 2.2	Dec-22	Reasonable	Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	Medium	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	Chief Operating Officer	Clinical Service Manager	Dec-22	Now March 2023 Now May 2023 Now August 2023 Now October 2023 Now December 2023 (as a consequence of Phase 2 and decisions to be taken).		In progress	October 2023 Update - Ongoing disccussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this workstream. A management structure including the governance role has been submitted to the executive board for review in Phase 2. This post has not been included in the OCP document as it cannot be fully funded at present.	August 2023 Update - Ongoing disccussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this workstream. A management structure including the governance role has been submitted to the executive board for review in Phase 2.
Radiology Service Review 4.1	Dec-22	Reasonable	a) Acknowledging that for 2022/23 the Standards of Behaviour Policy has been amended, and less categories of staff will be required to make a return, relevant staff within Radiology should be reminded of the relevance of the policy and the requirement to comply with it and complete an annual return. Where individuals fail to make a return, managers should continue to prompt staff to do so. b) Management should work with the Committee team to identify any gaps in the declaration of interest reporting.	Medium	a) The register of the declaration of interest information is maintained by the Corporate Service Department and submissions are registered and updated through this Department. A request for any outstanding declaration of interest will be made to the Corporate Services Department to identify those individual where these are outstanding and the relevant staff will be prompted to complete. b) A system of review will be agreed with the Corporate Services Department.	Chief Operating Officer	Corporate Services Manager/Clinical Service Manager	31st December 2022	Now October 2023		In progress	October 2023 Update - Request made for list of Radiolgy staff who would need to have signed the DOI is complete. If incomplete the Care group will encourage individuals to complete asap. Those listed have been contacted in September to complete their DoI submission. The two Radiographer staff have been actioned. The 3 M&D staff have been contacted.	August 2023 Update - Request made for list of Radiolgy staff who would need to have signed the DOI is complete. If incomplete the Care group will encourage individuals to complete asap.

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Board Awareness of Digital 1.1	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	Dec-23			Completed	October 2023 Update - Propose to close Suggestions have been made re: digital and the Board Development Programme	August 2023 Update - This recommendation is on track for completion by December 2023
Welsh Risk Pool 1.1	Jun-23	Reasonable	1.1a Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases. 1.1b Regular monitoring of the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported	Medium	1.1a Staff will be reminded of importance in next meeting in respect of closure. A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team. A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required. 1.1b In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	Director of Nursing	Head of Claims & Inquest Legal services Manager Head of Concerns & Business Intelligence	Jun-23	Now September 2023 Now December 2023		In progress	October 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. A draft checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. An SOP to support the training has been developed, further guidance regarding stages is in the process of being completed. Monthly audits will commence when guidance and training has been completed. A final audit is due by the end of the year, which should show compliance and therefore enabling this action to be closed. Rationale for revised implementation date: from Sept to Dec 23-Long term sickness of staff within the team resulted in a delay in training and therefore a delay to the commencement of the audit programme	August 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. A draft checklist has been developed outlining the current stages and requirements for closing records. This need to be tested on Datix Cymru. A SOP to support the training has been developed, further guidance regarding stages is in the process of being completed. Monthly audits will commence when guidance and training has been completed. An audit tool is being drafted. Baseline validation exercise of open claims currently being undertaken. Feedback being provided to the Claims Team Manager.
Welsh Risk Pool 2.2	Jun-23	Reasonable	Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	Medium	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	Director of Nursing	Legal services Manager Head of Concerns & Business Intelligence H	Jun-23	Now September 2023 Now December 2023		In progress	October 2023 update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. Validation of LFER is completed as part of the production of the weekly report. A cross reference of all deferred LFERs against WRP information was completed at the beginning of July 2023. Audit programme of new, closed and ongoing claims planned for December 2023. Rationale for revised implementation date:from Sept to Dec 23 Long term sickness of staff within the team resulted in a delay in training and therefore a delay to the commencement of the audit programme.	August 2023 Update Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Claims Investigation Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases. Validation of LFER is completed as part of the production of the weekly report. A cross reference of all deferred LFERs against WRP information was completed at the beginning of July 2023. Audit programme of new, closed and ongoing claims planned for September 2023.
Concerns Follow Up Review 3.1	Jun-23	Reasonable	3.1a Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes. 3.1b A training programme should be put in place to deliver the identified concerns training requirement. 3.1c A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward.	Medium	3.1a Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training 3.1b Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board 3.1c Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	Director of Nursing	Head of Concerns & Business Intelligence	3.1a August 2023 3.1b October 2023 3.1c October 2023	Now January 2024		In progress	October 2023 Update The Incident Management Framework and Concerns Policies & Procedures are currently being reviewed. To support the implementation of these documents a training strategy is being developed. Once these documents have been finalised a training needs analysis will be undertaken in conjunction with the Care Groups. A rolling 12 month training programme will be established to support the robust management and investigation of concerns. Rationale for revised implementation date: From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	August 2023 Update -A training needs analysis is currently being undertaken. The Internal Audit for Complaints and Incident Management both include recommendations for the undertaking a training needs analysis. A joint approach will be adopted to develop a training strategy for the investigation of concerns (complaints & incidents) that will identify the levels of training that are required i.e. awareness, management review, complex concern / RCA investigation training.
Concerns Follow Up Review 4.1	Jun-23	Reasonable	The information within the draft Early Resolution SOP in relation to re-classification of cases to PTR status should be reviewed to provide greater clarity on the exact timeframe and process to be followed.	Medium	Early Resolution SOP to be reviewed in line with the updated PTR Guidance, with more clarity around timeframes and process.	Director of Nursing	Concerns Manager	Jun-23	Now September 2023 Now December 2023		In progress	October 2023 Update A standard opertating procedure for the management of early resolution complaints is in place. Further review will be required following the release of the updated Putting Things Right Guidance. Rationale for revised implementation date: From Sept 23 to Dec 23 Finalisation of this action has been impacted by the review of Putting Things Right.	August 2023 Update - Standard Operating Procedure has been reviewed, with timescales and expectations outlined. Further update will be required following release of updated Putting Things Right Guidance. Awaiting updated guidance from the NHS Executive,

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PCH Programme Redevelopment 1.1	Aug-23	Reasonable	The Planning, Performance and Finance committee will receive a regular update/ assurance on the PCH Refurbishment Programme	Medium	Agreed. In line with Audit Wales recommendation regular reporting will be provided to the Planning, Performance & Finance Committee and the Board.	Director of Finance	Director of Finance/ Head of Capital	Aug-23			In progress	October 2023 - No update provided on this occasion	
PCH Programme Redevelopment 2.1	Aug-23	Reasonable	A timeline will be agreed for the reintroduction of monitoring of those community benefits suspended during the covid pandemic.	Medium	Agreed. A recent appointment within Supply Chain Partner has seen an improved engagement on community benefits.	Director of Finance	Responsible Officer PCH Programme	Aug-23	Now December 2023		In progress	October 2023 Update - Of the 9 measures temporarily suspended during the Covid period, 2 have re-commenced reporting and the remaining 7 have been instructed to recommence. The implementation date will need to change to the next reporting period as the data will take time to collate	
PCH Programme Redevelopment 2.2	Aug-23	Reasonable	A joint exercise should be undertaken with the Supply Chain Partner to agree the focus of community benefit efforts for the remainder of the programme.	Medium	Agreed. A meeting will be arranged to discuss future opportunities and focus.	Director of Finance	Responsible Officer PCH Programme	Aug-23			Completed	Oct 2023 Update - As an output of the Stakeholder Forum on the project, a matrix of events has been developed to target opportunities with community partner organisations.	
PCH Programme Redevlopment 3.1	Aug-23	Reasonable	Appropriate resource should be committed to resolving the 'open' changes as a matter of priority.	Medium	Agreed. The status of changes will be reviewed for accuracy in the first instance, and management efforts focused on resolving those longer standing changes.	Director of Finance	Responsible Officer PCH Programme	Aug-23			Completed	Oct 2023 Update - The need to minimise outstanding changes that have not been costed has been stressed to the Cost Advisor. Appropriate resource is being assigned to reducing the number and the position is reported on at each monthly Cost Report review meeting.	
PCH Programme Redevelopment 4.1	Aug-23	Reasonable	The remaining financial values and risk scores at the risk register should be reviewed for adequacy/ accuracy.	Medium	Agreed. The risk register was recently reviewed but will be reviewed with consideration of the recommendation prior to being circulation.	Director of Finance	Responsible Officer PCH Programme	Aug-23			Completed	Oct 2023 Update - The Risk Register has been reviewed and the number and rating of outstanding risks re-assessed and reduced to reflect the progress of the works.	

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Decontamination 1.0	Aug-23	Reasonable	The decontamination policy should be reviewed and updated to reflect the most up to date guidance and practices. The revision should ensure that the updated policy reflects the current decontamination monitoring arrangements, the roles and responsibilities of Decontamination Officer and the role and purpose of the Local Decontamination Groups. The policy should also reflect the impact of the Health Board's new operating model. Once revised and approved, the policy should be made available to relevant staff.	Medium	1a Update the Decontamination of Reusable Medical and Surgical Devices Policy (IPC 27). 1b Present the updated policy to the appropriate oversight committee for ratification. 1c Implementation of the updated policy to include appropriate team briefing and advisory support.	Director of Nursing	Deputy Lead IPCN/ Decontamination Lead	1a Sept 2023 1b Oct 2023 1c Nov 2023	1a October 2023 1b December 2023 to Decontamination Committee/ IPCC January 2024 1c January 2024		In progress	October update 2023- The Decontamination Policy is being reviewed and will be presented at the next Decontamination Committee meeting on the 5th December 2023 prior to going to IPC Committee in January 2024 Rationale for revised implementation date from Nov 23 to Jan 24 - Policy was not ready to be presented to last Decontmaintion committee which has delayed the approval process.	
Decontamination 2.0	Aug-23	Reasonable	A review of locally held decontamination procedures should be carried out to ensure standardised approach to the quality, content and approval.	Medium	2a Audit tools for approval in the next Decontamination Committee meeting (see action 5.1). 2b Audit programme to be carried out across all appropriate areas within CTM to inform local SOP status and revisions where required (see action 5.2). 2c All local SOPs are to have been reviewed and ratified for ongoing implementation.	Director of Nursing	Deputy Lead IPCN/ Decontamination lead	2a Sept 2023 2b July 2024 2c September 2024			In progress	October 2023 Update 04/10/23 - The Endoscopy, sterile service department and theatre audit tools were agreed in the Decontamination meeting on the 21/09/23. The audit programme has commenced. A SOP template for decontamination will be developed and presented at the Decontamination Committee meeting in December 2023 for ciruclation and use.	
Decontamination 3.0	Aug-23	Reasonable	Arrangements be put in place to ensure that there is a dedicated Microbiologist (Decontamination) in place for Princess of Wales site as soon as practically possible.	Medium	3a Escalation to the Deputy Medical Director and escalated to the last IP&C Committee meeting (11/07/23). 3b Multi-stakeholder meeting to discuss the current arrangements with active service level agreements, Public Health Wales and CTM to inform the programme of work required to reach an appropriate substantive outcome. 3c Outcome report and appropriate plan from stakeholder engagement to be presented to IPC Committee meeting.	Director of Nursing	3a Lead IPC Nurse Deputy Medical 3b Director and Deputy 3c Director of Nursing Deputy Medical Director	3a July 2023 3b September 2023 3c October 2023	3b October 2023 3c January 2024		In progress	October update 04/10/2023 - There is no dedicated Consultant Microbiologist for Decomntamintion at the Princess of Wales Hospital. This is a requirement for SSD accreditation and will be raised at IPC committee on the 17/10/23. Rationale for revised implementation date - Multi stakeholder meeting to take place in October 2023, outcome report to follow	
Decontamination 5.0	Aug-23	Reasonable	A schedule/programme of independent decontamination audits be implemented to evaluate and assess the decontamination facilities/arrangements across the Health Board. The outcome of these audits be summarised into a report for presentation to the Decontamination Committee so that appropriate actions can be taken.	Medium	5a Decontamination audit tools are currently being developed. Three audit tools will be taken to the next Decontamination Committee meeting for approval. Decontamination audit programme to commence. 5b Audit program to review decontamination facilities/arrangements across the Health Board to inform all appropriate future governance.	Director of Nursing	Deputy Lead IPCN/Decontamination Officer	5a Sept 2023 5b June 2024			In progress	October Update 4/10/23 - 3 audit tools agreed in September 2023 as planned	
National Incident Reporting Framework 1.1	Aug-23	Reasonable	Management should ensure all out of date guidance documents are removed from the intranet and only relevant policies and procedures are made available.	Medium	All policies and procedures relating to Incident & Concerns Management will be uploaded to SharePoint and previous versions removed.	Director of Nursing	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	01.10.23	Now January 2024		In progress	October 2023 update Following approval of the Concerns Policies & Procedures, Incident Reporting Policy and Incident Management Framework a review of all SharePoint sections relating to Concerns, Datix, Quality & Safety will be reviewed and updated. Rationale for revised implementation date: From Oct 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	

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National Incident Framework 1.2	Aug-23	Reasonable	The Incident Management framework should be reviewed and updated where necessary to take account of the Health Boards new operating model, the recently published updated guidance and incorporate information on reporting processes.	Medium	The Health Board's Incident Management Framework to be reviewed in line with the recommendation, duty of Candour requirements and agreed proposal to remove reference to the Locally Reportable Incident Proforma.	Director of Nursing	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	01.10.23	Now January 2024		In progress	October 2023 update A task and finish group has been established to review the Incident Management Framework. The first meeting took place on 14.08.23. A further meeting has been arranged for 18.09.23. Cross reference to the Incident Reporting policy, Concerns Policy & Procedures and NHS Executive Policy is included as part of the review. Rationale for revised implementation date: From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	
National Incident Framework 2.1	Aug-23	Reasonable	The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend incident management training and RCA training. As part of the process of identifying staff training needs, consideration should be given to if refresher training on Datix is required.	Medium	A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements. Following approval of the Strategy, a training need analysis will be undertaken and a training Programme established.	Director of Nursing	Clinical Lead for Serious Incidents Head of Concerns & Business Intelligence	01.11.23	Now January 2024		In progress	October 2023 Update The Internal Audit for Complaints and Incident Management both include recommendations for the undertaking of a training needs analysis. A joint approach will be adopted to develop a training strategy for the investigation of concerns (complaints & incidents) that will identify the levels of training that are required i.e. awareness, management review, complex concern / RCA investigation training. Rationale for revised implementation date: From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	
National Incident Framework 2.2	Aug-23	Reasonable	In the meantime, it should be ensured that at least one member of the investigation team on cases is RCA trained.	Medium	Ensure that a member of the Investigation Team has received the appropriate RCA Training. Remind Care Group Leads of the requirement to include one appropriately RCA trained member in the Investigation Team. Undertake checks during the Quality Assurance Process to confirm the requirement has been fulfilled. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	Director of Nursing	Clinical Lead for Serious Incidents	01.09.23	Now January 2024		In progress	October 2023 update All incidents reported are subject to a quality assurance process via the Care Group structure and this forms part of the questions raised at the Quality Assurance panels. Oversight of this is undertaken by the Quality & Safety / Patient Safety Team. These arrangements will be outlined in the Incident Management Framework. Rationale for revised implementation date:From Dec 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	
National Incident Framework 3.1	Aug-23	Reasonable	Management should ensure all documentation in relation to NRIs is appropriately completed with relevant documentation saved to Datix. This includes: • Evidence of rapid review meetings taking place or confirmation that one was not required. • NRI forms capturing the proposed investigation timeline which will allow future monitoring and reporting to take place. • The quality assurance checklist recording all relevant information such as who the RCA training investigators are, as opposed to just ticking that someone is RCA trained. • All relevant fields within Datix completed as required. • Copies of the RCA report saved to Datix. • A consistent approach to the saving of panel minutes to Datix, giving consideration to if a panel reviews more than one case, the data protection implications of saving the full set of minutes to individual Datix records.	Medium	Reminder to be sent to all Care Groups of the need to ensure that all documentation has been uploaded to Datix Cymru. Datix Cymru Incident Management Training to include the requirement to upload all documentation to Datix Cymru. The quality assurance process will include a check that ensures all required documentation has been uploaded. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible Care Group.	Director of Nursing	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	01.09.23	Now January 2024		In progress	October 2023 Update An email was sent out to all Care Groups Leads by the Executive Director of Nursing, Midwifery and Peoples Service on 05.07.23. A follow up email was sent on the 05.08.23. The quality assurance checklist is currently being reviewed and updated as part of the review of the incident management framework. Rationale for revised implementation date: Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	
National Incident Framework 4.1	Aug-23	Reasonable	Further work should be carried out to explore the option of accessing the action plan module in Datix, thus allowing the NRI to be closed in Datix more timely following completion of the investigation, yet still allowing the monitoring of the implementation of actions. Whilst this option is explored, it should be ensured that the action plans saved to Datix are adequately completed with evidence of actions taken to date and if necessary, a process for following up on actions following submission of the paperwork to the NHS Wales Executive (formerly the DU.)	Medium	Ensure that all required staff have access to the actions module and appropriate training is provided. This will be linked to the implementation of the revised Incident Management Framework. The quality assurance process will include an assessment to confirm that an action plan has been developed and upload to Datix Cymru. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	Director of Nursing	Head of Concerns & Business Intelligence	01.10.23	Now December 2023		In progress	October 2023 Update A programme for robust implementation of the actions module is currently being developed. A meeting took place on the 19.09.23 to support the implementation of the actions module within Mental Health. This work will then be progressed across the care groups. Mechanisms and templates for Extrapolation of action plans for monitoring and reporting are being developed. Rationale for revised implementation date: From Oct to Dec 23 This action has commenced but requires further time to roll out and embed across the organisation.	

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Performance Reporting Integrated Performance Report 1.1	Aug-23	Reasonable	The draft performance management framework should be reviewed to ensure: • There is alignment to the most up to date Welsh Government Performance Framework, ensuring all metrics and measures outlined are accurate and there is link the IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made available to relevant staff.	Medium	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Director of Digital	Executive Director of Strategy & Transformation / Director of Digital	QTR 4 2023 / 2024			In progress	October 2023 Update - Work Ongoing - no progress to date	
Performance Reporting Integrated Performance Report 3.1	Aug-23	Reasonable	It should be ensured that current versions and future iterations of the Integrated Performance Report include all relevant WG metrics that the Health Board is required to report on, as set out in the WG Performance Delivery framework.	Medium	Review the presentation of the Integrated Performance Report, recognising the dynamic nature of the report and the need to respond to metrics and ministerial priorities. The report will continue to provide all metrics whether as an appendices' or in the main body of the report.	Director of Digital	Director of Digital	QTR 3 2023 / 2024			Completed	October 2023 Update - Propose to Close New format and layout presented to the Board in September 2023. Further iterations will be made over the next 12 months, responding to comments from Board members	
Performance Reporting - Integrated Performance Report 3.2	Aug-23	Reasonable	3.2a. We acknowledge that work has already commenced to review the format of the Integrated Performance Report. As part of that review process, the views of stakeholders should be sought, and consideration given to alternative reporting formats such as an interactive dashboard in order to make the report more user friendly. 3.2b. Consideration should be given to: • Cross referencing the performance being reported on to either the relevant Health Board strategic aim and/or the relevant WG quadruple aim. It should be clear to the reader why the metrics reported on are included. • Including clear information pertaining to the most high-risk areas to ensure these are discussed and acted on appropriately and in good time.	Medium	3.2a. Review presentation and layout of the report as appropriate to the requirements of the Board. 3.2b. As 3.2a	Director of Digital	Director of Digital	QTR 3 2023 / 2024			Completed	October 2023 Update - Propose to Close New format and layout presented to the Board in September 2023. Further iterations will be made over the next 12 months, responding to comments from Board members	
Performance Reporting Integrated Performance Report 3.3	Aug-23	Reasonable	The reporting arrangements for the component parts of the Performance Report should be reviewed to ensure all aspects are being reported on and respective committees are aware of their responsibilities in relation to reporting. Consideration needs to be given as to how an integrated / Health Board wide view of performance will be achieved if performance monitoring is going to be undertaken in constituent parts.	Medium	As part of the performance report review, consideration will be taken for all component parts.	Director of Digital	Director of Digital	QTR 3 2023 / 2024			Completed	October 2023 Update - Propose to close High Level review undertaken and snapshot page includes a fully integrated picture. Finance will continue to report separately for the time being given the nature of the financial climate for the Health Board and NHS Wales	
Radiology Workforce Follow Up Review 1.2	Aug-23	Reasonable	The draft electronic staff folders SOP should be completed and finalising as soon as possible and rolled out across all sites to ensure consistency in approach.	Medium	Now rolled out across all sites. SOP finalised 06/07/23.	Chief Operating Officer	Radiology Clinical Service Group Manager	Jul-23			Completed		

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Radiology Workforce Follow Up Review 2.1	Aug-23	Reasonable	a) A review should be undertaken on the approach to how TOIL is managed across the service to ensure they are in line the Health Board Overtime Policy and that there some level of consistency across site (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 also be given to the number of hours staff are able to accrue as TOIL. This needs to be applied across all sites and reflected on the TOIL form (where used) so that everyone is aware of the agreed process.	Medium	SOP developed on management of TOIL for the Radiology department. Clarity has now been provided to all Superintendents. TOIL is currently managed via the Health Roster and paper format in Bridgend until the team are transferred on to the Health Roster.	Chief Operating Officer	Site Superintendent Radiographers	Jul-23			Completed		
Radiology Workforce Follow Up Review 2.2	Aug-23	Reasonable	Management at PCH need to liaise with the Service Improvements Systems Administrator within Workforce Development to ensure that the roles within Health Roster are set up correctly to allow for additional hours to be properly captured.	Medium	Contact made with Roster team on 08/06/23. Issues with accruals addressed as some staff members contracted hours were not accurately reflected.	Chief Operating Officer	Site Superintendent Radiographer	Jun-23			Completed		
Radiology Workforce Follow Up Review 4.1	Aug-23	Reasonable	Management at RGH should continue to liaise with the Learning and Development team to ensure the suggested amendments to learning profiles are implemented on ESR. It should be determined if similar exercises to refine learning requirements are required for staff at the PCH and POW sites.	Medium	Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development.	Chief Operating Officer	Superintendent Radiographer Quality and Governance	Sep-23	Now December 2023		In progress	October 2023 Update - Contact made with People's Services and L&D. The workforce team has been assigned to create new ESR positions for roles where there are differing requirements. Awaiting a further update from L&D. People's Services have also sent a chaser email.	
Radiology Workforce Follow Up Review 4.2	Aug-23	Reasonable	The CSG should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	Medium	Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	Chief Operating Officer	Radiology Clinical Service Group Manager	Ongoing	Now December 2023 (date not includesd in the last update)		In progress	October 2023 Update - Current compliance September 2023 64.13%. Increased compliance since August 2023 - from 64.04%. Teams are driving compliance in all areas. BILS training booked for Consultants on 09/10/23. Monthly reports sent out to all superintendents. Plans being developed to run in house training for Resuscitation and Manual Handling.	
Health & Safety Management 06	Aug-20	Reasonable	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Director for People	Head of Health, Safety & Fire	01/01/2021 Now 31 May 2022	01/07/2021 Trial Audit on Social Distancing completed August 2021. New completion date for audit package to be suitable for H&S Audits 31/01/2022 Now May 2022 Now September 2022 Now February 2023 Now June 2023 Now December 2023		Part Completed	October 2023 Update - The Health and Safety Team have fully explored the use of AMaT to undertake these type of audits. The AMaT package is unable to manage these audits so the Team are currently undertaking 2 further audits using a package called iPassport (used within Pathology services). Once the 2 audits have been completed an evaluation of the system capabilities will be undertaken.	August 2023 Update - Due to staff absence it has not been possible to obtain an update for this submission
Sunnyside Health & Wellbeing Centre 09	Aug-21	Reasonable	Performance of relevant parties should be monitored appropriately	Low	As above although there will be a delay with the appointment of a new contractor.	Director of Finance	Senior Project Manager	Sep-21	Now January 2022 for Contractor only Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023		In progress	October 2023 Update - Date delayed to expected date of appointment of new contractor when this can be put in place. Reasons for delay have been covered above	August 2023 Update - This remains ongoing

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Sunnyside Health & Wellbeing Centre 17	Aug-21	Reasonable	Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	Low	The Health Board already has in places processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Director of Finance	Senior Project Manager	Nov-21	Now 31 March 2022 Now July 2022 Now December 2022 Now March 2023 Now September 2023 Now November 2023		In progress	October 2023 Update - Variations have been mentioned above and the process will be confirmed to all partes on updated the PEP and recommencement of the project post approvals, timescales have been adjusted slightly in line with this	August 2023 Update - This remains ongoing
CSG & ILG Quality Assurance 2.0	Aug-22	Reasonable	Quality governance training should be provided to all relevant staff in the ILGs and their constituent CSGs to ensure a sound understanding of quality assurance principles and practices	Low	The Health Board launched a new Patient Safety Incident Management Framework and Toolkit in June 2022. This describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. In July 2022, the Health Board also launched a rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience. The training also introduces the important concepts of psychological safety, human factor errors and safety thinking. Attendance is recorded on the Health Board's Electronic Record System, which ensures that those undertaking incident investigations are appropriately, and consistently trained to improve standards and performance. Bespoke Datix training has been rolled out by the Datix Management Team following the adoption of the Once for Wales incident module, and is ongoing. The corporate team have initiated good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. Training sessions are supported by the Health Board's Communication channels, Intranet SharePoint system where further information and assistance for colleagues is signposted by the Patient Care and Safety site. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework.	Director of Nursing	Assistant Director Quality & Safety	The nature of this action is ongoing; however, the new structure will provide an opportunity to target CSGs. Quality & Patient Safety Framework December 2022	Now January 2023 Now June 2023 Now October 2023 Now January 2024		In progress	October 2023 Updated The Internal Audit for Complaints and Incident Management both include recommendations for undertaking a training needs analysis. A joint approach will be adopted to develop a training strategy for the investigation of concerns (complaints & incidents) that will identify the levels of training that are required i.e. awareness, management review, complex concern / RCA investigation training. Rationale for revised implementation date: Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	August 2023 Update - Following updated guidance from the NHS executive and the implementation of Duty Of Candour, a review of the incident Management Framework is being undertaken. The Framework will outline the requirements for management of incidents and all related externally reportable incidents. The Framework will link to the training strategy and needs analysis currently being undertaken. It will also outline the Datix Cymru actions required. It is antipated the revised framework will be implemented from 01.10.23
Concerns Follow Up Review 1.1	Jun-23	Reasonable	1.1a The concerns SOP should be revisited ahead of approval to ensure all sections are populated and reference is made to other relevant SOPs / supplementary documents. Consideration should be given to re-naming the SOP and removing the reference to 'written' concerns only. 1.1b The revised Concerns Policy and Standard Operating Procedures should be formally approved and made available to staff. The concerns pages on the CTM internet site should also be updated with the revised policy and the previous version removed.	Low	1.1a The Concerns SOP will be reviewed in line with the recommendation above and will be renamed and written concerns will be explained. 1.1b The various SOPs/policy will be made available on SharePoint for all staff to access once approval has been received in Quality & Safety Committee in July 2023.	Director of Nursing	Head of Concerns & Business Intelligence	1.1a May 2023 1.1b August 2023	Now September 2023 Now December 2023		In progress	October 2023 update Approval of the Concerns Policy & Procedure has been deferred to December due to the impending release of the updated PTR guidance and the review of the incident management Framework following revised National Incident Guidance from the NHS Executive. The Health Board's Concerns Share Point pages are being reviewed to ensure they are up to update and accurate information is available to support staff involved in the management of concerns. Rationale for revised implementation date: From Sept to Dec 23 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	August 2023 Update - A review of the Concerns Policies and Procedures has been undertaken, along with all underpinning Standard Operating Procedures. These have been strengthened to support robust triage and escalation where comments remain outstanding. The Concerns Policy & Procedure was scheduled to be approved at the July Quality & Safety Committee, this has been deferred to September due to the impending release of updated PTR guidance and the review of the incident management Framework following revised National Incident Guidance from the NHS Executive. The Health Board's Concerns Share Point pages are being reviewed to ensure they are to update and accurate information is available to support staff involved in the management of concerns.
Concerns Follow Up Review 9.0	Jun-23	Reasonable	Once the Assistant Director of Quality & Safety has commenced in post, the terms of reference for the Shared Listening and Learning Forum should be reviewed and formally agreed for use.	Low	Listening and Learning Forum TOR to be reviewed.	Director of Nursing	Assistant Director of Quality & Safety	Jun-23	Now October 2023		In progress	October 2023 Update Review of governance arrangements with regards to the Shared Listening & Learning Forum is ongoing by the Deputy Director of Nursing who is reviewing the ToR of this forum together with the Assistant Director of Quality & Safety. This work aligns to the outcome of OCP.	August 2023 Update - The Shared Listening & Learning Forum including its terms of reference is currently under review in light of the operating model changes and to ensure we have an increase in Clinical Engagement from across the health board at each of the quarterly forums
Decontamination 4.0	Aug-23	Reasonable	The Terms of Reference for the Local Decontamination Groups should be reviewed and revised (where applicable) and presented to the Decontamination Committee for overall approval.	Low	4a Update the terms of reference for the local decontamination meetings in CTM. 4b Updated and agreed terms of reference to be presented to the Decontamination Committee for discussion and ratification. 4c Present reviewed and agreed local decontamination terms of reference to IPC Committee for noting.	Director of Nursing	Deputy Lead IPCN/ Decontamination lead	4a August 2023 4b Sept 2023 4c October 2023	4b December 2023 4c January 2024		In progress	October 2023 Update - Terms of reference have been developed and will be presented at the next Decontamination Committee meeting for approval Rationale for revised implementation date - The terms of reference were not updated in time to be presented at the last Decontamination committee which has delayed them being presented at IPCC	
National Incident Reporting Framework 5.2	Aug-23	Reasonable	In order to allowing monitoring and ensure compliance with the 72-hour timeline placed in changing the new incident to 'make safe', the make safe date should be captured within Datix.	Low	An audit programme of new, open and closed incidents to be implemented to ensure that all required fields are completed in the required timescales. Feedback from the audits will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	Director of Nursing	Head of Concerns & Business Intelligence	01.10.23	Now December 2023		In progress	October 2023 update A data validation checklist is being developed to inform all users of the data requirements, which will be included in the Incident Management Framework. Once this has been disseminated, weekly audits will commence. Rationale for revised implementation date: From Oct to Dec 23 Completion of the Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.	
Radiology Workforce Follow Up Review 5.0	Aug-23	Reasonable	Work should continue to resolve the issues raised with the five Consultant job plans within PoW.	Low	Current compliance POW: • 7 signed off • 1 awaiting 1st sign off • 1 expired but booked – date arranged for 20/09	Chief Operating Officer	Radiology Clinical Service Group Manager, Consultant Radiologist	End September 2023	Now December 2023 (date not includesd in the last update)		In progress	October 2023 Update - POW 6 signed off, 1 in first sign off, 1 in second sign off. 1 Awaiting a second JP meeting due to a flexible working application.	
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	Now October 2023		Completed	October 2023 Update - COMPLETED - Internal Audit colleagues have confirmed that the recent changes made to the BAF including those relating to mitigating actions has further strengthened the report and addresses the recommendation.	August 2023 Update - Due to capacity within the Team this element of the BAF review has been delayed as focus has been targeted towards risk scoring rationale and risk treatment options. Request an extension to the end of October 2023.

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

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Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Audit of Accounts Addendum 2020/2021 02	Aug-21	The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	CTM Focussed Review	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	Director for People		Immediate	Now August 2022 Now October 2022 Now December 2022 Now March 2023 Now August 2023 Now December 2023		In Progress	October 2023 update - It has been confirmed a partnership group is being established under the Welsh Partnership Forum Business Committee to develop an All Wales Pensions Policy. The timescale for the policy to be developed is autumn 2023. The work on the CTM Pension Policy has been halted on the request of the NHS Confederation, however our draft policy has been shared with the WPF Business Committee to inform the All Wales policy. The implementation date has been amended to December 2023, but this date will be dictated by the WPF.	August 2023. - The new NHS Pension Scheme Benefit Flexibilities Policy is being presented to the People and Culture Committee on the 9th August 2023 for approval for implementation across the Health Board. After which this audit recommendation will be closed down.
Audit Wales/HIW Quality Governance Follow Up Review R2.3	Aug-21	The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically; a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board c- The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework	CTM Focussed Review	The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows: • Strengthened focus on quality on strategic planning; • Individuals' voices are better heard; • Shared learning and continuous quality improvement; • Risk better articulated, shared and mitigated; • Strengthened two-way 'point of service delivery' to Board sight; and • Extensive review and improvement of the management of concerns and serious incidents. Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's . The revised framework will provide improved granular detail in respect of ILG governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSG/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded.	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022 Now May 2023 Now June 2023 Now October 2023		Part Completed	October 2023 update: OCP consultation completes 29/09/2023 at 17:00. Timeline agreed and aiming for structural implementation by December 2023. Alignment arrangements will be commenced from closure of OCP consultation and confirmation of agreed modelling by 13/10/2023.	August 2023 Update - awaiting outcome of phase 2 of the Operating model. The OCP process will be completed within the next 8 weeks-this will allow for substantive aligning of the actions detailed in the framework to be aligned accordingly.
Audit Wales/HIW Quality Governance Follow Up Review R6.1	Aug-21	There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	CTM Focussed Review	Health Board purchased CIVICA (captures population feedback using a patient insight software platform)	Director of Nursing		Jul-21	Now December 2021 Now July 2022 Now March 2023 Now December 2023 Now December 2024 when Civica contract ends		In Progress	October 2023 update- Due to recruitment freeze band2 and band 3 roles have been delayed despite funding being approved as part of 23/24 financial HB investment from the unavoidable cost pressure investment fund. Job roles are being taken to the exception review panel W/c 2/10/23. Delays being seen with inputting of patient feedback due to resource issues. National survey has gone live for Covid-19 investigation, ED to be automated approx. November 2023 but paper copies and survey live within CTM. Palliative care survey being phased in, due to resource issues in service area- Advanced supportive care in heart failure to go live w/c 2/10/23 and the remainder of CTM palliative care to follow approx. end of Oct23. Roadshow's scheduled across 3x acute sites and comms plan being developed. Strategy and scoping exercise currently being undertaken. The Q&SC were presented with the CIVICA 2021/22 Patient Feedback themes and trends for assurance	August 2023 Update - The funding agreement process for CIVICA has been concluded. The workforce and implementation plan is now being actioned. An analysis of the CIVICA Patient Experience feedback 2022/23 has been completed and will be presented to Q&SC in September 23
Audit Wales/HIW Quality Governance Follow Up ReviewR8.6	Aug-21	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	CTM Focussed Review	Quality Governance Framework to reflect enhanced governance processes	Director of Nursing		Dec-21	01/03/2022 Now June 2022 Now December 2022 Now January 2023 Now May 2023 Now June 2023 Now October 2023		Part Completed	October 2023 update: OCP consultation completes 29/09/2023 at 17:00. Timeline agreed and aiming for structural implementation by December 2023. Alignment arrangements will be commenced from closure of OCP consultation and confirmation of agreed modelling by 13/10/2023.	August 2023 Update - Quality & Safety agenda shared amongst the clinical care group directors, awaiting outcome of phase 2 of the Operating model the OCP process will be completed within next 8 weeks-this will allow for substantive aligning of actions detailed in the framework to be aligned accordingly
Audit Wales/HIW Quality Governance Follow Up Review R7.7b		There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	CTM Focussed Review	Undertake audit of compliance against Royal College of Anaesthesia (RCOA) Standards (ACSA process) identify and develop standards to meet with RCOA recommended GPICS (set standards by RCOA for Anaesthetic services) baseline and inform continuous improvement programmes and improve compliance against the standards.	Medical Director		Jul-24			In progress	October 2023 Update - This work will be picked up further following the completion of 'Phase 2', once the new Clinical Director for Anaesthetics has been recruited. This individual will take up the ACSA lead role.	August 2023 Update - No further progress has been made since the update provided in June 2023

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Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Equality Impact Assessments R4	Nov-22	Reviewing public bodies' current approach for conducting EIAs: While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	National Review	CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSED. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	Director for People	EDI Practitioner	Mar-23	Now May 2023 Now July 2023 Now October 2023 Now January 2024		In Progress	October 2023 update - The EDI Lead has met with Strategy & Transformation to look at the implementation of EIA within the IMPT. The EDI lead has also met with Quality to discuss the alignment of EIA process with QIA process to reduce duplication; another meeting is due to take place with the lead on this. There is also close links to the current organisational review of the development of Policies which will be in two phases. There is a commitment to embed the EIA in future policy development; as well as current policies and procedures. The EIA process sits within our Strategic Equality Plan (SEP) which the ED&I Lead will take to People & Culture Committee for sign off on 8th November 2023. Within the SEP; we are also including an educational offer around the application of the EIAs as a diagnostic has identified that there is a gap in understanding the use of the EIA and this has led to numerous queries as an outcome to the OD&I (Organisational Development & Inclusion) Team. As well as CTM's internal review, the All Wales Equality Leadership Group (which our ED&I Lead is a member of) have decided to collectively review all EIA processes for all Health Boards across Wales so that there is an alignment with each other and best practice is utilised. This review will be carried prior to PHW review of an All Wales digital approach, as it is understood this may take some time. Deadline for completion of the all wales Review and an EIA process being agreed is End of Q3 (December); with an educational offering starting with CTM in Q4.	August 2023 - New ED&I Lead started in post and is undertaking a final review of the EQIA process, including guidelines and monitoring, as it has to sit within the Operational Plan following the Strategic Equality Plan consultation which ended 14th July. There is a need to pause and review if it is fit for purpose. This will land within the next 4 to 8 weeks. This will also link in with the current organisational review of the development of Policies being undertaken by the Corporate Governance and Risk Dept. Public Health Wales are currently undertaking an All Wales review of the EQIA procedure together with developing an All Wales digital approach. The ED&I Lead is a member of the All Wales Equality Leaders Group, which will feed in to this review and will update as it moves along.
Transformational Leadership Programme Board – Baseline Governance Review R1	Dec-22	Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: a) taking a longer-term approach to its planning beyond five years, b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.	CTM Focussed Review	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners	Director of Strategy & Transformation	Head of Regional Collaborative Unit	31 March 2023	Now 31 March 2024		In Progress	October 2023 Update - A model focussing on two pathways Urgent and emergency care and population health management have been agreed that aligns the efforts of 6 Goals of UEC, ACD and RIF. Regional work streams have been aligned to new national specifications and identified 'transformation resource' (RIF) to support local leadership, facilitate change and disseminate learning. By aligning programmes and core resources will support longer terms sustainability.	August 2023 Update - The Health and Social Care Regional Integration Fund (the RIF) is a 5-year fund to deliver a programme of change from April 2022 to March 2027. The RIF builds on the learning and progress made under the previous Integrated Care Fund (ICF) and Transformation Fund (TF) and seeks to create sustainable system change through the integration of health and social care services. Key features and values of the Fund include; • A strong focus on prevention and early intervention • Developing and embedding national models of integrated care • Actively sharing learning across Wales through communities of practice • Sustainable long-term resourcing to embed and mainstream new models of care • Creation of long-term pooled fund arrangements • Consistent investment in regional planning and partnership infrastructure The RIF is a key lever to drive change and transformation across the health and social are system and in doing so will directly support implementation of several key pieces of policy and legislation over the longer term.
Transformational Leadership Programme Board – Baseline Governance Review	Dec-22	Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated	CTM Focussed Review	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	October 2023 Update - There remains uncertainty over any additional resource to implement further faster (noting AHP funding being received) and recognition that there exists an ever-increasing financial challenge the need to accelerate the rebalancing of the health and care system, ensuring that existing resources are utilised most effectively and strive towards the Further Faster ambitions remains. Effective transformation of our existing model of care including engagement, understanding resistance to change, create a learning environment that studies each change and is flexible to respond to new knowledge and data is needed	August 2023 Update - Further Faster will establish a comprehensive community care model ensuring a full range of preventative and early intervention services are available locally. This will involve new delivery structures, moving the workforce and creating new roles so that, for example, community first responder services, more therapy and reablement workers, enhanced domiciliary care roles, community nursing and allied health professionals are the priorities for service and workforce development. Building on successful models service specifications will be developed nationally upon which to benchmark and model regional delivery. Risk registers are maintained centrally and reported to Leadership Board.
Transformational Leadership Programme Board – Baseline Governance Review R5	Dec-22	Regional Commissioning Unit Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team.	CTM Focussed Review	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Director of Strategy & Transformation	Head of RCU	31 December 2022	Now December 2023		In Progress	October 2023 Update - Director for Integration post appointed, expected to commence in role mid-November. Capital planning officer started within regional team at the beginning of October. NEST Co-ordinator / Children and young people lead to be appointed and 3x Capital development roles expected to be in post before end of December (Funded through Integrated Care Capital Resource for 2 year fixed term. Further opportunity to create capacity to support Integration Director being explored.	August 2023 Update - Additional Infrastructure for Capital had been agreed regionally and scope for further programme management linked to IRCF funding to support business case development and Community hub infrastructure. Partnership Leadership Team tasked with developing robust model for community services within which Programme management requirements to be identified. To deliver the integration agenda at pace a Director for Integration post has been agreed at Chief Executive level between the health board and Local Authorities. RCTCBC have agreed to host the post on a two-year fixed term. The grading for the post will need to reflect the expectation of the role. In addition to the Director role consideration has been given to existing infrastructure that can be realigned to support as well as top slicing additional infrastructure and wider RIF resource. External Consultant short term capacity has also been considered however determined that local knowledge of existing service configuration is critical.
Transformational Leadership Programme Board – Baseline Governance Review	Dec-22	Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core	CTM Focussed Review	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	October 2023 Update - No further update. Awaiting further guidance from WG following Consultation response.	August 2023 Update - Welsh Government officials are currently working to review Part 2 and Part 9 Codes of Practice (Social Services and Wellbeing Act 2014) which will further strengthen partnership arrangement and collaborative service delivery (Consultation planned Autumn 2023). As part of the amendments to codes of practice the duty to co-operate will be established as lying equally on Local Authorities and Health Boards and the role of the RPB as a key vehicle through which that duty should be exercised. Furthermore within chapter 5, pooled funds positioned more clearly within joint commissioning context and greater flexibility given in relation to pooling resources at Regional, sub-regional pan cluster, cluster and individual levels.
Transformational Leadership Programme Board – Baseline Governance Review R7	Dec-22	Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities	CTM Focussed Review	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health	Director of Strategy & Transformation	Chair TLPB	31 March 2023	Now 31 March 2024		In Progress	October 2023 Update - Staffing challenges have been experienced in the delivery of community services however issues are now being compounded by recruitment freezes and blanket stops on recruitment by the health board affected integrated community teams. This is considerably impacting the functioning of community services and the overall 'flow' of patients in an already very pressurised health and social care system in advance of the winter period. Within Bridgend there are currently 11 RIF vacancies in service. Posts have been added to TRAC over the last 3 months but unfortunately have not been authorised, this is adversely impacting on service delivery. Directors across CTM partnership are committed to maintaining community capacity through RIF funding. A letter has been drafted to support this position.	August 2023 Update - One of the four quadruple aims outlined in the document, 'A Healthier Wales: Our Plan for Health and Social Care', is to have a motivated and sustainable health and social care workforce that delivers a truly seamless system of health and care, and calls for a fundamental shift in our understanding of who constitutes the workforce, and how we support the contribution that each individual makes. Requiring not only 'greater parity of esteem' between health and social care professionals, but also recognising and supporting the vital role played by the informal workforce of unpaid carers and of volunteers. To support new models of care, health and social care services must strengthen the support, training, development and services available to the workforce, with a focus on building skills across a whole career and supporting their health and wellbeing. New seamless models of health and care that emerge, require a clear and coherent approach to developing and planning the whole workforce. To meet this need, WG commissioned Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) to develop a long-term workforce strategy, in partnership with NHS and Local Government, the voluntary and independent sectors, as well as regulators, professional bodies, and education providers. The workforce strategy aims to address the Parliamentary Review's call for joint regional workforce planning. The workforce strategy also identifies dynamic leadership will be needed to instigate change, empower others and lead by example, as well as create conditions for continuous innovation and improvement, to drive up the quality and value of services
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	October 2023 Update - A communication and engagement group has been set up to provide coordination for all activities relating to SBUHB SLAs. This will enhance existing processes, enabling proactive engagement with Llais regarding service changes.	August 2023 Update - An update has not been provided against this recommendation 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			Completed	October 2023 Update - There are commissioning meetings with each Care Group to capture any commissioned service risks. These may be highlighted for inclusion on the corporate risk register if appropriate.	August 2023 Update - An update has not been provided against this recommendation 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 - Complete b) 31st August 2023 31.10.2023 - Part 2 of action. c) 30th June 2023 31.10.2023 d) 30th June 2023- Complete	Now 31 October 2023 for completion of Action B		In Progress	October 2023 Update A) Complete. B) Further work is required in terms of Advisory Groups and this will be explored and may require further support to leads in this area. It is anticipated that the pace of change for the Advisory Groups may take longer than originally assessed and a revised implementation date of 31.10.2023 is proposed. c) Complete. Cover reports updated and relaunched. d) Complete.	August 2023 Update A) Complete. Public agendas now include a section indicating the topics discussed at closed sessions where appropriate. B) Agenda bundles for all Board and Board Committees are published in a timely manner on the Website. Further work is required in terms of Advisory Groups and this will be explored and may require further support to leads in this area. It is anticipated that the pace of change for the Advisory Groups may take longer than originally assessed and a revised implementation date of 31.10.2023 is proposed. c) An extension to this action is required as the team would wish to incorporate the activity around the Duty of Quality in its review of cover papers and this is being explored with other Health Boards for consistency. d) Complete. Presentation cover sheets continue to be quality assured to ensure key risks and issues are considered. Communication and Engagement colleagues are reviewing the Presentation template and this will therefore be revisited again at this point.

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Structured Assessment 2022 R3	Apr-23	**Strengthening performance management arrangements** The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.	CTM Focussed Review	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable the Board to align measures to strategic priorities etc., the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.	Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)		30th September 2023 The workshop with Board Members is scheduled for Quarter 1 – 2023-2024.	Now December 2023		In Progress	October 2023 Update - First adaptation of the performance report was presented at Sept board	August 2023 Update - An update has not been provided against this recommendation 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.	Director of Strategy & Transformation		30th June 2023 Now September 2023	Now December 2023		Part Completed	October 2023 Update - This work is ongoing and we are also exploring measures of social value to be utilised in community and partnership arena	August 2023 Update - This work has been completed for the Living Well Strategy Group and the Ageing Well/Dying Well Strategy Group. The work is still in progress for the Starting Well and Growing Well Strategy Groups.
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.	Director of Strategy & Transformation		30th June 2023			Completed	October 2023 Update a) Recommendation understood and is an ongoing action. The recommended action will be included in all appropriate documents moving forward. Action complete b) Action complete c) Recommendation understood and is an ongoing action. The ability to complete this action will be supported by the launch of the revised integrated performance management framework in September 2023. Action complete	August 2023 Update - No further update for this month
Structured Assessment 2022 R9	Apr-23	**Maximising the benefits of digital technologies and solutions** There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it indents to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	CTM Focussed Review	The themes identified in the existing Digital Strategy continue to be aligned to the NHS Wales Digital Strategy and are embedded and will continue to evolve with the CTM2030 strategy in relation to digital activity. The Health Board has performed an analysis and identified a minimum set of resources (staff and capital/revenue) required over the next 3 years. Aligned to this work, during 2022 the Health Board completed a functional map of services required from a Digital and Data perspective. The next stage in the process is to align staffing resources to the functions, which will be achieved by following organisational change process. For significant Digital and Data changes (i.e. projects/programmes) the Health Board has developed a process of creating business cases to support service transformation. These business cases indicate the resources (staffing & Infrastructure) required to implement service change and ensure ongoing provision of support services to sustain change. The Health Board is committed to adopting all National Digital developments, where appropriate, and has invested heavily in the deployment of these products across the Health Board. The current strategy is to continue to operate in this manner and ensure it maximises resources efficiently and effectively.	Director of Digital		31st December 2023 (Qtr. 3) Qtr. 1 – Business Case for Patient Centred Contact. Qtr. 2 – Business Case for e-prescribing. Ongoing as National Digital Developments are released.			In Progress	October 2023 Update - We have completed the initial recruitment with colleagues starting during September and October. However given the current recruitment constraints we are unable to recruit further at this point in time	August 2023 Update - An update has not been provided against this recommendation on this occasion
Review of Orthopaedic Services R3	Jun-23	The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	National Review	The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place: • Ensure that prehab services are improved by setting up a Prehabilitation Service to ensure patients are medically optimised for surgery. Both digital and face to face options to be considered. • The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board • Increase the capture of PREMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures –timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement • Updated GIRFT action plan to be created with new CD and monitored through the reconfiguration programme. • Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved.	Chief Operating Officer	COO / Planned Care Director/ Clinical Restart Manager/DTS Director/USC Care Director/ Planned Care Medical Director	Various Dates from between May 2023 - April 2024			In Progress	October 2023 Update - Work continues in this area as part of the Planned Care Programme and other projects. In particular, the Prehabilitation Service has just been launched and monitoring of the GIRFT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.	August 2023 Update - An update has not been provided against this recommendation on this occasion
Review of Orthopaedic Services R4	Jun-23	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	National Review	The Health Board will undertake the following in order to ensure the recommendations are achieved: • The fragility of a small CMATS team was recognised within physiotherapy. Since the merger with Bridgend the UHB has invested training and development into the band 7 clinical specialist team in order to increase the number of staff working at the advanced practice level, to meet the demand across CTM. • In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialties, Nurse led, Consultant led and AHPs • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Chief Operating Officer		No target date for completion identified			In Progress	October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting.	August 2023 Update - An update has not been provided against this recommendation on this occasion

CTM Internal [date]

Red -
Orange -
Yellow -
Green -
Blue - Action

Ref	Date added	Recommendation	CTM Focussed Review/ National Review	Management Action Agreed	Responsible Executive Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates During this period/latest update	Update provided for Previous meeting
Review of Orthopaedic Services R5	Jun-23	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	National Review	The Health Board will undertake the following in order to ensure the recommendations are achieved: • Within POWH, PREMS and PROMs data is currently being captured electronically for all arthroplasty patients and utilising the MyMobility applications AI system, patients with anticipated poorer outcomes are having enhanced Therapies input digitally. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Within POWH, all Arthroplasty patients are enrolled on the MyMobility application to provide prehab for all patients awaiting surgery to try and minimise the harm caused by delays and ensure patients are medically optimised. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Single Clinical Director Leadership required to establish performance structure and review of current services. • Weekly performance reviews that monitor waiting list volumes and actions being taken to address and recover the position • Action plan development with singe CD for performance and governance structure across CTMUHB	Chief Operating Officer	COO / Planned Care Director/Medical Group Director/ Clinical Director	From April 2023 to April 2024			In progress	October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting.	August 2023 Update - An update has not been provided against this recommendation on this occasion

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
5.2.1

Audit & Risk Committee

CONSULTANT JOB PLANNING

Dyddiad y Cyfarfod / Date of Meeting	24/10/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr Nerys Conway Assistant Medical Director for Medical Workforce
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

BMA	British Medical Association
CAVUHB	Cardiff and the Vale University Heath Board
CTM	Cwm Taf Morgannwg
DCC	Direct Clinical Care
ILG	Integrated Locality Group
LNC	Local Negotiating Committee
NWSSP	NHS Wales Shared Services
PTHB	Powys Teaching Health Board
SAS	Specialty & Associate Specialist
SPA	Supporting Professional Activities
UHB	University Health Board

1. Situation /Background

The purpose of this paper is to provide the Audit & Risk Committee with an update on the progress around job planning.

2. Specific Matters for Consideration

2.1 Job plan completion and sign-off

- Job planning is a contractual requirement that needs to be completed and signed off by Consultant and SAS Doctors.
- Signed-off job plans currently stand at 50% for consultants and 46% for SAS doctors.
- The 50% target set for April 2023 was reached.
- The Care Group Medical Directors have a responsibility to allocate and ensure that the job planning process is being completed appropriately within their Care Group. The Care Groups are in the process of appointing Clinical Directors who will be instrumental in ensuring that job planning is completed.
- There is a new SPA document guide for Consultants and one in its final stages for SAS Doctors.
- An automatic job plan sign off reminder is now sent to colleagues who have completed but not signed off their job plans. Further joint correspondence is due to be sent collaboratively between BMA and the Medical Directors team regarding compliance of job planning.
- A job plan checklist and proforma has been prepared by the AMD for Medical Workforce to ensure equity and parity with the job planning process. This has been sent to LNC for comments and a meeting has been arranged to address these.

2.2 Weekly number of sessions, activities and outcomes

- Development of a SPA policy document was required to standardise the approach across the UHB for SPA and DCC split, to ensure fairness and equity. This document has been distributed to Consultants within CTM and a draft SAS version is in its final stages with our LNC.

2.3 Clear personal outcomes within the job plan

- As part of the job planning training, clear personal outcomes will be factored into the process and are now recorded in new job plans. The training that has been rolled out across the UHB has covered this area. The job plans have clear outcomes regarding the site where the activity is to be undertaken, the type and duration of activity, and clarity around whether the activity constitutes a DCC or a SPA.
- However, further work is needed to quantify the specific amount of the clinical activity that is expected from the specified duration of the DCC.
- The new SPA document deals with ways of seeking objective evidence of the activity undertaken as an SPA.

2.4 Job Planning Quality Assurance Group

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

2.5 Additional Duty Hours (ADH)

- Executive colleagues have agreed with a Rate Card for Non-Consultant CTM staff. This is due to be presented on 5th October 2023 and go live across CTM on 19th October 2023.
- The Non-Consultant Rate Card mirrors that of ABUHB to ensure there is consistency across South East Wales.
- A consultant rate card requires further work and analysis. Of note CAVUHB have just released a Consultant Rate Card to their medical workforce.

3. Key Risks / Matters for Escalation

3.1 None.

4. Assessment

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

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

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

5. Recommendation

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

6. Next Steps

6.1 Meet with LNC to approve further job planning materials.

6.2 Launch rate card across CTM.

Archwilio Cymru
Audit Wales

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

Date issued: October 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

About this document

1 This document provides the Audit and Risk Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Certification
2022-23 Charity Account.	Executive Director of Finance	The statutory audit of the Health Board's Charitable Funds Account.	We issued the Audit Plan on 18 September 2023 and are scheduled to commence the audit in November.	By 31 January 2024

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Joint Review Follow up (Local work 2022)	Chief Executive	This work will examine the Health Board's progress in implementing the recommendations made in the Joint Review Report from 2019.	Completed	October 2023
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We	Report drafting	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		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.		
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

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Structured Assessment 2023 – Core	Executive Director of Corporate Governance	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 Structured Assessment work will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Fieldwork	December 2023
Structured Assessment 2023 – Deep Dive	Executive Director of Finance	We had previously indicated an intention to undertake deeper dive work to examine digital arrangements. However, given the significantly challenging financial position across NHS Wales, we are now looking at replacing the work on digital with focused work examining the approaches NHS bodies are taking in respect of achieving	Planning	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		cost improvements, efficiencies, and financial sustainability.		
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from our 2022 review. The specific focus of this work is to be confirmed.	Scoping	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
NHS Workforce Data Briefing	**September 2023**
NHS Wales Finances Data Tool - Up to March 2023	**September 2023**
Approaches to achieving net zero across the UK	**September 2023**

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

8 There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Welsh Language Report 2022-23	October 2023
Biodiversity and Resilience of Ecosystems Plan	July 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.

Archwilio Cymru
Audit Wales

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Cwm Taf Morgannwg University Health Board - Quality Governance Arrangements Joint Review Follow-up

August 2023

The Auditor General has prepared this report under section 61 of the Public Audit (Wales) Act 2004, and in accordance with section 145 of the Government of Wales Act 1998. The work has been undertaken jointly with Healthcare Inspectorate Wales.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. HIW inspects services, and regulates independent healthcare providers against a range of standards, policies, guidance, and regulations to highlight areas requiring improvement.

Contents

Introduction and background

1 Cwm Taf Morgannwg University Health Board (the Health Board) provides primary, community, and hospital services to the populations of Merthyr Tydfil, Rhondda Cynon Taf, and Bridgend.

2 In November 2019, we undertook a joint review of the quality governance and risk management arrangements at the Health Board[1]. This work followed a report by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives which identified serious concerns and service failings with maternity and neonatal services. The Royal Colleges' report threw into sharp focus the concerns we had previously articulated about the Health Board's quality governance and risk management arrangements.

3 As a result of the Royal Colleges' report, in April 2019 the Health Board's maternity and neonatal services were placed into 'special measures' and the organisation was escalated to the status of 'targeted intervention' within the NHS Wales escalation and intervention framework[2]. An Independent Maternity Services Oversight Panel (IMSOP) was also established by Welsh Government to provide challenge and support to the Health Board as it sought to improve these services.

1 A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board (2019)

2 The NHS Escalation and Intervention Arrangements

4 Our 2019 joint review identified a number of fundamental weaknesses in the Health Board's governance arrangements in respect of quality of care and patient safety. We made 14 recommendations in total to support improvements in the following areas:

- strategic focus on quality, patient safety and risk;
- leadership of quality and patient safety;
- organisational scrutiny of quality and patient safety;
- directorate arrangements for quality and patient safety;
- risk management arrangements;
- management of concerns; and
- organisational culture and learning.

The Health Board fully accepted the findings and began to respond to the report's recommendations.

5 In May 2021, we jointly undertook a follow-up review[3] which concluded that the Health Board had made good progress in addressing the recommendations made in 2019, particularly when taking account of the challenges it faced in response to the COVID-19 pandemic. We also noted the considerable commitment, drive, and enthusiasm from the Health Board, and a clear desire to get things right. However, despite the progress made, we felt that work was still required in each area where recommendations were made. As a result, we agreed that each of the 14 recommendations would remain open.

3 An overview of quality governance arrangements at Cwm Taf Morgannwg University Health Board: A summary of progress made against recommendations (2021)

6 Since our last review, there have been several developments and changes:

- In November 2022, the Minister for Health and Social Services announced the decision to de-escalate maternity and neonatal services from 'special measures' to 'targeted intervention' based on IMSOP's assessment of the Health Board's progress in delivering the required improvements. IMSOP was stood down by the Minister at the end of 2022.
- In March 2023, the Minister for Health and Social Services announced the appointment of a new Chair, whose term began in April 2023[4].
- The Health Board has stabilised its senior leadership team by appointing a permanent Executive Director of Therapies and Health Sciences; Executive Director of Strategy and Transformation; and Chief Operating Officer. The Health Board has also created two new Deputy Chief Operating Officer roles - one for acute services and one for primary, community, and mental health services.
- In March 2022, the Board approved the creation of a new operating model with the aim of supporting post-pandemic recovery; improving service quality; streamlining management arrangements; and facilitating joint working across the Health Board. Phase 1 of implementing the new operating model involved replacing the Integrated Locality Group (ILG) structure with new Health Board wide Care Groups[5]. Phase 1 was completed in November 2022. Phase 2, which was underway at the time of our work, involves establishing and implementing the Clinical Service Group layer of the Health Board. The Health Board is aiming to complete Phase 2 by September 2023.

7 Given the nature of the concerns identified by our joint review in 2019, our assessment of the Health Board's position against the recommendations in May 2021, and the changes outlined above, we decided to undertake a further follow-up review, which commenced in March 2023.

8 We present the findings of our follow-up review in this report, along with our assessment of the Health Board's position against the 14 recommendations we made in our 2019 report. The approach we adopted to deliver our work is detailed in **Appendix 1**.

4 https://www.gov.wales/new-chair-appointed-cwm-taf-morgannwg-university-health-board

5 There are six care groups in total: Planned Care Group; Unscheduled Care Group; Children and Families Care Group; Diagnostics, Therapies and Specialities Care Group; Mental Health and Learning Disabilities Care Group; and Primary and Community Care Group.

Key findings

9 The Health Board has made significant progress in addressing the substantial concerns and recommendations set out in our 2019 report.

10 As part of our work, we reviewed the Health Board's arrangements for overseeing the implementation of our 2019 recommendations and the delivery of the required improvements to maternity and neonatal services. We found that the Health Board's arrangements were effective and transparent. Senior Executives and Independent Members have been fully involved, providing a good balance of support, scrutiny, and challenge. The Health Board has also ensured that staff and other stakeholders have appropriately been informed of progress on an ongoing basis.

11 The Health Board has a stronger strategic focus on quality and patient safety compared to 2019. The Health Board's new three-year Quality Strategy clearly articulates the organisation's quality vision, mission, pledge, ambitions, and goals. It also sets out clearly the Health Board's approach to quality, as well as what success will look like. The strategy, together with the new three-year Quality and Patient Safety Framework, provides a good foundation to support the delivery of the new Duty of Quality[6] and Duty of Candour[7], which came into effect in April 2023. At the time of our work, the Health Board was developing an Annual Quality Work Plan to set out the quality objectives to support delivery of the strategy. Whilst this is a positive development, finalising the plan at pace must remain a priority for the Health Board to ensure corporate and operational teams fully understand their role in delivering the quality ambitions and goals of the organisation. The Health Board also needs to put robust arrangements in place to monitor the delivery of the plan and strategy to ensure they are improving quality outcomes as intended.

6 The Duty of Quality in Healthcare

7 The NHS Duty of Candour

12 There is greater clarity on roles, responsibilities, accountability, and governance in relation to quality and patient safety compared to 2019. At an executive-level, the Executive Director of Nursing, Midwifery, and Patient Care; Executive Medical Director; Executive Director of Therapies and Health Sciences; and interim Executive Director of Public Health share responsibility for quality and patient safety. This is a significant improvement compared to 2019, when responsibility for quality and patient safety rested solely with the Executive Director of Nursing, Midwifery, and Patient Care. The Health Board has also significantly increased capacity to support its quality and patient safety arrangements, with several new roles established at both a corporate and operational level. At an operational level, the quality and patient safety governance model of the new Care Groups is clearly set out in the three-year Quality and Patient Safety Framework. The Health Board was making positive progress in embedding the new governance model at the time of our work. However, further work is required, particularly around embedding the Clinical Director roles to ensure full collective responsibility for quality and safety at an operational level.

13 The organisational scrutiny of quality and patient safety has improved considerably, with greater openness and transparency evident in comparison to 2019. The Health Board's Quality and Safety Committee is operating effectively. The quality of the papers prepared for the committee has improved, and we observed Independent Members providing a good balance of support, scrutiny, and challenge. Independent Members told us that they feel more supported to undertake their roles and have good access to learning and development opportunities. There is also greater scrutiny of the Health Board's Clinical Audit Programme. The Health Board has also established new arrangements to oversee, scrutinise, and escalate quality and patient safety matters at an operational level. This includes establishing new groups, such as the Operational Management Board and Improving Care Board. Whilst this is a positive development and a clear improvement on the situation in 2019, the Health Board still has more to do to ensure the arrangements are fully embedded and operating effectively as intended across the new Care Group structure.

14 The Health Board has significantly improved its risk management arrangements since 2019. There is greater awareness of risk management across the organisation, and clearer processes in place for identifying, managing, and escalating risks. The Health Board has an approved Board Assurance Framework (BAF), which is operating well. The BAF, which is actively reviewed at each public Board meeting, clearly identifies the strategic / principal risks to the delivery of the Health Board's strategic goals and provides good information on gaps in controls and assurance, as well as mitigating actions. The BAF is underpinned by a comprehensive risk management strategy and a suite of risk management policies and procedures, which have been updated to reflect the new operating model. The organisational (corporate) risk register has also been strengthened, and there is good evidence of corporate risks being actively reviewed and managed. DATIX is well embedded across the Health Board, with improved oversight and governance arrangements in place. Operational risks have been transferred from the previous operating model (ILG) risk registers to the risk registers of the new Care Group, and the Operational Management Board is beginning to provide good oversight of risks across the new structure. However, opportunities remain to strengthen the content of Care Group risk registers, particularly around the identification of mitigating actions.

15 The Health Board has improved its approach to the management of concerns and complaints since 2019. The concerns and complaints process is clear, and new corporate roles have been created to support implementation and ensure consistency. Whilst training is provided, the Health Board needs to do more to ensure that all relevant clinical and managerial staff are fully involved in the process of proactively identifying and addressing operational quality and patient safety issues. There is also an improved culture of learning within the Health Board, with a range of arrangements now in place to support the identification and sharing of learning and improvement. The new structures and groups established under the new operating model also appear to be creating better opportunities for sharing learning and improvement at an operational level. However, the Health Board is still dealing with a significant concerns legacy as it has failed to submit a number of Learning From Events Reports (LFERs) within the mandatory timescales. The Health Board needs to address the situation as a matter of urgency, and improve its processes to ensure LFERs are submitted on a timelier basis in future.

16 The Health Board has also taken a number of steps to improve the culture of the organisation since 2019. The Health Board has a clear Values and Behaviours Framework in place, which appears to be well embedded across the organisation. There are good examples of the values and behaviours being used to shape recruitment, performance, and organisational development processes. Staff report that the Health Board's culture is much improved, and they also feel that senior leaders are more visible and accessible. However, responses to our staff survey indicate that there are still pockets of poor behaviour within operational teams that need to be addressed, particularly in relation to bullying and harassment.

17 There is early evidence of the new operating model supporting further improvements in organisational culture. The staff we spoke to were positive about the changes. In their view, the new operating model should reduce silo working and strengthen the "one CTM" ethos. However, there is still work to be done to fully integrate the Princess of Wales hospital into the organisation's operational arrangements following the change to the Health Board's geographical footprint in 2019. Whilst this is disappointing, we feel reasonably assured that the new Care Group operating model should ensure the hospital becomes fully integrated. Staff did raise concerns about the delays and lack of communication around the implementation of Phase 2 of the operating model. The Health Board should seek to address these concerns as a matter of urgency to avoid creating any further uncertainty to staff.

18 As in 2019 and 2021, we conducted a survey to capture a snapshot of staff views at the time of our work[8]. Whilst not representative of all staff opinions across the organisation, the responses provide helpful insights into the areas we were reviewing. They key messages from the survey are summarised below:

- The majority of respondents felt that they are providing a safe and effective service to patients. However, they felt there are not enough staff to support the delivery of safe and effective care. They also felt that insufficient staffing levels was having a negative impact on staff well-being and morale. This was a common theme from the 2019 survey results.
- Around a half of respondents felt that communication between senior managers and staff was not effective. Again, this was a common theme from the 2019 survey results.

8 The survey was conducted with staff working within surgery, theatres, and emergency departments across the Prince Charles, Royal Glamorgan, and Princess of Wales hospitals. We received a total of 121 responses in 2019, 54 responses in 2021, and 40 responses in 2023.

- Respondents were generally positive about the nature of teamwork within their department, as well as their ability to speak up and take action when poor care is identified. However, around a third of respondents said they had personally experienced bullying, harassment, or abuse at work from a manager or a colleague; and almost half of respondents felt that the organisation does not take effective action if staff are bullied, harassed, or abused by other staff members. Again, this was a common theme from the 2019 survey results.
- Almost all respondents felt that staff are encouraged to report errors, near misses, or incidents. Furthermore, almost all respondents felt that learning from errors, near misses, and incidents is shared with staff. This is a significant improvement on the 2019 survey results.
- The majority of respondents were positive about participating in formal learning and development opportunities, and the majority had also received an appraisal or performance and development review of their work in the last 12 months. This was a slight improvement on the 2019 survey results.

Whilst the results show improvements in a number of areas since 2019, they also highlight the need for the Health Board to continue making further improvements in relation to ensuring safe staffing levels and tackling bullying, harassment, and abuse in the workplace.

19 Our assessment of the Health Board's progress against the 2019 recommendations is summarised in **Exhibit 1**. We set out our findings against each recommendation in more detail in the next section of the report.

Exhibit 1: status of our 2019 recommendations

Implemented	Partially Implemented	Superseded	**Total**
9	4	1	**14**

20 Overall, this is a positive achievement and a clear demonstration of the Health Board's commitment, drive, and desire to address our concerns in full and put things right. Nevertheless, the Health Board still needs to take further action to fully embed its revised quality governance arrangements across the organisation and implement all remaining recommendations in full. Specifically, the Health Board needs to:

- Address the concerns of staff about the delays and lack of communication around the implementation of Phase 2 of implementing the new operating model to avoid creating any further uncertainty.
- Finalise the Annual Quality Work Plan to ensure full operational roll-out and ownership of the strategy, and establish robust arrangements to monitor delivery of the plan and Quality Strategy to ensure they are improving quality outcomes as intended.
- Establish clear performance monitoring and management arrangements within the new Care Group structure.
- Fully embed the Clinical Director roles as part of Phase 2 of implementing the new operating model to ensure full collective responsibility for quality and safety at an operational level.
- Ensure all new operational quality and patient safety groups have clear terms of reference, and provide sufficient administrative support to ensure they operate effectively as intended.
- Make better use of real-time patient feedback to make immediate changes and improvements to the overall patient experience, where appropriate.
- Ensure that patient experience features more prominently in routine performance and quality reports to the Board and relevant committees.
- Ensure clinical audits are appropriately staffed and supported to target areas of concern, and to complete revalidation to assess whether improvements have been made.
- Continue to improve the content of Care Group risk registers, particularly around the identification of mitigating actions.

- Ensure all relevant practitioners, including those within community healthcare teams, have access to DATIX to report and manage incidents in line with the Health Board's process.
- Fully integrate the Princess of Wales hospital into the organisation's operational arrangements.
- Continue to challenge and address behaviour that is inconsistent with the organisation's Values and Behaviours Framework.
- Tackle the LFERs backlog, and put improved processes in place to ensure LFERs are completed and submitted on a timelier basis in future.

It will also be necessary for the Board to continue overseeing the effectiveness of the Health Board's revised quality governance arrangements to ensure they consistently support the delivery of safe and high-quality healthcare and positive patient outcomes. Based on the findings set out in this report, we do not feel it is necessary to schedule any further detailed follow up work. Where we have identified the need for continued action, we will maintain oversight of the Health Board's progress in these areas through our respective routine work programmes.

Detailed findings

21 We set out our detailed findings of the Health Board's progress against each recommendation below. We also indicate which recommendations the Health Board has implemented, partially implemented, or which recommendation has been superseded.

Recommendations to improve the strategic focus on quality, patient safety, and risk

Recommendation 1	The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety. This should be reflected within an updated version of the Health Board's Quality Strategy.
Findings	**The Health Board has developed and adopted a new three-year Quality Strategy, which clearly articulates the organisation's quality priorities.** The Board approved a new three-year Quality Strategy for the Health Board in March 2023. The strategy, which is aligned to the Institute for Healthcare Improvement's six domains of quality[9], clearly articulates the organisation's quality vision, mission, pledge, ambitions, and goals. The strategy outlines the Health Board's approach to quality, as well as what success will look like. The strategy, together with the Quality and Patient Safety Framework, provides a good foundation to support the delivery of the new Duty of Quality and Duty of Candour, which came into effect in April 2023. At the time of our work, the Health Board was developing an Annual Quality Work Plan to set out quality objectives to support the delivery of its quality ambitions and goals. We reviewed early drafts of the plan during our work and, in our view, the actions the Health Board were developing were clear, concise, and measurable. Finalising the plan at pace must remain a priority for the Health Board to ensure full operational roll-out and ownership of the strategy. Furthermore, the Health Board also needs to establish robust arrangements to monitor delivery of the plan and strategy to ensure they are improving quality outcomes as intended.
Status	Implemented

9 Improving Health and Health Care Worldwide | IHI - Institute for Healthcare Improvement

Recommendation 2 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 Board Assurance Framework (BAF) reflects the objectives set out in the current Integrated Medium-Term Plan (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.

d. Terms of reference for the relevant committees, including the Audit Committee, QSRC[10] and CBM[11], reflect the latest governance arrangements cited.

Findings

The Health Board has made significant improvements to its strategic and operational risk management arrangements, which are operating well.

The Health Board has an approved Board Assurance Framework (BAF), which is operating well. In March 2022, the Health Board approved and introduced a new BAF. This is a significant improvement on the 2019 position, where the BAF was out of date, not aligned to the Health Board's risk management strategy, and did not reflect the priorities of the Health Board's IMTP. The BAF is now an integral part of the Health Board's system of internal control, and clearly defines the strategic / principal risks which could impact upon delivery of the organisation's four strategic goals[12]. It provides good information on gaps in controls and assurance, as well as mitigating actions. The Board actively reviews the BAF at each public meeting. At the time of our work, the BAF clearly referenced the strategic / principal risks to achieving the Health Board's quality ambitions and goals, and had good links to the organisation's revised quality governance arrangements.

10 In December 2019, the Quality, Safety, and Risk Committee (QSRC) became the Quality and Safety Committee, and the Audit Committee became the Audit and Risk Committee.

11 Clinical Business Meetings (CBM) were stood down following the introduction of the new operating model.

12 The Health Board's four strategic goals are: Creating Health, Improving Care, Inspiring People, and Sustaining our Future.

Findings

The Health Board's risk management strategy and associated policies and procedures are comprehensive, up-to-date, and reflect the new operating model. In January 2021, the Health Board updated its risk management strategy and associated policies and procedures. These documents are comprehensive and have been kept under constant review and updated to reflect relevant changes within the Health Board. In May 2022, the Board approved a revised risk management policy, risk appetite statement, and risk scoring matrix. In May 2023, the Health Board made further changes to the risk management strategy, risk management statement, and the risk domain and scoring matrix to reflect the organisation's new operating model. We discuss the Health Board's risk management arrangements in more detail in a later section (see **Recommendation 10**).

The Health Board has revised its Quality and Patient Safety Framework to support the national Quality and Patient Safety Framework, its own Quality Strategy, and the new operating model. In January 2023, the Board approved a revised Quality and Patient Safety Framework. The three-year framework reflects the requirements of the national Quality and Patient Safety Framework, and the Health and Social Care (Quality and Engagement) Act 2020 which introduced a strengthened Duty of Quality and Duty of Candour for the NHS In Wales in April 2023. The framework is comprehensive and fulfils the requirement to have a Quality Management System to ensure that care meets the six domains of quality as identified by the Institute for Healthcare Improvement. The framework also reflects the Health Board's new operating model and links clearly to the values of the organisation.

Findings	**Terms of Reference for the relevant committees are up-to-date and reflect the latest governance arrangements.** The Health Board has updated the Terms of Reference of all relevant committees to reflect the latest governance arrangements and new operating model. The Corporate Governance Team undertakes an annual review of Board and committee Terms of Reference as part the Health Board's wider review of Board effectiveness. Any changes made to the Terms of Reference are reported to the Board for approval. The Clinical Business Meeting model no longer exists following the introduction of the new operating model. However, further work remains to be done to ensure there are clear performance monitoring and management arrangements within the new Care Group structure (see **Recommendation 9**).
Status	Implemented

Recommendations to improve leadership of quality and patient safety

Recommendation 3	Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: a. Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety. b. Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates. c. Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.

Findings

The Health Board has significantly strengthened and clarified roles, responsibilities, and resources in relation to quality and patient safety across the executive team and new Care Group structure.

There is clear collective responsibility for quality and patient safety across the executive team. However, further work is required to ensure full collective responsibility for quality and patient safety at an operational level. In addition to the professional leadership roles for their respective disciplines, the Executive Medical Director; Executive Director of Nursing, Midwifery, and Patient Care; Executive Director of Therapies and Health Sciences; and interim Executive Director of Public Health[13] all have specific responsibilities for quality and patient safety at an executive-level. The Executive Director of Nursing, Midwifery and Patient Care continues to act as the Executive Lead for quality and patient safety. Whilst the Health Board has strengthened the role and responsibilities of Clinical Directors, these arrangements have not yet been fully embedded at an operational level. The Health Board is aware of this and plans to fully embed the Clinical Director roles as part of the next phase of implementing the new operating model. This should lead to greater collective responsibility for quality and safety at an operational level.

The Quality and Patient Safety Framework provides clarity on roles, responsibilities, accountability, and governance in relation to quality and patient safety. In January 2023, the Board approved a new three-year Quality and Patient Safety Framework, which functions as its Quality Management System. The framework is aligned to the Health Board's organisational strategy and wider governance arrangements and reflects national guidance. The framework provides clarity on corporate and operational roles and responsibilities, and clearly sets out the corporate (Board-level) assurance process, as well as the Care Group quality and patient safety governance model. Under the model, each Care Group is required to have a Quality and Safety Forum. Each forum reports to the Health Board-wide Operational Services Management Board which, in turn, provides assurance to the Board via the Quality and Safety Committee. We discuss the effectiveness of these arrangements in a later section (see **Recommendation 4**).

13 At the time of our work, the Executive Director of Public Health role was vacant and interim arrangements were in place.

Findings

The Health Board has significantly increased capacity to support quality and patient safety, at both a corporate and operational level. The Health Board has taken a number of positive steps to increase capacity to support quality and patient safety at all levels of the organisation. Corporately, the Executive Director of Nursing, Midwifery and Patient Care is supported by a Deputy Director of Nursing, an Assistant Director of Concerns and Claims, an Assistant Director of Nursing and Patient Experience, an Assistant Director of Governance and Risk, and an Assistant Director of Quality and Safety. There are also three Heads of Quality, three Senior Lead Nurse roles, and five Patient Safety Improvement Manager roles which are aligned to the new Care Groups. The Health Board has also centralised its operational Quality Governance Teams. These teams support the Care Groups to manage:

- patient safety incidents;
- investigations
- complaints, compliments and putting things right regulations work;
- patient experience;
- mortality and harm reviews;
- patient safety solutions;
- external action plan reviews; and
- quality improvement and faculty advocates.

This is a positive development, which should strengthen resilience and ensure greater consistency in the way these matters are overseen and managed across the Health Board. The central DATIX function has also been transferred to the Corporate Quality Governance Team. We discuss the transfer further in a later section (see **Recommendation 11**).

Status

Partially implemented

Recommendations to improve organisational scrutiny of quality and patient safety

Recommendation 4 The roles and function of the QSRC need to be reviewed to ensure that it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following:

a. Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively.

b. Improvements to the content, analysis, clarity, and transparency of information presented to QSRC.

c. Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications, and training.

Findings

The Quality and Safety Committee's role is clear and fit for purpose, and it is operating effectively.

The Health Board's plans for implementing subgroups to support the Quality and Safety Committee were stood down in 2020. The Health Board decided in 2020 not to implement the planned subgroups to support the Quality, Safety and Risk Committee. As a result, this aspect of the recommendation has been superseded.

Findings	**The Health Board has continued to refine and improve reporting to the Quality and Safety Committee.** In 2021, we reported positively on the information presented by the Integrated Locality Groups (ILGs) to the committee. The Health Board has recently revisited these arrangements to reflect the new operating model. Now, the new Care Groups provide assurance to the committee via a template report. The template aims to ensure that information is presented in a consistent format in a way that meets the needs of the committee. However, as the arrangements were very much in their infancy at the time of our work, we found that the level of detail provided by the Care Groups in their respective reports varied. The Health Board recognises this and intends to work with each Care Group to agree the correct level of detail for future reports. Our observations of committee meetings found that Independent Members provide a good balance of support, scrutiny, and challenge. We also observed good openness and transparency on a range of quality and patient safety matters. We found that the committee makes appropriate use of Patient Stories, with the Health Board clearly demonstrating how it has learnt from issues or concerns. **The Quality and Patient Safety Framework clearly articulates the governance arrangements, and work to embed these arrangements within the Care Groups is progressing well.** As noted previously, the new Quality and Patient Safety Framework provides clarity on the arrangements within the Health Board to maintain oversight of quality and patient safety at all levels of the organisation. Several new groups have been established under the framework, such as the Operational Services Management Board and Improving Care Board. However, not all groups have clear terms of reference in place yet (e.g., the Improving Care Board). Whilst these groups were at various stages of maturity at the time of work, they were well attended by operational and executive staff. However, we found that their effectiveness was potentially being hampered by an inconsistent approach to their administration. In particular, we found examples of some papers being submitted late or submitted in the incorrect format. The Health Board will need to address these administrative issues to ensure the groups operate effectively as intended.
Status	Partially implemented

Recommendation 5	Independent Members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.
Findings	**Independent Members are appropriately supported to meet their responsibilities.** The Health Board has taken a number of positive steps to improve its induction and development programmes for Independent Members (IMs). All IMs appointed to the Health Board attend the Welsh Government IM induction programme and receive training on a range of topics to further develop their skills. Further support is provided to new IMs through the Health Board's bespoke Induction Pack. The contents of the pack are detailed and cover the breadth of the role. The pack provides a clear map of the Health Board's governance and assurance structure, and information is provided on the remit of each committee, with links to their Terms of Reference. The map has recently been updated to reflect the new appointments to the senior executive roles within the Health Board. IMs receive regular appraisals with the Chair and have good access to training and development opportunities to meet their particular needs. During our work, IMs told us that they felt adequately supported by the Health Board. They were complimentary about the routine briefing meetings held by the Chair and Chief Executive which enable them to keep abreast of the relevant challenges and issues facing the Health Board. In their view, these meetings are open and constructive. IMs also spoke positively about Board Development Sessions, which now give them greater opportunities to discuss and explore topics (such as risk management) in greater depth.
Status	Implemented

Recommendation 6 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.

Findings

The Health Board's approach to gathering, analysing, monitoring, and learning from patient experience has improved. However, further work is required to ensure prompt learning and improvement from patient feedback, and patient experience could feature more prominently in quality performance reporting to Board and committees.

The Health Board has taken a number of positive steps to improve its arrangements for gathering, analysing, monitoring, and learning from patient experience. In terms of gathering patient experience information, the Health Board has increased capacity within its Patient Advice and Liaison Service (PALS), and recruitment to the new posts was underway at the time of our work. The Health Board also has an agreed framework in place for Board member walkarounds. The framework and walkarounds appear to be working well, with good reporting on the key findings and observations to the Quality and Safety Committee. However, we found that the Health Board could make better use of real-time patient feedback to make immediate changes and improvements to the overall patient experience, where appropriate. The Health Board has also improved its use of patient stories and they now feature more prominently at Board, Quality and Safety Committee, and relevant operational meetings. The Health Board has a planned programme in place to support the gradual roll-out of the Friends and Family Test[14], patient rated outcome measures, and patient rated experience measures. Whilst these developments are encouraging, the Health Board could do more to ensure that patient experience features more prominently in routine performance and quality reports to the Board and relevant committees.

Status Partially implemented

14 The Friends and Family Test aims to help service providers understand whether patients are happy with the service provided, or where improvements are needed.

Recommendation 7	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.
Findings	**There is sufficient visibility of clinical audit across the organisation at both a corporate and operational level. However, opportunities remain to target clinical audit into areas of concern, as well as to use revalidation to assess whether improvements have been made.** Since our 2019 work, the Health Board has centralised its clinical audit function, moving it from the office of the Medical Director to the Corporate Governance Team. Our work in 2019 found that although the Audit Committee received the Clinical Audit Plan, there was insufficient scrutiny of the range of audit and improvement activity at the corporate level. In 2021, the Health Board agreed a Clinical Audit Assurance Framework which clearly sets out the role and responsibilities delegated by the Board to the Quality and Safety Committee and the Audit and Risk Committee in seeking assurances in relation to clinical audit. The framework is operating well, with regular reporting to both committees on the delivery of the plan as well as outcomes and impact. We found evidence of greater learning from clinical audit, including the use of a clinical audit newsletter promoting the work of the clinical audit team. The introduction of the Audit Management and Tracking (AMaT) system has also provided better oversight and real time organisation-wide monitoring of the delivery of clinical audit, and compliance with National Institute for Health and Care Excellence (NICE) guidelines. Training is also more evident than previously, with a range of bespoke clinical audit and effectiveness training delivered to staff including pharmacy trainees and trainee doctors as part of the post-graduate teaching programme. However, the capacity of appropriate staff to be involved in the national Tier 1 audits remains challenging. Furthermore, the March 2023 update to the Quality and Safety Committee noted the delay in delivering planned Tier 2 audits as clinical audit resources had been diverted to underpin the prioritised COVID-19 mortality review cases. As a result, opportunities are being missed to target clinical audit into areas of concern as well as to use revalidation to confirm where changes have been made that improvements have been achieved.
Status	Implemented

Recommendations to improve the arrangements for quality and patient safety at directorate level

Recommendation 8	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.
Findings	**There are clear accountabilities and responsibilities for quality and patient safety at all levels of the organisation. There is also greater clarity on the role and responsibilities of the Heads of Nursing within each of the three acute sites in respect of quality and patient safety.** Accountabilities and responsibilities for quality and patient safety have been strengthened across the Health Board. This is evident by the greater emphasis now provided across the Health Board in areas such as Infection, Prevention, and Control; the management of pressure ulcers; and the prevention of falls. Operational accountabilities and responsibilities were being embedded across the new Care Group structure at the time of our work. The accountabilities and responsibilities of the Heads of Nursing in relation to site management and quality and patient safety are also clearly articulated. Whilst some have only recently been appointed to their posts, we found they have a clear sense of responsibility and ownership over the quality and safety agenda. However, as we found in 2021, there continues to be an over-reliance on the Heads of Nursing to provide the overall clinical perspective at key quality and patient safety meetings, with limited input from medical teams. As mentioned previously, the Health Board is aware of this, and plans to fully embed the Clinical Director roles as part of the next phase of implementing the new operating model. This should lead to full collective responsibility for quality and safety at an operational level, and greater medical input at key quality and patient safety meetings.
Status	Implemented

Recommendation 9 The form and function of the directorate governance committees and CBMs (Clinical Business Meetings) must be reviewed to ensure there is:

a. Clear remit, appropriate membership, and frequency of these meetings.

b. Sufficient focus, analysis, and scrutiny of information in relation to quality and patient safety issues and actions.

c. Clarity of the role and decision-making powers of the CBMs.

Findings

This recommendation has been superseded.

This recommendation related to a previous structure in place during our 2019 review. These arrangements were replaced in 2020 when the Health Board made significant changes to the way it organised and managed its business by establishing three clinically led ILGs. Since our 2021 review, the Health Board has embarked on a further organisational restructure, with the ILGs replaced by six new Care Groups in November 2022. New oversight arrangements are now in place, including the Operational Management Board and the Improving Care Board. We have commented on the effectiveness of these arrangements in an earlier section (see **Recommendation 4**). However, the performance management arrangements for the Care Groups had not been established at the time of our work. The Health Board needs to ensure these are established promptly, particularly given the performance challenges facing the organisation. In doing so, the Health Board should issue Accountability Letters that clearly set out the accountabilities and responsibilities of Care Groups in relation to performance, finance, and quality. The Accountability Letters should also set out the arrangements for escalating Care Groups that fail to meet their responsibilities in relation to quality, performance, and finance.

Status Superseded

Recommendations to improve the identification and management of risk

Recommendation 10 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.

Findings

There are clear and comprehensive risk management arrangements at all levels of the Health Board, with a clear process in place for escalating risks from service to Board.

The Health Board has significantly improved its risk management arrangements since our 2019 review. The Health Board has a clear risk management strategy in place, which is underpinned by a suite of policies and procedures. The Corporate Governance Team provides effective risk management support for operational teams, the executive team, and the Board and its committees. At the time of our work, the Health Board had provided risk management training to over 360 members of staff. This training, along with the wider support provided by the Corporate Governance Team, appears to have significantly improved awareness of risk management across the organisation, particularly amongst operational teams. As part of introducing the new operating model, the Health Board has disaggregated the ILG risk registers, and the risks have been transferred to the risk registers of the new Care Groups. This process has been handled well, with good oversight provided by the Audit and Risk Committee. However, opportunities remain to strengthen the content of Care Group risk registers, particularly around the identification of mitigating actions. There are clear arrangements in place for the escalation of risks from services to the Board. The new Operational Management Board has specific responsibility for reviewing all the operational risks identified for escalation to the organisational (corporate) risk register to ensure they are scored in accordance with the risk management strategy and that control measures and mitigating actions are robust. We have observed this happening in practice, with Care Groups bringing operational risks to the Operational Management Board for check and challenge. The organisational (corporate) risk register has also been strengthened, and there is good evidence of corporate risks being actively reviewed and managed by the executive team.

Status Implemented

Recommendations to improve the management of incidents, concerns, and complaints

Recommendation 11	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.
Findings	**DATIX is well embedded across the Health Board, with improved oversight and governance arrangements in place.** In 2021, we found that the oversight and governance of DATIX was much improved, with greater engagement at all levels of the organisation around learning and managing actions required following incidents, complaints, and claims. However, further work is still required to ensure that all practitioners, such as those within community healthcare teams, can access DATIX to report and manage incidents in line with the Health Board's process. Greater use is made of DATIX reports, which are regularly discussed at the relevant quality, patient safety, and patient experience meetings. Weekly concerns reports are also generated and reviewed, with good engagement from senior executives. As noted earlier, the central DATIX function has been transferred to the Corporate Quality Governance Team. This is a positive development, which has ensured a more consistent approach to the management and escalation of incidents and concerns. The Corporate Quality Governance Team also provides reports to all Care Groups on legacy DATIX information for risks, incidents, complaints, and claims.
Status	Implemented

Recommendation 12	The Health Board must ensure staff receive appropriate training in the investigation and management of concerns. In addition, directorate staff need to be empowered to take ownership of concerns and take forward improvement actions and learning.
Findings	**The Health Board has improved the provision of training for staff on the investigation and management of concerns.** The Health Board has significantly improved its approach to the management of concerns and complaints. The Health Board's concerns and complaints process is clearly set out, and new roles have been created to support and oversee its implementation including an Assistant Director of Concerns and Claims, a Head of Concerns, and a Concerns Team Manager. The Health Board ensures that staff receive appropriate training. As a result, staff are now more skilled in managing concerns and complaints. There is also greater ownership of concerns at an operational level. Concerns and complaints are regularly discussed at the relevant operational quality, patient safety, and patient meetings, and action on learning and improvement is taken forward. Learning and improvement is also shared with the Operational Management Board. as part of their upward reports.
Status	Implemented

Recommendations to improve organisational culture and learning

Recommendation 13 The Health Board must ensure the timely development of a Values and Behaviours Framework with a clear engagement programme for its implementation.

Findings

The Health Board has a clear Values and Behaviours Framework, which is actively being used across the organisation. However, further work is required to address pockets of poor behaviour at an operational level.

The Health Board has a clear Values and Behaviours Framework in place. The framework appears to be well embedded across the organisation, and we saw evidence of the values and behaviours being actively used to shape job roles, and inform recruitment processes, induction arrangements, and leadership development programmes. The staff we spoke to during our recent work told us that Health Board's culture is much improved. Whist they told us that senior leaders are more visible and accessible, the results of the staff survey we undertook suggest that communication between senior management and staff is not as effective as it could be. However, we were also told about examples of poor behaviour in some operational teams which remain to be addressed, particularly around bullying and harassment. This was reinforced in the results of the staff survey we undertook. Around a third of respondents said they had personally experienced bullying, harassment, or abuse at work from a manager or a colleague; and almost half of respondents felt that the organisation does not take effective action if staff are bullied, harassed, or abused by other staff members. Further work is also required to fully integrate the Princess of Wales Hospital following its transfer in 2019 to the Health Board from Abertawe Bro Morgannwg University Health Board (which is now known as Swansea Bay University Health Board). We feel reasonably assured that the new Care Group operating model should ensure the hospital becomes fully integrated into the organisation's operational arrangements. The Health Board is aware of these issues, and is committed to enhancing the culture of the organisation on an ongoing basis.

Status Implemented

Recommendation 14	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.
Findings	**There is an improved culture of learning within the Health Board. However, further improvements are required, particularly in relation to completing and submitting Learning From Events Reports on a timelier basis.** The Health Board has strengthened its approach to organisational learning, with formal arrangements now in place to support the identification and sharing of learning and improvement. These arrangements include the Listening and Learning Framework, the Learning Repository, and Listening and Learning Events. Whilst these developments are positive, we found the Health Board could encourage greater clinical engagement with the Listening and Learning Events. The Health Board's improvement function – iCTM – is also effective at facilitating learning and improvement across the organisation. During our recent work, we found good examples of learning being rolled out and applied in practice, such as the "safe to start" huddles. We also saw some early evidence of the new structures and groups established under the new operating model creating better opportunities for sharing learning and improvement at an operational level. The Health Board should ensure that learning and improvement remain a priority for the new Care Groups and operational groups, such as the Operational Management Board and Improving Care Board. The results of the staff survey we undertook also show improvements in this area. Almost all respondents felt that staff are encouraged to report errors, near misses, or incidents. Furthermore, almost all respondents felt that learning from errors, near misses, and incidents is shared with staff. Whilst there is an improved culture of learning across the organisation, the Health Board is still dealing with a significant concerns legacy. The Health Board recently received a penalty of £25,000 from the Welsh Risk Pool due to delays in completing the mandatory Learning From Events Reports (LFERs). LFERs should be produced within 12 months following the investigation of a nationally reportable incident, or a clinical claim or redress investigation. The Health Board has made a commitment to address all historical LFERs by the end of December 2023. The Health Board will need to ensure robust joint clinical ownership to tackle the backlog and ensure the learning is captured and shared appropriately. Furthermore, the Health Board will need to put improved processes in place to ensure it completes and submits to LFERs on a timelier basis in future.
Status	Partially implemented

Appendix 1 – Review methodology

The methods we used to deliver this work are set out in **Exhibit 2**. Our evidence is limited to the information drawn from the methods below.

Exhibit 2 – Review methods

Review method	Description
Self-assessment	We asked the Health Board to self-assess its progress against our 2019 recommendations, which we reviewed prior to undertaking fieldwork.
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes. • Key governance documents, including Terms of reference for the Quality and Safety Committee, Quality Framework and local Quality and Governance terms of reference; • Operational Management Board and Improving Care Board, agendas, papers, and minutes • Clinical Audit plans and delivery updates • Key organisational strategies and plans, including the IMTP. • Quality Strategy and Implementation plan and documents relating to the Quality and Governance frameworks and models. • Key documents relating to the consultation, design, and implementation of the new operating model • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register and operational risk registers within surgical services. • Relevant policies and procedures. • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter Fraud Service, and other relevant external bodies.

Review method	Description
Observations	In addition routine attendance at Audit and Risk Committee, and the observation of regular business at Board and the Quality and Safety Committee, the follow up review drew specifically on observations at the following meetings: • Board (30/03/2023) • Audit and Risk Committee (13/02/2023 and 19/05/2023) • Quality and Safety Committee (16/03/2023) • Operational Management Board (22/03/2023) • Improving Care Board (05/04/2023) • Quality, Patient Safety, and Experience meetings within the Planned Care Group (23/03/2023), the Children and Families Care Group (23/03/2023), and the Mental Health and Learning Disabilities Care Group (12/4/2023)
Staff Survey	We repeated the staff survey (limited to teams within surgical services) from both our original 2019 review, and 2021 follow-up review.

Review method	Description
Interviews	We interviewed the following: • Chair of the Board • Chair and Vice Chair of the Audit and Risk Committee & Vice Chair • Chief Executive • Director of Corporate Governance • Chief of Staff • Executive Medical Director • Executive Director for People • Executive Director of Nursing, Midwifery & Patient Care • Chief Operating Officer • Executive Director for Therapies and Health Science (Lead for HB Quality Strategy) • Deputy Chief Operating Officer for Acute Services • Assistant Director Nursing - Quality, Safety & Safeguarding (Nursing Quality Lead) • Assistant Director Nursing - Patient Experience • Assistant Medical Director for Legal • Assistant Medical Director for Quality • Assistant Director of Concerns & Claims • Assistant Director of Governance & Risk • Planned care Group – Group Service Director • Planned Care Group – Medical Director • Planned Care Group – Nurse Director • Deteriorating Patients Lead for CTMUHB
Focus Groups	We held focus groups with the following: • Surgical Specialty Leads - Planned Care (Royal Glamorgan Hospital) • Surgical Speciality Leads - Planned Care (Prince Charles Hospital) • Surgical Clinical Service Group - Acute Site Leads Royal (Glamorgan Hospital) • Surgical Clinical Service Group - Acute Site Leads (Princess of Wales Hospital) • Surgical Clinical Service Group - Acute Site Leads (Royal Prince Charles Hospital)

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Cwm Taf Morgannwg University Health Board

Audit & Risk Committee
Internal Audit Progress Report

October 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.

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1 Introduction

1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at **17 October 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 August meeting of the Committee four reports have been finalised, three reports are in draft, and we have ongoing fieldwork in relation to eight reviews. A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
IT infrastructure	1	3	1	5	Reasonable
Interventions Not Normally Undertaken (INNU)	3	1	1	5	Limited
WHSSC – Welsh Kidney Network	-	1	2	3	Substantial
Follow up - Facilities governance 2022/23	2	6	-	8	Limited

3 Delivering the Plan

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

Table 2 – Performance Indicators 2023/24

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	Green	71%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days per Internal Audit Charter]	Red	25%	80%	v>20%	10%<v <20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from management response to issue of final report [10 working days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

4 Feedback

4.1 Our final reports are issued with a post audit questionnaire, which is our way of getting feedback on the audit process so that we can look to make improvements. We have issued four feedback requests to date.

5 Other activity

Meetings

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

Appendix A – 2023/24 Programme of work

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

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
22	Follow up – Radiology – workforce	Reasonable	Q1	Final	Y	N	Reported at August AC.
19	IT Infrastructure	Reasonable	Q1	Final	Y	N	-
-	Interventions Not Normally Undertaken (INNU)	Limited	-	Final	Y	N	-
4	Estates Assurance / condition	Limited	Q1	Draft	Y	-	Part of all Wales review - Draft report issued in August. Report is being updated to reflect better practice lessons learned.
7	Deprivation of Liberty Safeguards (DoLS)	Reasonable	Q2	Draft	N	-	Draft report issued 13.10.23.
-	Arrangements for financial savings	Substantial/ Reasonable/ Limited	-	Draft	N	-	Revised report issued 22.09.23. Brought forward from 2022/23.
3	Performance management of 4-hour target	-	Q1	WIP	-	-	Fieldwork completed report being drafted.

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
2	Gastro-intestinal pathway	-	Q1	WIP	-	-	Fieldwork started later than planned. Slow receipt of information.
6	Management of controlled drugs	-	Q2	WIP	-	-	Fieldwork started later than planned. Slow communication.
9	Adult mental health – CSG review	-	Q2	WIP	-	-	Fieldwork started 06.10.23.
18	IT Service Management	-	Q2	WIP	-	-	Fieldwork started 14.09.23.
5	Charitable funds	-	~~Q2~~ Q3	Planning	-	-	Management request to start later in year.
1	Leadership and management development	-	~~Q1~~ Q4	Planning	-	-	Management request to move to Q4 as internal development ongoing.
8	Finance - Budgetary controls	-	Q2	Planning	-	-	Scoping meeting 08.08.23 cancelled by CTM and rescheduled to 19.10.23.
23	Follow up – medical variable pay	-	Q2	Planning	-	-	Have had to reschedule as audit tracker identifies implementation date of

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
							actions moved to end of October 2023.
25	Follow up – reasonable offer	-	Q3	Planning	-	-	Have had to reschedule as audit tracker identifies implementation date of actions moved to end of October 2023.
24	Follow up – digital operating model	-	Q3	Planning	-	-	Fieldwork planned for Q3.
T12	Finance – Savings delivery	-	Q3	Planning	-	-	Meeting rescheduled to 19.10.23.
T13	Decarbonisation	-	Q3	Planning	-	-	Brief has been drafted.
T10	Regional integration fund	-	Q3	-	-	-	Propose to move to 2024/25.
T11	Job planning medical pay	-	Q3	-	-	-	-

Table 4: Status of PCH plan work 2023/24

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

Assignment	Status	Assurance	Notes
Financial management and change control	WIP	-	Fieldwork is concluding.
Quality – Site supervisor role	WIP	-	Fieldwork is concluding.
Validation of management actions	Planning	-	-

Table 5: Hosted bodies programme of work

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	WHSSC – Integrated commissioning plan (ICP)	-	Q1	WIP	-	-	Fieldwork concluded. Report being drafted.
2	WHSSC – Welsh Kidney Network	Substantial	Q2	Final	Y	Y	-
3	WHSSC – Mental Health	-	Q4	Defer	-	-	Strategy for MH delayed. Previously agreed to do in Q1 2024/25.

Interventions Not Normally Undertaken (INNU)

Final Internal Audit Report

October 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-2223-11
Report status:	Final
Fieldwork commencement:	11 March 2023
Fieldwork completion:	30 August 2023
Draft report issued:	8 September 2023
Management response received:	10 October 2023
Final report issued:	11 October 2023
Auditors:	Geoffrey Woolley, Principal Internal Auditor Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Gethin Hughes, Chief Operating Officer
Distribution:	Sarah James, Deputy Chief Operating Officer Tarek Allouni, Director of Operations - Planned Care
Committee:	Audit & Risk Committee

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

Acknowledgement

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

Executive Summary

Purpose

The overall objective of our review was to provide assurance that there are effective arrangements and processes in place to in relation to INNU activity across the Health Board.

Overview

We have issued limited assurance on this area. The key matters which require management attention are:

- There appears to be a lack of awareness of the Health Board's INNU policy.
- There is no standard operating procedure to support the application of the policy.
- Lack of concise evidence on patient files to support the need for an INNU to take place meant we were unable to undertake testing to ensure compliance with the policy.
- Lack of monitoring and therefore challenge of INNU activity.

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	Policy and procedures are in place.	Limited
2	Correct processes have been followed.	Not assessed
3	'Do-Not-Do' interventions are not undertaken.	Limited
4	Mechanisms to monitor compliance with the policy.	Unsatisfactory

[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	INNU policy and Standard Operating Procedure	1	Operation	High
2	Evidence to support interventions taking place	2	Design	High
4	Mechanisms for capturing all activity	2 & 3	Design	Medium
5	Monitoring arrangements	4 & 5	Operation	High

1. Introduction

1.1 Management requested that we undertake a review of Interventions Not Normally Undertaken (INNU) as part of the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board'). We experienced some difficulties accessing information during the fieldwork, so this report will be included in our 2023/24 annual report.

1.2 As part of the Health Board's strategic goals of 'Improving Care' and 'Sustaining our Future', consideration has been given to ensure that only effective treatments are undertaken, and resources are only used for procedures where there is a benefit to the patient. As such, the Health Board has identified a number of interventions that would not normally be undertaken. These interventions would be where there is:

- currently insufficient evidence of clinical and /or cost effectiveness; or
- the intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE), or the All Wales Medicines Strategy Group (AWMSG); and/or
- the intervention is considered to be of relatively low priority for NHS resources.

1.3 An example of an INNU would be the removal of a tattoo, or certain body contour procedures. The Health Board's policy suggests that these interventions should only be undertaken where set criteria have been met.

1.4 In addition, a number of 'Do-Not-Do' interventions exist, for which there are no exceptions as they are not supported for use under NICE Guidance.

1.5 Our review sought to provide assurance that there are effective arrangements and processes in place to support consistent application of the INNU list across the Health Board.

1.6 We planned to sample test interventions for patients across the three hospital sites and range of clinicians. However, as there was no SOP in place there was no guidance setting out how evidence should be retained within patient files to confirm the patient met the criteria for an INNU to take place. As such, without significant clinical support to review the documentation contained in each of the files in our sample, we were unable perform this testing.

1.7 The associated risks were:

- Patients undergo procedures that only have marginal effectiveness, are ineffective or have limited clinical value.
- NHS resources are not used in the most effective way.
- Patients are not treated equitably.

2. Detailed Audit Findings

Objective 1: An up-to-date INNU policy and supporting procedures are in place and accessible to all relevant stakeholders.

2.1 In January 2023 staff completed a review the INNU policies of the former Cwm Taf and Abertawe Bro Morgannwg health boards and developed a revised Cwm Taf Morgannwg policy, taking into account the most relevant NICE guidance.

2.2 The policy was endorsed for approval at the Operational Management Board in late January 2023 and approved at the March 2023 Quality & Patient Safety Committee.

2.3 The INNU policy is available to staff via the Health Board's intranet site. However, our discussions with staff from the Planned Care Group, during our fieldwork we identified that staff were generally unaware of the new policy. We understand that there has not been a communication to inform staff of its update, or training in relation to the revised policy. However, we acknowledge that the interventions listed in the revised policy, do not vary considerably from the previous policy, so staff should have a degree of awareness of the approach to INNU. **(Matter Arising 1)**

2.4 We reviewed the policy and note that the information relating to the use of the Individual Patient Funding Request (IPFR) was not clear. **(Matter Arising 1)**

2.5 In addition, there was no Standard Operating Procedure (SOP) to support staff in the consistent application of the policy. **(Matter Arising 1)**

Conclusion:

2.6 The Health Board has an up-to-date INNU policy that is accessible to staff. However, this has not been communicated to inform staff of the revised policy and reinforce its implementation. We identified limited awareness of the policy during our fieldwork. In addition, there is no SOP in place to support the application of the policy. As such, we have provided Limited Assurance against this objective.

Objective 2: Where INNUs are undertaken, the correct process has been followed to support the decision to carry out the intervention.

2.7 We note that 61/69 of the interventions listed in the INNU policy have clinical codes attributed to them. Our analysis of INNU activity against the 61 interventions between January to May 2023 showed:

- 1,064 interventions had been carried out by 113 clinicians in relation to 26 different interventions.
- The split of activity across the three main hospital sites was PoW 55%, PCH 28% and RGH 14%.
- Of the 1,064 procedures, 23% were carried out by four clinicians, all of which were based at PoW.

2.8 To test that the correct process had been followed we selected three interventions of high activity: excision of gall bladders; tonsillectomies and benign skin

conditions. We planned to sample test interventions for patients across the three hospital sites and range of clinicians. However, as there was no SOP in place there was no guidance setting out how evidence should be retained within patient files to confirm the patient met the criteria for an INNU to take place. As such, without significant clinical support to review the documentation contained in each of the files in our sample, we were unable to test. **(Matter Arising 2)**

2.9 The lack of a summary document or checklist on patient files could hinder staff within the Health Board undertaking any monitoring of INNU activity. Similarly, there is no form of cross checking or approval carried out to confirm the INNU policy criteria has been met ahead of adding a patient to a relevant waiting list. **(Matter Arising 2)**

2.10 We understand that the Health Board is reviewing the INNU waiting lists for each specific procedure, to identify patients that may not fully meet the INNU criteria and as such may have been incorrectly listed. Independently reviewed checklists on patient files may aid future waiting list reviews the Health Board wishes to perform.

2.11 Furthermore, from our analysis of the data in relation to the INNU procedures carried out, we identified a small number of cases where the clinicians name had not been recorded, and instead the name 'Mrs Mid Wife' or 'Dr Midwife' had been used. We have not been provided with an explanation of why the clinicians actual name had not been recorded to ensure accountability and accurate medical records. **(Matter Arising 3)**

2.12 There is no activity data for eight interventions as they did not have a clinical code listed in the INNU policy. **(Matter Arising 4)**

Conclusion:

2.13 Due to the lack of a standardised approach to capturing information on patient files if it is believed the criteria for an INNU intervention has been met, we have been unable to perform any testing. As such we have not been able to provide an assurance opinion against this objective.

Objective 3: Interventions listed as 'Do-Not-Do' are not undertaken.

2.14 The INNU policy identifies 13 interventions that are categorised as 'Do Not Do' (DND). 6/13 of the interventions had clinical codes and we confirmed that during January to May 2023 no activity was coded against them.

2.15 The remaining 7/13 interventions, which include interventions such as abrasion arthroplasty for knees, chronic fatigue syndrome and electrical & electromagnetic field treatments in non-union of bones, had no clinical codes assigned so we were unable to identify activity levels. When discussed further with management it was confirmed that a mechanism would need to be put in place to allow the identification of any activity taking place against these DND interventions. **(Matter Arising 4)**

Conclusion:

2.16 We confirmed that for 6/13 of the DND interventions listed in the INNU policy, there was no activity during the five-month period we reviewed. However, there are no mechanisms in place to identify if there had been activity against the remaining interventions. We have provided Limited assurance against this objective.

Objective 4: Mechanisms are in place to monitor compliance against the policy, with compliance / non-compliance appropriately reported.

2.17 The INNU policy states, *'compliance with the policy will be monitored through Care Group performance meetings reviewing the monthly reports of patients listed for INNUs or DND procedures which is available on the Qlik Information system'*.

2.18 We acknowledge that the care groups have recently been established and the governance and meeting structures has not yet been finalised. We understand that, at an operational level, reports are not currently being produced for monitoring. Therefore, non-compliance with the policy is not identified or escalated, nor is there reporting to the Board's committees. **(Matter Arising 5)**

2.19 As we note in objective 3, there is no mechanism in place to allow monitoring of activity where clinical codes have not been identified. **(Matter Arising 4)**

Conclusion:

2.20 Whilst the Health Board has set out its intentions in relation to monitoring INNU and DND activity, this was not taking place at the time of our fieldwork. We have provided Unsatisfactory Assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: INNU policy and Standard Operating Procedures (Operation)		**Potential Impact**
The Health Board has a recently updated and approved its INNU policy. However, it appears that the updated policy has not been well communicated to staff as our fieldwork identified that key staff were not aware of the policy. There are no Standard Operating Procedures (SOP) or guidance notes to provide step by step information on the processes to be followed to implement the policy. Our review of the policy identified some points of ambiguity. Reference is made to applying, in exceptional circumstances through the Individual Patient Funding Request (IPFR) process, for interventions included on the INNU list. The policy states that in relation to the list of 'Do Not Do' (DND) interventions, that these are *'interventions where there are no exceptionalities'*. However, against each DND intervention listed in the appendix of the policy, it says *'There are no agreed criteria for use without an IPFR'* suggesting IPFR applications can be made for these interventions. We have not been able to determine any clarity on this matter.		The Health Board's INNU policy is not consistently applied. This may result in patients undergoing interventions that have marginal effectiveness, NHS resources not being used in the most effective way, and patients may not be treated equitably.
Recommendations		**Priority**
1.1	Key staff, especially those listed as the target audience at the start of the INNU policy, should be made aware of the revised policy and its contents. Where necessary, training should be carried out to ensure staff understand the policy and the application of it.	**High**
1.2	A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	**High**
1.3	The policy, and an associated SOP, should provide greater clarity on whether the IPFR process can be used for those interventions that are listed as 'Do Not Do' and the relevant process to follow.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Sept 23	Executive Medical Director Director of Operations Planned Care
1.2	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Jan 24	Head of Planning and Partnerships Strategic and Operational Planning Director of Operations Planned Care
1.3	Application of the above actions	Jan 24	Executive Medical Director Director of Operations Planned Care

Matter Arising 2: Clear evidence to support interventions taking place (Design)	**Potential Impact**
Without an SOP or any detailed guidance, no summary, or any form of authorisation is captured on patient records to demonstrate that the criteria for the INNU intervention to take place had been met. As part of our fieldwork, we considered reviewing patient files to determine if there was sufficient evidence to support the decision for the patient to be added to an INNU list. However, this approach would have required clinical input to help analyse the contents of the files. Given the clinical time and resource this would have required, and earlier communication from management that we were unlikely to sight the evidence we would expect to see, a decision was made to not progress with our testing.	Interventions are inconsistently carried out, without supporting evidence, with marginal benefit to the patient and at a cost to the Health Board.

	Recommendations	**Priority**
2	For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy or within WHSSC guidance has been met. Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	**High**

	Agreed Management Action	**Target Date**	**Responsible Officer**
2	Individual patient funding request panel to be re-established to receive INNU intervention requests necessary. Application and outcome to be documented and WPAS to be updated.	Jan 24	Executive Director of Strategy & Transformation

Matter Arising 3: Accurate records are retained (Operation)			**Potential Impact**
Our analysis of the INNU activity during the period January to May 2023 identified a small number of cases where the clinician's name had been recorded as 'Mrs Mid Wife' or 'Dr Midwife', as such there are potentially inaccurate medical records held for these patients and a lack of accountability.			Inaccurate information retained preventing effective monitoring of activity.
Recommendations			**Priority**
3	The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Review and update of waiting list 'holding names' to be undertaken.	March 24	Director of Operations Planned Care

Matter Arising 4: Mechanism for capturing activity (Design)	**Potential Impact**
Clinical codes are used to identify and categorise interventions and can be used to inform monitoring. 8/69 of the INNU interventions listed in the policy do not have a clinical code attributed to them. In addition, the INNU policy lists 13 'Do Not Do' (DND) interventions which have '*no exceptionalities and are not supported for use under NICE guidance'.* For 7/13 of these interventions there was also no clinical code attributed to them. For these 14 interventions we were unable to establish activity levels. When discussed with management to determine if there was an alternative way to identify activity, we were informed that a mechanism would need to be put in place to allow the future capturing of this information.	Interventions listed as 'Do-Not-Do' may be undertaken in contravention with the INNU policy.

	Recommendations	**Priority**
4	A mechanism should be put in place that will allow the Health Board to monitor if activity has taken place against interventions that are classed as DNDs where no clinical code currently exists and the level of activity against the INNU interventions where no clinical code is recorded.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4	Data workstream established to look at the recording of INNU's across CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented.	March 24	Executive Medical Director

Matter Arising 5: Monitoring arrangements (Operation)	**Potential Impact**
The INNU policy sets out how the monitoring of INNU and DND activity will take place through care group performance meetings. While we acknowledge that the governance arrangements in relation to the care groups is still being embedded, we understand that INNU monitoring is not taking place.	Interventions continue to be carried out which are not compliant with the policy and action is not taken to prevent this.

Recommendations		**Priority**
5.1	The monitoring mechanisms set out in the INNU policy should be implemented as soon as possible. Appropriate reports should be produced monthly to monitor INNUs at an operational level which are distributed to all relevant stakeholders. These should include totals by month and by specialty/clinician so that trends and anomalies can be easily spotted and investigated. Sample checks back to patient records should be carried out to confirm all criteria had been met. The use of a checklist as recommended in Matter Arising 2 would aid this process. An appropriate mechanism should be in place for addressing any matters identified, so that corrective action can be promptly taken.	**High**
5.2	Consideration should be given to the need to periodically report compliance / non-compliance at a relevant level within the Health Board.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	With the establishment of the recording and monitoring mechanism. Monthly reports will be produced with trends and anomalies highlighted. Any matters that require addressing will be via the Care Group with the service performance meeting structures.	March 24	Chief Operating Officer Directors of Operations and Service Group Directors
5.2	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	March 24	Chief Operating Officer Director of Operations Planned Care

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Follow-up: Facilities Systems
Final Internal Audit Report

October 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

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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 Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

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Executive Summary

Purpose

The objective of the audit is to provide the Health Board with assurance regarding the implementation of the agreed recommendations made in our June 2022 facilities systems audit.

Overview of findings

We identified seven matters arising in our original review, which included five high, seven medium, and two low priority recommendations.

From our meetings with staff, our review of documentation, and sample testing we have confirmed that there has been good progress to address some of the recommendations, and as such, we have closed six of these. However, while there has been some progress against the remaining recommendations two high and five medium remain open. The areas where further action is needed are in relation to:

- Ensuring staff that have been identified as having procurement training requirements as part of their role, attend the training sessions organised.
- The ongoing use of retrospective orders for payments of invoices and lack of documentation to support some orders.
- Clarifying purchasing responsibilities between the central hub and the local facilities teams based at the different hospital sites.
- Regular receipt of invoices on hold report.

Follow-up Report Classification

		Trend
Limited 	**Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.	⇔

Progress Summary

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
Requisition of goods and services				
1	Procurement process training	Medium	⇔	Medium
2	Use of retrospective orders	High	⇔	High
3	Competitive quotations	High	⇑	Medium
4	Monitoring compliance with No PO, No Pay policy	Medium	⇔	Medium
Budgetary control				
5	Budgetary holder training	Medium	⇑	Low
Governance				
6	Areas of responsibility	High	⇔	High
7	Financial system approval hierarchy	High	⇑	Closed

1. Introduction

1.1 A follow-up audit of the recommendations made in our review of facilities systems was completed in addition to the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board'). Our original audit report was finalised in June 2022, after the 2022/23 audit plan for the Health Board had been agreed.

1.2 We issued a limited assurance opinion for our original review of facilities systems. The review covered budgetary control, governance areas and the requisitioning of goods and services. We have followed up the recommendations made in relation to these three areas.

1.3 In June 2022, management indicated that significant work had started in relation to implementing the agreed recommendations. The audit tracker presented at the August 2022 Audit and Risk Committee meeting showed that all recommendations had been implemented and closed on the tracker. Our review sought to provide assurance that action has been taken as stated to implement the agreed recommendations.

1.4 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.

1.5 The potential risks considered during our review were:

- Unauthorised expenditure or expenditure above delegated limits if orders are not processed through the correct system.
- Value for money not obtained where procurement processes are not followed.
- Non-compliance with legislation or Financial Control Procedures or the Scheme of Delegation.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations following our recent fieldwork:

Original Priority Rating	Number of Recommendations	Implemented (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	5	3	2	0
Medium	7	1	6	0
Low	2	2	0	0
Total	**14**	**6**	**8**	**0**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

2.3 With regards to the high and medium priory recommendations that have been closed:

- The matter arising in relation to the Oracle hierarchy, which included two recommendations (one high, one medium) has been closed. The Health Board has introduced a process for sharing the hierarchy that all departments can access to review.
- The high priority recommendation under matter arising two, use of retrospective orders, has also been addressed. Our testing confirmed that work has been carried out to raise awareness of current procurement processes for those staff that manage of contracts. However, this can be improved further, if all identified staff attend training sessions, (see Matter Arising one)
- We raised one high and one medium priority recommendation for our competitive quotations matter arising. While we consider the high priority recommendation in relation to working with procurement to review existing contract arrangements closed, further action is required to address the medium priority recommendation.

2.4 While eight recommendations remain open, in most cases we have seen that action has been taken to start to address the findings, with some sub-findings closed. This includes:

- Working with procurement to reaffirm the processes, identifying training requirements, issuing guidance and development appropriate procedures.
- Development of a contracts schedule that is reviewed during regular meetings between Facilities and Procurement in order for appropriate action to be taken in relation to contract renewal requirements.

Appendix A: Management Action Plan – for outstanding matters arising

Requisitioning of Goods and Services

Previous Matter Arising 1: Procurement process training (Operation)		
Original Recommendation		Original Priority
While the lunch and learn sessions should improve the knowledge of staff, management should ensure that there are structured training arrangements in place for the Oracle I-Procurement module for all staff responsible for, and involved with, the delivery of the purchase to pay process.		**Medium**
Original Management Response	Original target date	Responsible Officer
Arrangements have been made for structured training on the Oracle I-Procurement module for all staff responsible for, and involved with, the delivery of the purchase to pay process.	Management considered this complete at the time the original report was finalised.	Wayne Lewis – Head of Technical Services
Current findings		**Residual Risk**
A training needs analysis has been undertaken to identify those staff that require Oracle I-Procurement training, basic introduction to procurement training, and Qlik-view training. We acknowledge that training sessions for facilities staff have been arranged and the department maintains a record of all staff invited and attendees. However, the training records identify that there are still a number of staff who are yet to attend the required training.		Non-compliance with legislation, Financial Control Procedures of the Scheme of Delegation.
New Recommendation		**Priority**
1	Management should ensure that staff who are yet to attend training sessions identified as a requirement for their role, do so as soon as is practicable.	**Medium**

	Management Response	Target Date	Responsible Officer
1	A change in the Facilities structure was implemented in September 2023. The hub and non-hub services have merged into one service. The ILG service Managers are no longer accountable for Facilities services. Leadership is new and all facilities services are under review. Training records will be amalgamated. Any employees who have missed the training will receive the recommended training. A total of 77% have completed Qlik Finance system training and 66% have completed P2P Procurement training. Further training to be arranged.	20/02/24	Claire Masters – Quality Assurance, Performance and Compliance Jill Venables - Divisional Director of Facilities

Previous Matter Arising 2: Use of retrospective orders (Operation)		
Original Recommendations		Original Priority
2.2a Those members of staff with responsibility for managing contracts should work with colleagues in Procurement to identify the contracts where it would be appropriate to have alternative mechanisms for raising orders and paying invoices, for example the use of 'call off / open' orders. 2.2b In liaison with Procurement, clear guidance should be developed around when it may be acceptable to utilise 'call off / open' orders and the process staff need to follow to ensure appropriate controls are in place. The FCP should also be updated accordingly.		**Medium**
2.3 Where a retrospective order is deemed appropriate staff should be encouraged to complete the notes section in Oracle explaining the reason for the use of a retrospective order, including details of who requested the goods and services to be procured.		**Medium**
2.4 Documentation to support all orders should be retained and made available if required.		**High**
Original Management Response	Original Target Date	Responsible Officer
2.2 We have worked with procurement and finance business partners to co-produce an agreed process compliant with All Wales No PO No Pay Policy. There is also an agreement that allows us to raise retrospective orders against Emergency POs for specific contracts.	Management considered this complete at the time our original report was finalised.	Wayne Lewis – Head of Technical Services
2.3 Noted and agreed staff have been advised.	Management considered this complete at the time our original report was finalised.	Wayne Lewis – Head of Technical Services

2.4 A process is being developed to ensure all documentation in relation to orders for goods/services are available in the Oracle financial system.		Wayne Lewis – Head of Technical Services

Current findings	Residual Risk
2.2a We understand that Facilities and Procurement are working together to identify contracts where it would be more appropriate to have alternative mechanisms for raising orders and paying invoices. However, this work remains ongoing. Our analysis of retrospective orders found that high numbers continue to be placed with a number of suppliers. Our testing of a sample of these orders identified instances where 'open' / 'call off' orders could have been raised in advance, as opposed to raising a retrospective order, but were not. 2.2b The Procurement team have provided a number of training sessions regarding procurement processes. However, we have not seen any guidance in relation to when it may be acceptable to use a 'call off / open' order, and the FCP has not been updated. The Facilities team, in conjunction with Procurement, have developed a series of action cards to act as prompts. While one card sets out a retrospective order flowchart, this does not make it clear that the use of retrospective orders is only acceptable in exceptional circumstances, as set out in the FCP.	Non-compliance with Financial Control Procedures. Inability to demonstrate value for money.
2.3 We tested a sample of retrospective orders and found that the 'notes' tab in Oracle was not used to capture the reason for the retrospective order. We understand that the function to add notes is only available to Procurement and Accounts Payable staff. Requisitioning staff with the Facilities Central Hub are only able to add attachments to the system when raising a requisition.	
2.4 We tested a sample of orders to confirm if all documentation to support the order was in place. For 2/10 of our sample no supporting documentation was provided. The original management response identified that a process was being developed in relation to the retention of documentation when ordering goods and services. We had been informed that Facilities management had worked with procurement to develop 'action cards' that would contain information on the agreed process for retaining documentation. However, there is no information in relation to the retention of supporting documentation within the action cards. Similarly, the FCP is silent on the need to retain such information.	

New Recommendations		Priority
2.2a 2.2b	Management should continue to work with Procurement to review arrangements with suppliers where large numbers of retrospective orders continue to be raised, with a view to using 'call off / open' orders instead (where practicable). In liaison with Procurement, clear guidance should be developed for when it may be acceptable to use 'call off / open' orders and the process staff need to follow to ensure appropriate controls are in place. The FCP should be updated accordingly.	**Medium**
2.3	Management should clarify the access arrangements to the notes section in Oracle for requisitioning staff, in order for information to be captured on why a retrospective order has been used.	**Medium**
2.4	Management should remind staff of the requirement that documentation to support all orders should be retained. Consideration should be given to including information on the retention of documentation to support orders on the action cards. This information should align to any relevant information contained in the FCPs.	**High**

Management Response		Target Date	Responsible Officer
2.2	2.2a We will continue to work closely with Finance and Procurement colleagues to identify further opportunities for using call of orders instead of using retrospective orders. 2.2b We have developed and issued a new action card to remind staff of their responsibilities for attaching supporting information/documentation in respect to open/call off orders and to provide information on the retention of information/documentation to support orders. Although informative action cards have been designed there is no evidence that the cards are utilised and adhered to. A monitoring procedure will be added to Facilities Key Performance Indicators and will be monitored monthly.	20/02/24	Wayne Lewis – Head of Technical Services. Jill Venables, Divisional Director of Facilities
2.3	We have developed and issued a new action card to remind staff on how to access the notes section on Oracle reminding them of their responsibilities in relation to attaching	Completed	Wayne Lewis – Head of Technical Services.

	and entering supporting information in respect of retrospective orders and providing the rationale for raising a retrospective order. Although staff have been advised, no monitoring has taken place. There is therefore no evidence that the procedures are being followed. This procedure will be added to the Facilities Key Performance Indicators and will be monitored monthly.	20/02/24	Jill Venables, Divisional Director of Facilities
2.4	We have reminded staff of their responsibilities in relation to the requirement that supporting documentation to support all orders should be retained. Further work is required. These procedures require monitoring monthly to ensure compliance. All procedures will be added to the Facilities Key Performance Indicators and will be monitored monthly. An Action Plan Tracker will follow this report which will include specific actions, accountability and completion dates. The Tracker will be submitted in November 2023.	20/02/24	Wayne Lewis – Head of Technical Services. Jill Venables, Divisional Director of Facilities Jill Venables, Divisional Director of Facilities

Previous Matter Arising 3: Invoices requiring competitive quotations (Operation)		
Original Recommendation		Original Priority
3.2 Management should remind staff that procurement guidance requires three quotations to be obtained where expenditure for goods and services to be procured are expected to exceed £5k. Consideration should be given to provider refresher training in relation to this.		**Medium**
Original Management Response	Original Target Date	Responsible Officer
3.2 All staff have been reminded that procurement guidance requires three quotations are to be obtained where expenditure for goods and services to be procured are expected to exceed £5k. Procurement P2P initial training has now been provided for Facilities Central Services staff in relation to this.	Management considered this complete at the time our original report was finalised.	Russell Hoare – Assistant Director OSS (Facilities)

Current findings	**Residual Risk**
Training has been made available to Facilities Central Services staff, although at the time of our follow up fieldwork, a number of staff were yet to attend. We note the 'action cards' that have been produced as prompts do not provide guidance on the requirement for three quotes where expenditure will exceed £5k, or where tenders are required. We tested a sample of orders over £5k, but for 2/10 orders we were unable to confirm if the correct process had been followed as we were not provided with copies of documentation.	Health Board may incur unnecessary excess expenditure. Value for money not obtained where procurement processes are not followed.

New Recommendation		**Priority**
3.2	As we note in 2.4 above, management should ensure that staff are reminded that documentation to support all orders, including the evidence of quotes, is retained and accessible. Management should ensure that staff who have not had refresher training, receive this as soon as practically possible. Management should consider enhancing the action card prompts that have been developed to remind staff of the quotes and tender thresholds, while ensuring they align to FCPs.	**Medium**

Management Response		Target Date	Responsible Officer
3.2	We have reminded staff that documentation to support all orders, including the evidence of quotes, is retained and accessible. We have developed and issued an action card reminding staff and management of the guidance in relation to the requirement of obtaining three quotes where expenditure for goods and services to be procured will exceed £5k, or where tenders are required.	Completed	Wayne Lewis – Head of Technical Services.

Previous Matter Arising 4: Monitoring compliance with the No PO No Pay process (Operation)		
Original Recommendation		Original Priority
Management should liaise with Finance and Procurement colleagues to ensure ongoing regular receipt of details of any invoices 'on hold' for Facilities and then review and take appropriate action to 'release' the hold. When reviewing the reason for the 'holds' management should note the issues, such as use of retrospective orders and take appropriate action, including arranging further training of staff if necessary, to ensure that the issues do not recur.		**Medium**
Original Management Response	Original Target Date	Responsible Officer
Weekly (invoices on hold) lists are now shared with Facilities for review and action.	Management considered this complete at the time our original report was finalised.	Wayne Lewis – Head of Technical Services
Current findings		**Residual Risk**
Departments receive notifications in relation to invoices that have been placed on hold. Following our original audit, the Facilities department started to receive a supplementary weekly report providing additional information. Weekly meetings, specifically to support Facilities, were also in place. The supplementary reports and meetings paused due to year end pressures within procurement but have since restarted. We understand that the Facilities department felt that during the period when the supplementary reporting paused, the number of queries received directly from suppliers increased substantially.		Delay in Health Board paying suppliers on time.
New Recommendation		**Priority**
4 The level of ongoing additional support provided by procurement to Facilities should be reviewed with an aim to reducing it over time as more Facilities staff complete training.		**Medium**

	Facilities staff should reminded suppliers that queries should be directed through 'Action Point' in the first instance, and not directly with the department.	

	Management Response	Target Date	Responsible Officer
4	We have requested the reinstatement of the 'invoices on hold' reports with an agreed frequency from procurement. Reports are generated and distributed	07/10/2023	Wayne Lewis – Head of Technical Services.

Budgetary Control

Previous Matter Arising 5: Budget Holder Training (Operation)		
Original Recommendation		Original Priority
5.1 A training needs assessment of all budget holders within the Facilities directorate should be carried out to identify those that need training on the QlikView system and those that need general budgetary control training. In liaison with the Finance Business Partners, a consistent approach to training delivery should be adopted across the Directorate.		**Medium**
Original Management Response	Original Target Date	Responsible Officer
5.1 A training needs assessment has been completed of all budget holders within Facilities. In liaison with Procurement staff, general budgetary control training and guidance through Procurement P2P training has now been provided for Facilities Central Services staff. Facilities Governance Manager has met with Finance Systems team to discuss and arrange a QlikView training plan and an accompanying guide for those staff identified in the training needs assessment.	Management considered this complete at the time our original report was finalised.	Claire Masters – Quality Assurance, Performance and Compliance

Current findings	**Residual Risk**
Whilst QlikView training sessions have been provided, we note that 7/26 staff identified as requiring training are yet to attend. We acknowledge that some staff may be using the QlikView system based on existing experience.	Incorrect decisions made where staff are not suitable trained to understand their financial reports.

New Recommendation		**Priority**
5	Management to ensure that outstanding staff receive QlikView training as soon as practicable.	**Low**

	Management Response	Target Date	Responsible Officer
5	Additional training sessions will be arranged with Finance colleagues to ensure that the staff who require the training receive it and training records are updated accordingly.	07/10/2023	Claire Masters – Quality Assurance, Performance and Compliance

Governance

Previous Matter Arising 6: Areas of responsibility (Operation)		
Original Recommendation		Original Priority
For those issues that have been identified management should review the circumstances and take appropriate action to ensure that there is no recurrence of the issue. Management should also consider providing further information and guidance that clarifies purchasing responsibilities for the Central Facilities Hub and ILG's Facilities Teams. Management should also consider reviewing the original schedules drawn up as part of the revised operating model to see if the details are still applicable or whether any changes are required. Where changes are required, management should ensure that they are approved by an appropriate forum. The changes should then be communicated to all relevant staff and the Oracle purchasing hierarchy and scheme of delegation should be amended as required.		**High**
Original Management Response	Original Target Date	Responsible Officer
Work programme has been initiated with finance colleagues to identify where ILG generate demand that the Facilities Hub have no managerial control over. Processes have been developed to capture spend against activity and demand generated by the ILGs with initiatives to mitigate and reduce this spend where possible.	Management considered this complete at the time our original report was finalised.	Wayne Lewis – Head of Technical Services
Current findings		**Residual Risk**
We understand that work takes place to address issues as they arise in relation to the locality Facilities teams raising orders against Central Facilities team budget. The previous management response advised that a work programme has been initiated and processes developed to pro-actively manage the issue. Despite a request for evidence to support this, none has been forthcoming.		Expenditure inappropriately authorised or incurred.

New Recommendation			Priority
6	Management should review and clarify purchasing and budgetary arrangements and responsibilities for Central Facilities Hub and ensure that they align to the Health Board's revised Operational Structure.		**High**
Management Response		**Target Date**	**Responsible Officer**
6	The Facilities Hub and non-hub no longer exist. Systems are now in place to track and monitor, however further review is required to reduce activity and achieve budget. The services se arears are significantly overspent. Further control measures need to be determined, implemented and monitored.	03/10/23	Jill Venables – Divisional Director of Facilities

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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IT Infrastructure

Final Internal Audit Report

October 2023

Cwm Taf Morgannwg University Health Board

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Distribution:	Paul Chilcott, Lead Infrastructure Architect
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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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

Executive Summary

Purpose

The purpose of the review was to provide assurance to the Audit and Risk Committee that a process is in place for ensuring that the IT infrastructure hardware is tracked, maintained, supported, and that the network is managed sufficiently to provide services for the Health Board#.

Overview

We have issued Reasonable assurance on this area.

There are records of the infrastructure assets, together with a process for monitoring both the state of the assets and of the network. There is patching in place for devices, although switches are not fully patched.

The infrastructure equipment is generally within its life, although we note the presence of older equipment.

The key issues requiring management action are:

- removing old equipment from the estate;
- formalising the alerts process.
- formalising the patch process; and
- ensuring environmental controls are adequate across all sites.

Report Opinion

		Trend
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	None

Assurance summary[1]

Objectives		Assurance
1	The IT infrastructure is maintained with appropriate monitoring, support, and risk management in place.	Reasonable
2	The use of the network is managed to ensure stability, and capacity is appropriate for the organisation.	Substantial

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
2	Old equipment	1	Operational	Medium
3	Alerts process	1	Design	Medium
4	Patch process	1	Operational	High
5	Environmental controls	1	Operational	Medium

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or 'organisation') we reviewed the management of IT Infrastructure.

1.2 The purpose of the review was to provide assurance that a process is in place for ensuring that the infrastructure hardware is tracked, maintained, and supported and that the network is managed sufficiently to provide services for the Health Board.

1.3 The review considered the infrastructure equipment which is managed / controlled by the Health Board and not the management of national infrastructure.

1.4 The potential risk considered in the review was as follows:

i. Loss of key processing or networking services.

2. Detailed Audit Findings

Objective 1: The IT infrastructure is maintained with appropriate monitoring, support, and risk management in place.

2.1 A complete and accurate asset register is a necessary control in the effective maintenance and operation of any IT infrastructure. However, there is currently no definitive, single asset register. Assets are recorded across several spreadsheets.

2.2 The Health Board has assigned a fixed term asset manager role with a specific aim to identify and collate the assets for the three main sites into a single register / configuration management database (CMDB).

2.3 The Health Board use a software tool, Track IT, to record end user devices (EUD) including printers. This records desktop devices, laptops and tablets and currently contains information on over nine thousand devices used across the organisation.

2.4 There are spreadsheet records of infrastructure equipment relating to Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) which include servers, network devices such as switches, and firewalls. However, at present there is limited asset information for the Princess Of Wales (PoW) site due to the lack of access into the network by Health Board staff. We understand that the intent for the register is to develop a fully functional CMDB which will contain all relevant information about the hardware and software components used at the three sites, and show the relationships between these components. **Matter Arising 1**.

2.5 Management of infrastructure items within the Bridgend area, which includes the PoW, is currently undertaken by Swansea Bay University Health Board (SBUHB) through a service level agreement (SLA), and as such Health Board staff have limited access to information relating to the current operational state of individual devices. We note that work is ongoing to bring this function in house.

2.6 The infrastructure is built predominantly using Cisco network equipment and Dell servers, with the server estate being largely virtualised. We note that there is

ongoing work to further increase virtualisation, which will reduce the risk associated with individual servers.

2.7 The majority of the infrastructure equipment is protected under warranty, although we note that there are some older devices in use that are out of support. At the time of our fieldwork, there were 2,248 Cisco network devices of which 144 were classed as 'Out of Support Date' at the start of 2023. There were also 92 Cisco switches showing an 'end of life' date between March 2014 and October 2021. These network devices are no longer supported, and no updates are provided.

2.8 Furthermore, the server estate contains 57 older servers, including windows 2003 and 2008. These older items present an increased risk of failure and contain security vulnerabilities. **Matter Arising 2**

2.9 The risks associated with the end of life equipment are recorded on the departmental risk register, with actions defined to mitigate the risks. We note that there is a rolling replacement programme that is ongoing.

2.10 There is a process in place for the Health Board to monitor the 'health' of its IT infrastructure equipment. The Health Board uses the Solarwinds software application, which monitors servers, switches and firewalls and tracks key performance metrics such as CPU utilisation and memory use. Solarwinds is used by ICT staff to monitor Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH). Princess Of Wales Hospital (PoW) is not represented on the Health Board's Solarwinds map as it is monitored by SBUHB IT as part of the SLA agreement, currently, the Health Board manually monitor PoW systems on site at PoW.

2.11 Solarwinds provides a dashboard functionality, which shows the current position of the infrastructure and highlights items with issues, it provides the ability to drill down into individual devices to identify problems. Solarwinds is configured and managed by a single lead individual. There is no documentation for this which leads to a risk of loss of core competency should the individual leave the organisation. **Matter Arising 3**

2.12 The monitoring system produces e-mail and text alerts to report unexpected events or process failures. At present, alerts are issued to the relevant staff involved in server management operations and maintenance. We note that there is no defined SOP for responding to the alerts in terms of prioritising, clearing and reporting them. **Matter Arising 3.**

2.13 Our testing of the functionality of Solarwinds confirmed that it was able to drill into each device. The server team demonstrated how they are able to monitor the server environment. These 'live' remote demonstrations are applicable to RGH and PCH as access to PoW is limited to being on site and is controlled by SBUHB.

2.14 There is a patch process in place, which management review each month. The patch process includes servers and all Window devices. Patching of servers is undertaken in a structured manner using Ivanti Security Controls. While the laptops and desktops are patched using Microsoft System Centre Configuration Manager

(SCCM), the process is not set out within a formal policy or procedure document. **Matter Arising 4**

2.15 Patching of switches is undertaken where possible due to the location and disruption some switches may cause as a result of a re-boot after patching. However, we note that switches are 'monitored' for vulnerabilities and are patched at a 'convenient' time for the individual departments. As such, there are some switches not running the most up to date software, meaning that the versions in place contain security vulnerabilities. We acknowledge that there is a balance between disruption and security, however this decision and rationale is not set out within any formal documentation. **Matter Arising 4.**

2.16 Solarwinds backs up all switch configurations each night, therefore no configuration is more than twenty-four hours old. Solarwinds uses Network Configuration Manager to 'push' out any configuration changes to switches, routers and fire walls when required. Going forward, we note that management plan to develop SCCM to link into Track IT and use SCCM Patch Management to distribute security updates to end user devices.

2.17 Infrastructure equipment is held in dedicated, secure rooms within each site. We visited the RGH and PCH data centres and note that they were in good condition with sufficient air conditioning and had a dedicated power supply. There is an uninterruptible power supply (UPS) system in place which is maintained by the Estates department. Estates conduct a regular test on the external generator and the UPS systems. The last generator test was June 2023, while the UPS 1 and UPS 2 were serviced in November 2022. PCH are due to have a generator and UPS test in July 2024.

2.18 We note some issues regarding security at PCH where the room used to house the UPS system was unlocked (the IT portacabin), one of the comms rooms was marked on the door with 'Hub', and the second comms room had windows but no covering which enables people outside to see where key infrastructure items are held. **Matter Arising 5.**

2.19 The Health Board 'inherited' the working environment at PoW when the Bridgend area transferred from the old Abertawe Bro Morgannwg Health Board. While management are in the process of addressing issues, our site visit identified a number of issues relating to the management and security of equipment.

2.20 Cable management at PoW was poor with no labelling, access to the PABX room at PoW was unlocked and the condition of the room was poor. We also noted that the comms room within the young patients' mental health building at PoW has no air conditioning. The room temperature was in excess of 25c degrees, which leads to a risk of equipment overheating and failing. **Matter Arising 5.**

Conclusion:

2.21 Generally, the Health Board is aware of the infrastructure items it holds, although the information is documented across a number of registers. The infrastructure is mainly within its normal life, however there are a number of older items in place which introduce security vulnerabilities. There is a process for monitoring and

managing the infrastructure estate, and a process for patching end user devices and servers, however, switches are not subject to such rigorous patching. The infrastructure items are generally held in secure, environmentally protected areas, although there are weaknesses, in particular within the PoW site. Accordingly, we have provided **Reasonable** assurance over this objective.

Objective 2: The use of the network is managed to ensure stability, and capacity is appropriate for the organisation.

2.22 There is a team in place with responsibility for managing the network, with dedicated (sub) teams for specific areas.

2.23 We note that although there are visual representations of the network within the monitoring tools, there is limited documentation relating to the network. Currently there are no Visio (or similar) diagrams depicting the network topology. **Matter Arising 6**

2.24 As we note above, Solarwinds is used to monitor the performance of the network and enables management to identify issues with network routing.

2.25 Monitoring is also undertaken using the Castle Rock tool and Cisco Prime, which tracks the use and stability of the network. The monitoring processes for the network team provide dashboards and highlights the nodes with the most alerts triggered. There are also alerts provided by text and email to key staff within the department.

2.26 There is good Wi-Fi coverage within the Health Board, although there are some anomalies in PCH due to asbestos in areas, and some black spots with lower quality or absent Wi-Fi are present in RGH due to the fabric of the building. There are heat maps showing the availability and coverage in the areas.

2.27 The network capacity is sufficient. There have been recent improvements, with 10GB links between the main sites, although this is currently limited to 3GB by BT. RGH and PCH are running close to this limit, but increased capacity can be released if needed.

2.28 Smaller sites have an average of 1GB link and some remote sites have been upgraded to fibre. We understand that management consider the current capacity to be appropriate.

Conclusion:

2.29 The network provision is appropriate to the needs of the organisation, and there have been recent improvements. The use and stability of the network is monitored with an alert process in place. Accordingly, we have provided Substantial assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: IT asset register (Operation)			Impact
There is no definitive, single IT asset register, currently assets are captured in several spreadsheets. In addition, asset information for PoW is limited. We note that the Health Board has assigned a fixed term asset manager role with a specific aim to identify and collate the assets for all three sites into a single register / configuration management database (CMDB).			Potential risk of: • Loss or misconfiguration of assets
Recommendations			**Priority**
1.	Work to complete the register / CMDB should be progressed. Asset information for the Bridgend area should be included and kept up to date.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	The Asset manager has been extended to March 2024. They will continue to gather and maintain records of these assets. Service Management tooling and the related CMDB are not in place and a system for this requires investment. A case will be developed to support with the specification, costs and resources required for this.	29/03/2024	Assistant Director of Digital Delivery

Matter Arising 2: Old equipment (Operational)			Impact
There are some older devices in use that are no longer supported. At the time of our fieldwork, there were 2,248 Cisco network devices, such as switches, of which, 144 were classed as 'Out of Support Date' by the start of 2023. There were also 92 Cisco switches showing an 'end of life' date between 31 March 2014 and 31 October 2021. Furthermore, the server estate contains 57 older servers, including windows 2003 and 2008. These older items present an increased risk of failure and contain security vulnerabilities which increase the risk of inappropriate access to data and systems.			Potential risk of: • Essential kit failing in sensitive areas. • Vulnerability exposure.
Recommendations			**Priority**
2.1	Older, out of support devices should be removed from use.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Continue to prioritise and review aged assets with a view to replacement, balanced with limited funding sources. Manage and maintain the related risk within the Departmental risk register.	Ongoing	Assistant Director of Digital Delivery

Matter Arising 3: Alert process (Design)			Impact
We note that Solarwinds, which monitors servers, switches and firewalls and tracks key performance metrics such as CPU utilisation and memory use, is configured and managed by a single lead individual, however there is no documentation for this which leads to a risk of loss of core competency should the individual leave. In addition, there is no defined Standard Operating Procedure (SOP) for how to action, prioritise and clear alerts. The lack of SOPs leaves the handling and interpretation of alerts to the individual to make a judgment call. This may lead to an inconsistent approach and ambiguity when presented with an alert.			Potential risk of: • Unactioned alerts lead to failure.
Recommendations			**Priority**
3.1	Documentation should be produced that sets out the processes for: - Managing and configuring Solarwinds; and - Handling of alerts.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The individual has now left. Management of the SolarWinds platform is now shared across the infrastructure team, although there is no lead and documentation produced is of limited value. Develop the skills and documentation within the team to maximise the use and value of the system for monitoring purposes. Recruit Additional staff in line with the Infrastructure Review resource plan.	28/06/2024	Assistant Director of Digital Delivery

Matter Arising 4: Patch process (Operational)			Impact
There is a patch process in place, but the process is not documented within a formal policy or procedure. Patching of switches (devices that provide the network) is undertaken where possible due to the location and disruption some switches may cause as a result of a re-boot after patching. As such, there are switches not running the most up to date software, and the versions in place contain security vulnerabilities. We note that there is a balance between disruption and security, however this decision and rationale is not set out within formal documentation.			Potential risk of: • Security vulnerabilities
Recommendations			**Priority**
4.1	The approach to patching and the mechanisms for undertaking this should be set out within formal documentation.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Create a patching policy and procedure document to cover patching of managed devices.	29/12/2023	Interim Head of Cyber Security

Matter Arising 5: Environmental controls (Operational)	Impact
We note issues within the physical environment for infrastructure equipment: • At PCH the door of the Hub room, which contains the network equipment, was labelled HUB. • Cable management at PoW was poor, with no labelling or use of colours for specific connection types. • Not all the comms rooms, where network equipment is held, that we visited had air conditioning or an uninterrupted power supply (UPS). • Access to the PABX comms room on the ground floor of PoW was via the main switchboard area and was unlocked. • The overall condition of the PABX comms room of PoW was very poor, for example, water pipes traverse the data cabinets. • the comms room within the young patients' mental health building at PoW, was internal to the building and therefore has no windows and was on the first floor. The room was approximately 10m^2 and clean, but has no air conditioning. The room temperature was in excess of 25c degrees, which leads to a risk of equipment overheating and failing.	Potential risk of: • Unauthorised access to the comms rooms. • Damage and loss of equipment and service.

Recommendations		Priority
5.1	Doors to rooms should be locked when not in use, and signage that indicates where equipment is held should be removed.	**High**
5.2	Rooms used to house equipment within PoW, should be assessed to ensure appropriate power and heat protection is in place.	

Agreed Management Action		Target Date	Responsible Officer
5.1	This action will be reviewed in detail and prioritised plan will be developed in order to ensure the areas of highest risk are addressed.	30/11/2023	Assistant Director of Digital Delivery

Matter Arising 6: Network diagram (Operational)			Impact
While there are visual representations of the network within the monitoring tools, there is limited documentation relating to the network. Currently there is no Visio (or similar) diagrams depicting the network topology. As such, the Health Board is reliant on the continued operation of the monitoring tools and staff knowledge in order to be able to map and plan the network.			Potential risk of: • Loss of service
Recommendations			**Priority**
6.1	The network topology and make up should be recorded outside of the monitoring tools.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Plans in place to review and document individual sites. Staffing levels will determine the time it will take to complete the work. Priority will be given to the critical sites, as this also supports the review work required for NIS-D assessment.	29/03/2024	Head of Voice and Data Communications

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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