

CTM Audit & Risk Committee

Thu 15 August 2024, 10:30 - 12:30

Virtual Via Teams



Agenda

10:30 - 10:35
5 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Patsy Roseblade, Chair

1.2. Apologies for Absence

Information Patsy Roseblade, Chair

1.3. Declarations of Interest

Information Patsy Roseblade, Chair

10:35 - 10:45
10 min

2. CONSENT AGENDA

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 20th June 2024

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

2.1.1 Unconfirmed Minutes 20.06.24 CTM ARC 15 August 2024 v3 PR.pdf (11 pages)

2.1.2. Unconfirmed In Committee Minutes of the Meeting held on 20 June 2024

2.1.2 Unconfirmed In Committee Minutes ARC 20 June 2024 v2 PR SM.pdf (4 pages)

2.1.3. Unconfirmed Minutes of the Extra Ordinary Meeting held on 10 July 2024

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

2.1.3 Unconfirmed Minutes EO ARC 10.07.24 ARC 15th August 2024 v1 GW.pdf (6 pages)

2.1.4. Committee Annual Report 2023-24

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

2.1.4a Committee Annual Report 2023-24 ARC 15 August 2024.pdf (4 pages)

2.1.4b Draft Audit Committee Annual Report 2023 2024 ARC 20 June 2024.pdf (16 pages)

2.2. Items for Noting

2.2.1. Annual Cycle of Business 2024-25

Information Gareth Watts, Director of Corporate Governance/Board Secretary

2.2.1 Annual Cycle of Business Cover Report ARC 15 August 2024.pdf (4 pages)

2.2.1a Appendix 1 - Annual Cycle of Business ARC 15 august 2024.pdf (4 pages)

2.2.2. Committee Forward Work Plan

Information *Patsy Roseblade, Chair*

 2.2.2 Forward Work Plan Audit & Risk Committee 15 August 2024.pdf (4 pages)

2.2.3. Declarations of Interest and Gifts and Hospitality Report

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

 2.2.3a DOI and GHS Cover Report - August 24.pdf (4 pages)

 2.2.3b Appendix 1 - Declarations of Interest Register 24-25 Board and Non Board.pdf (13 pages)

10:45 - 10:55 3. MAIN AGENDA

10 min

3.1. Action Log

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

 3.1 Action Log ARC 15 August 2024.pdf (7 pages)

3.2. Matters Arising Not Contained Within the Action Log

Discussion *Patsy Roseblade, Chair*

10:55 - 11:25 4. SUSTAINING OUR FUTURE

30 min

4.1. Local Counter Fraud Report

Discussion *Matthew Evans, Local Counter Fraud Officer*

 4.1 Local Counter Fraud Update Report ARC 15 August 2024.pdf (3 pages)

 4.1a Local Counter Fraud Update Report ARC 15 August 2024.pdf (3 pages)

 4.1b Appendix 1 Counter Fraud Benchmark Report ARC 15 August 2024.pdf (5 pages)

 4.1c Appendix 2 -Counter Fraud Investigations Update ARC 15 August 2024.pdf (12 pages)

4.2. Procurements & Scheme of Delegation Report

Information *Sally May, Director of Finance*

 4.2 Procurement SoD ARC 15 August 24.pdf (9 pages)

4.3. Losses & Special Payments Report

Discussion *Sally May, Director of Finance*

 4.3 Losses Special Payments Report ARC 15 August 2024.pdf (9 pages)

 4.3a Report Appendices June 24.pdf (8 pages)

4.4. Breaches to the Standing Orders

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

 4.4 Breaches to Standing Orders ARC 15 August 2024 - CH.pdf (4 pages)

11:25 - 12:20 5. IMPROVING CARE

55 min

5.1. Organisational Risk Register

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

- 📄 5.1a Org RR July 24 - Cover Paper - ARC 15 August 2024.pdf (8 pages)
- 📄 5.1b App 1 Org RR July - ARC 15 August 2024.pdf (8 pages)

5.2. Audit Recommendations Tracker

Information Gareth Watts, Director of Corporate Governance/Board Secretary

- 📄 5.2a Audit Recommendations Tracker - ARC 15824 - Cover Paper.pdf (9 pages)
- 📄 5.2b Appendix 1 - AMaT Audit Recommendations Tracker_ARC 15.08.2024.pdf (18 pages)
- 📄 5.2c Appendix 2 - Audit Tracker Devpt Work Prog LIVE as at 31.07.2024.pdf (5 pages)
- 📄 5.2d Appendix 3 - HIW Tracker Quality & Safety Committee 23.07.2024 1.1.pdf (25 pages)

5.3. JAG Update

Discussion Gethin Hughes, Chief Operating Officer

- 📄 5.3 JAG Update ARC 15 August 2024.pdf (7 pages)

5.4. Internal Audit Progress Report

Discussion Paul Dalton, Head of Internal Audit

- 📄 5.4 IA Progress Report ARC 15 August 2024.pdf (7 pages)

5.4.1. Internal Audit Review – PCH Key Project Objectives

Discussion Internal Audit

- 📄 5.4.1 IA Review - PCH Key Project Objectives Final Report ARC 15 August 2024.pdf (20 pages)

5.4.2. Internal Audit Review - PCH Plan 2024/25

Discussion Internal Audit

- 📄 5.4.2 IA Review - PCH - Audit plan 2024-25 ARC 15 August 2024.pdf (5 pages)

5.4.3. Internal Audit Review - Technical Resilience (Updated Management Actions)

Discussion Internal Audit

- 📄 5.4.3 IA Review - Technical Resilience Updated Mmt Actions ARC 15 August 2024.pdf (20 pages)

5.5. Audit Wales - Audit & Risk Committee Update

Discussion Audit Wales

- 📄 5.5 Audit Wales Update Report ARC 15 August 2024.pdf (12 pages)

5.5.1. Audit Wales Report - MIU Follow Up

Discussion Audit Wales

- 📄 5.5.1 Audit Wales YCC MIU Follow up Report ARC 15 August 2024.pdf (10 pages)

5.5.2. Audit Wales Report - Joint Review Follow Up - Quality Governance

Discussion Audit Wales

- 📄 5.5.2 Audit Wales Outcome of Joint Review Follow Up Quality Governance (July 2024) ARC 15 August 2024.pdf (8 pages)

12:20 - 12:25 5 min 6. CLOSE OF BUSINESS

6.1. Any Other Urgent Business

Discussion Patsy Roseblade, Chair

6.2. Committee Highlight Report to Board

Discussion Patsy Roseblade, Chair

12:25 - 12:30 7. PRIVATE/IN COMMITTEE SESSION

5 min

Discussion Patsy Roseblade, Chair

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

Organisational Risk Register - Business Sensitive Risks

Audit Recommendations Tracker

12:30 - 12:30 8. DATE AND TIME OF NEXT MEETING

0 min

Information Patsy Roseblade, Chair

17th October 2024 at 2:00 pm

Agenda Item Number:

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee Meeting Held via Microsoft Teams

20 June 2024

Members Present:	
Patsy Roseblade Ian Wells Kath Palmer Geraint Hopkins	Independent Member (Chair) Independent Member (Vice Chair) Independent Member (Health Board Vice Chair) Independent Member
In Attendance:	
Sally May Dom Hurford Vicki Wallace Paul Dalton Emma Samways Martyn Lewis Matthew Evans Mark Jones Nathan Crouch Owen James Amanda Legge Gareth Watts Claire Brown Kelly Eddington Sue Baxter Emma Walters Kathrine Davies	Executive Director of Finance & Procurement Medical Director (in-part) Deputy Director of Strategy & Partnerships (in-part) NWSSP- Internal Audit & Assurance NWSSP- Internal Audit & Assurance NWSSP- Internal Audit & Assurance Head of Local Counter Fraud Services Audit Wales Audit Wales Head of Corporate Finance Post Payment Verification Manager (in-part) Director of Corporate Governance/Board Secretary Head of Quality Assurance and Compliance Quality Assurance & Compliance Officer Head of Partnership Governance, NHS West Yorkshire Integrated Care Board (Observing) Head of Corporate Governance & Board Business Corporate Governance Manager (Secretariat)
1.	PRELIMINARY MATTERS
1.1	Welcome & Introduction P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would

	be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.
1.2	Apologies for Absence There were no apologies received.
1.3	Declarations of Interest There were no interests declared.
2.	CONSENT AGENDA
2.1	FOR APPROVAL
2.1.1	Unconfirmed Minutes of the Meeting held on 18 April 2024
Resolution:	The Minutes were APPROVED as a true and accurate record subject to one minor amendment of apologies for K. Palmer, Independent Member.
2.1.2	Unconfirmed Minutes of the In Committee Meeting held on 22 February 2024
Resolution:	The Minutes were APPROVED as a true and accurate record subject to one minor amendment of apologies for K. Palmer, Independent Member.
2.2	FOR NOTING
2.2.1	Audit & Risk Committee Annual Cycle of Business for 2024-25
Resolution	The Committee NOTED the Annual Cycle of Business.
2.2.5	Committee Forward Work Plan
Resolution	The Committee NOTED the forward work plan.
3.	MAIN AGENDA
3.1	Audit & Risk Committee Action Log The Committee reviewed the Action Log and noted the following updates from G. Watts:

	• 3.2 Committee Effectiveness Survey - The Statement of Internal Control was a precursor to the Annual Governance Statement, which the Committee will now review as part of the year end Annual Report and Accounts. The Assurance Framework should be referenced as the Board Assurance Framework for the health board and the terminology will be updated in the next Annual Survey to ensure that Members and attendees have clarity on what is being referred to. • 4.1 Local Counter Fraud Annual Report – The Annual Report has now been amended and is attached to the Local Counter Fraud Report as an appendix. • 4.5 Progress on the Grant Thornton Recommendations – Wording has been revised in relation to the Born Well Strategy and was circulated to members in April 2024. • Audit Recommendations Tracker – Bridgend Transfer of Services – update was provided to I. Wells outside of the meeting. • 5.5.3 Internal Audit Review – Ongoing with Head of Pharmacy and hoping to bring an update to the August 2024 meeting. • 5.5.5 Internal Audit Review Decarbonisation – On Agenda for the meeting today. The Chair referred to the action in relation to the JAG Accreditation and sought an update on when the Committee would receive a report or presentation. G. Watts advised that he would query this following the meeting.
Resolution	The Committee NOTED the Action Log and updates provided.
Action	To query the outstanding action in relation to the JAG Accreditation update.
3.1.1	Matters Arising not Contained within the Action Log There were no matters arising.
4.	SUSTAINING OUR FUTURE
4.1	Local Counter Fraud Update Report M. Evans presented the report that provides detail on tasks and actions undertaken with the four strategic counter fraud work areas. I Wells referred to the upcoming trial and queried what arrangements were being put in place with regard to communications due to the possibility of national and local media interest. M. Evans advised that they were in contact with the Communications Team and will have extra auxiliary support in place if required. The Chair commented that the benchmarking for attendees at live trials training events was significantly lower than the Welsh average. M. Evans

Resolution:	advised that they had looked at other mechanisms of communicating to staff and the message was getting across but historically it had been a problem. He added that a guilty verdict would help to attract interest in counter fraud and the internal communications were lined up to make the most of that opportunity and embed this into the minds of staff. G. Watts advised that since he has been in post he had been raising the profile of governance at the Executive Leadership Group. In terms of the live trial Executive colleagues are aware of it receive weekly updates. G. Watts advised that he would be happy to work with M. Evans to potentially showcase some of the work that he undertakes and also the training available to staff for raising awareness. The report was NOTED.
4.2	Losses and Special Payments Report S. May presented the report. The Chair referred to the table with the schedule of personal injury claims and reference numbers and queried whether there was any value in the Committee receiving this information. K. Palmer stated that she agreed with the Chair's comments in that they did not add any value. In response, S. May advised that she would check the exact requirements and review how the report could be better presented. K. Palmer referred to the cash write offs and commented that it would helpful to see how these compared to previous years. S. May advised that they could add some context to this for future reports. K. Palmer sought an explanation with regard to the increase of net claims Expenditure of £421k. S. May advised that it was down to increased levels of claims and costs and it was so important that the clinical governance systems were in place in terms of learning from and managing situations so that future claims do not arise and that was very much part of the Welsh Risk Pool process. She advised that the Committee had received a specific report from the Executive Director of Nursing on how they were managing this. O. James advised that for claims like Clinical and Medical Negligence there is a budget under the Patient Care & Safety Director, so in the vast majority of cases the excess of £25k is charged there. For other claims it will be with the Care Group, but in the majority of cases the value for the claims/costs would be under the excess value anyway, so full value would be charged. However, the number of claims have been high for a couple of years and these were reported to the Directorate on a regular basis, also keeping an eye on the type of claims going through.

Resolution: Action:	O. James advised that they would provide more detail for future reports moving forward looking at the increase or decrease of the provision with the cash write offs and a comparison year on year. I Wells referred to the medical negligence claims on table 2 which were increasing and queried whether there was an underlying cause and whether investigations were carried out as to why they were increasing. S. May advised that the Quality & Safety Committee receive regular reports on claims. In response, D. Hurford advised that claims were increasing across the board and there were a number of very high cost cases. He added that it was a mixture of those high claims and that people were making claims now when they previously would not have. The Chair queried whether fewer claims led to a reduced contribution to the overall cost and whether the health board benefited from that. S. May advised that over the last year and the overall pot had increased by around £0.5m based on the fact that their share of the claims had increased. The Committee: • NOTED the losses and special payments made for the period 1 January 2024 to 31 March 2024. • NOTED the Welsh Risk Pool overspend and the CTM share of overspend; which has been incorporated into the LHB's annual final revenue position. • NOTED the overspend on net claim expenditure and the impact of this on the final in-year revenue position highlighted in Table 2. This expenditure is charged to the Patient Care & Safety revenue position. To provide more context to the report for future meetings including comparators for year on year with regard to cash write offs.
4.3	Procurement & Scheme of Delegation Report S. May presented the report for Committee and highlighted the position on procurement matters for the period 1st February 2024 to 31st March 2024. K. Palmer referred to the Business Case for the Hospital Sterilisation and Decontamination Unit that had not been approved but the member of staff had then raised eight separate revenue requisitions for the system previously requested via the Capital Business Case. K. Palmer commented that it was good this issue had been identified which in order to ensure that staff follow the correct procedure. S. May confirmed that they were able to manage this within the capital resource limit and this would now provide an opportunity for learning and ensuring that the procurement training is undertaken by staff. The Chair referred to the change in the request for the Standing Financial Instructions and the Scheme of Delegation and queried whether this was

Resolution:	to simplify the process. S. May confirmed that any cases of £0.5m would have to be approved by the Chief Executive and herself. The Committee: • NOTED the position on procurement matters for the period 01.02.24 to 31.03.24 • NOTED the update regarding Purchase to Pay and achievement of PSPP target for period of 2023/24. NOTED the key escalation points raised in relation to non-compliance of procurement processes and payment of NHS invoices without PO. ENDORSED FOR BOARD APPROVAL the update to the Scheme of Delegation detailed in Appendix 1.
4.4	Post Payment Verification Annual Report A Legge presented the end of year Annual Report for 2023-24. K. Palmer queried the process for dentistry and who had the responsibility for reporting this. A Legge advised that it was undertaken by the Business Services Centre and was never moved across to Shared Services. The Chair queried why they had not included the normal tables with the report that they had previously received. A Legge advised that they had been asked to cut down on the detail of the report and not narrowing down to individual practices. However, she advised that if the Committee require further detail and information she would be happy to provide this outside of the meeting.
Resolution:	The report was NOTED .
5.	IMPROVING CARE
5.1	Organisational Risk Register G. Watts presented Members with the report and highlighted key updates to members. I. Wells referred to the new risk 5755 for the Children and Family Care Group where the electrical system had failed and queried if that had already happened as there was no detail. G. Watts advised that he was not sure of the detail but would take this away and check. K. Palmer referred to the timescales for the controls on risk 5177 and sought an update on this. G. Watts advised that some of the risks had been updated since this report had been produced. However, he confirmed that he would check on this as a priority and would respond back to the Committee.

Resolution Action	The Chair referred to risk 1183 with regard to long term sustainability of staff in the Royal Glamorgan Hospital (RGH) that had been reduced from 20 to 12 but had created an overspend that had added an additional risk and queried whether this was a reasonable way to reduce the risk. G. Watts advised that he would come back on this and provide some clarity. S. May commented that she agreed with the Chair's comments and that the wording 'at risk' meant without a plan and she would expect a plan to be in place in order to manage the risk. The Committee NOTED the report. To provide further clarity and updates with regard to risks 5755 and 1183.
5.2	Audit Recommendations Tracker G Watts presented an update to the Audit & Risk Committee on reported progress of audit report recommendations and actions in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module. K. Palmer thanked the team for all the work they had been undertaken. She referred to the high overdue tracker actions such as the performance management framework Audit Wales 2023, stroke and a request for a refresh of the digital strategy and arrangements for managing service level agreements (SLA's) and asked if these could be reviewed and updated. G. Watts, in response, advised that he had recognised the points made and there is an aspiration to draw out thematic issues that come out of audit reviews. He advised that they would look at these in more detail. G. Watts advised that in terms of digital, discussions had been held with the digital team and this would be updated by the next meeting. I Wells suggested that in terms of navigating lots of different information it would be helpful to have a hypertext link which took you to the table. G. Watts advised that they would take this suggestion on board. N. Couch in response to K. Palmer's comments, advised that Audit Wales would be following up on the recommendations during their structured assessment work and would also be doing a deep dive with regard to the digital strategy within the health board. P. Dalton advised that internal audit have developed a thematic approach looking at common themes and putting some intelligence around them moving forward and he would be happy to work with G. Watts in terms of the work they were considering. E. Samways advised that with regard to the managing of SLA's, internal audit would be undertaking a follow up piece of work on that for this year.

Resolution:	The Chair referred to the June 2022 audit on the patient pathway appointment management process where it stated that internal audit were undertaking an audit and queried if this was part of a regular follow up or whether they were looking to see if this was still relevant given that it referred to the Integrated Locality Groups. E. Samways confirmed that it was a follow up piece of work that would be presented to the next meeting.
Action:	The Audit & Risk Committee NOTED the report and AGREED the assurances provided particularly in relation to closed recommendations.
	To review the high level overdue tracker actions and bring an update back to the next meeting.
5.3	National Clinical Audit Plan D. Hurford presented the Clinical Audit Forward Plan for 2024-2025. I Wells referred to the National Core Diabetes Audit where it had stated that they had been unable to participate due to a technical anomaly/outlier and queried if that had been resolved. D. Hurford confirmed that it had been resolved and that the Care Group Director for Primary Care had now taken over as the primary care lead for diabetes.
Resolution:	The Committee NOTED the report and the update provided.
5.5	INTERNAL AUDIT
5.5.1	Internal Audit Progress Report The Chair advised that there was no progress report on this occasion due to the Internal Audit Annual Report and Opinion being received by the Committee at the 'Closed' In Committee session and provided the status on all the 2023-24 work.
5.5.2	Internal Audit Review – Workforce - Leadership and Management Development P. Dalton presented the report that had been given a 'reasonable' assurance rating.
Resolution:	The report was NOTED .
5.5.3	Internal Audit Review – Welsh Risk Pool (WRP) P. Dalton presented the review of the WRP compensation claims. And had been given a reasonable assurance rating overall. P. Dalton advised that the general trajectory was improving.
Resolution:	The reported was NOTED .
5.5.4	Internal Audit Review – Technical Resilience

Resolution: Action:	M. Lewis presented the report on Technical Resilience that had received an overall reasonable assurance. I Wells referred to the agreed management action at paragraph 4.1 and commented that the response was lacking in assurance for something so important and that he would like more robust information on this to provide assurance. M. Lewis advised that as part of the audit work they had discussed the findings with the digital team who were fully aware of the need to have a recovery plan and what was required to be done. He confirmed that they would ensure that this would be expanded to provide assurance. I Wells referred to paragraph 5.1 and commented that this was the same as 4.1 and required updating. M. Lewis confirmed that he would feedback to the digital team following the meeting and would request an update and bring back to the next meeting. The Committee NOTED the report. Digital Team to provide a more robust update on the agreed management actions on 4.1 and 5.1 and provide an update to the next meeting.
5.4.5 Resolution:	Internal Audit Review – Risk Management E. Samways presented the report that had received a reasonable assurance rating. The report was NOTED.
5.4.6 Resolution:	Internal Audit Review – Revised Decarbonisation Audit V. Wallace presented the report that provided the updated recommendations at 4.1 and 4.2. The Committee NOTED the report.
5.4.7 Resolution:	Internal Audit Review – Adult Mental Health CSG Review E. Samways presented the report that had received a reasonable assurance rating. The Committee NOTED the report.
5.5	AUDIT WALES
5.5.1	Audit Wales Audit & Risk Committee Update M. Jones and N. Couch updated Members on Audit Wales current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.

Resolution:	The report was NOTED .
5.5.2	Audit Wales CTMUHB Detailed Audit Plan 2024 M. Jones and N. Couch presented the report. G. Watts thanked Audit Wales colleagues for the presentation of the report and advised that there were a number of queries that had been raised by himself and colleagues which related to the £24m deficit from 2023 which meant that the Health Board would not be able to meet its financial duty over the three year rolling programme and questioned why this was still flagged as a risk. G. Watts also referred to the audit work completed with regard to the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) that had now formed the NHS Wales Joint Commissioning Committee (JCC) and advised that for transparency and understanding analysing out the cost of the audit work for the core CTM accounts and aspects relating to the JCC would be helpful going forward. M. Jones, in response, advised with regard to the resource limits they had discussed this with the Director of Corporate Governance and that from an Audit Wales perspective there could be a possibility of a significant audit adjustment arising that could offset the £24million deficit and therefore it should be retained as a risk. He confirmed that having spoken with the Auditor General they would provide separate figures in the Audit Plan for CTM and the JCC for 2025. S. May in response, confirmed that she would welcome a breakdown of the audit fees by CTM and JCC going forward.
Resolution:	The Committee NOTED the report
6.	CLOSE OF BUSINESS
6.1	Any Other Urgent Business There was no other urgent business to report.
6.2	How Did We Do The Committee Chair advised that if Committee Members had any comments to raise as to how the meeting went today, then they could share these with herself and the Head of Corporate Governance outside the meeting.
6.3	Highlight Report To Board The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.

7.	PRIVATE/IN COMMITTEE SESSION Members noted the following items were discussed at the In Committee session: • CTMUHB – Draft Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2023-2024 (Including WHSSC, EASC and NIAW Annual Governance Statements / Compliance Statements (as appendices) • Draft Head of Internal Audit Opinion and Annual Report 2023-24 • CTMUHB Draft Accounts 2023-2024 - Draft Subject to Final Audit Review (Including WHSSC and EASC Draft Accounts as appendices) • CTMUHB Audit Enquiries Letter (Including EASC and WHSSC Audit Enquiries Letters as appendices) • Organisational Risk Register - Cyber Security Risks • Audit Recommendations Tracker • Financial Control Procedure – Medical Variable Pay
8.	DATE AND TIME OF NEXT MEETING 10 July 2024 – Extra Ordinary Audit & Risk Committee Meeting to approve the Annual Accounts and Accountability Report

Agenda Item Number:

Cwm Taf Morgannwg University Health Board (CTMUHB)

Minutes of the Audit & Risk In-Committee held on 20 June 2024 held via Microsoft Teams

Members Present:	
Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member (Vice Chair)
Kath Palmer	Independent Member (Health Board Vice Chair)
Geraint Hopkins	Independent Member
In Attendance:	
Sally May	Executive Director of Finance & Procurement
Dom Hurford	Medical Director (in-part)
Paul Dalton	NWSSP- Internal Audit & Assurance
Emma Samways	NWSSP- Internal Audit & Assurance
Matthew Evans	Head of Local Counter Fraud Services
Mark Jones	Audit Wales
Nathan Crouch	Audit Wales
Owen James	Head of Corporate Finance
Abigail Harris	Interim Chief Commissioner, JCC
Stacey Taylor	Director of Finance, JCC
Helen Tyler	Head of Corporate Governance, JCC
Paul Worthington	Lay Member, JCC
Gareth Watts	Director of Corporate Governance/Board Secretary
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Head of Corporate Governance & Board Business
Kathrine Davies	Corporate Governance Manager (Secretariat)
1.	PRELIMINARY MATTERS
1.1	Welcome & Introduction P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.

1.2	Apologies for Absence Apologies were received from: • Stephen Harrhy - Board Director/Chief Ambulance Service Commissioner • Gwenan Roberts – Committee Secretary / Deputy Director Corporate • Jaqueline Maunder-Evans - Committee Secretary and Associate Director of Corporate Services
1.3	Declarations of Interest There were no interests to declare.
2.	DRAFT ANNUAL REPORT 2023-2024
2.1	CTMUHB – Draft Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2022-2023 G. Watts presented the Health Boards’ Draft Annual Report and Annual Accounts for the financial reporting period 2023-2024. The report included the Welsh Health Specialised Service Committee (WHHSC), Emergency Ambulance Services Committee (EASC) and the National Imaging Academy Wales (NIAW) Annual Governance Statements Resolution: The Committee Members ENDORSED the current draft of the Annual report and NOTED the Governance Statements received from the Health Boards’ Hosted Organisations in Appendices 2-4.
2.1.1	Head of Internal Audit Opinion Paul Dalton presented the report. Members noted that a draft opinion of “Reasonable Assurance” was being proposed and noted that a final version of the report would be presented to the July 2024 Extra-Ordinary Audit & Risk Committee for endorsement prior to subsequent Board approval. Resolution: The report was NOTED.
2.2	CTMUHB Draft Accounts 2023-2024 - **Draft Subject to Final Audit Review** S. May presented the draft accounts and updated to the Audit & Risk Committee on the Draft Financial Statements for the financial year ended 31st March 2024. S May highlighted the key risks within the financial year. Members noted that a number of errors had been identified which had been shared with Audit Wales. Resolution: The Committee NOTED:

	- the Draft Annual Accounts for 2023-24, subject to any issues that may arise from the ongoing external audit process. - the key critical judgements and estimates that have been used in the accounting period 2023-24 - the Health Board did not meet two statutory duties for 2023-24: - Revenue Resource Limit - the UHB did not meet its statutory duty of remaining within its Revenue Resource Limit. This is because the Limit is assessed on a 3 year rolling period and in 2022-23 the UHB reported an over-spend of £24,481k. There is an overall cumulative deficit of £24,200k over the 3-year period. The 2022-23 reported deficit will also impact in 2024-25 reported performance against this duty - Approved Integrated Medium Term Plan - the UHB submitted an Annual Plan for the period 2023-2024, however as the Board were unable to approve a financially balanced plan, WG approval was not given and the UHB failed to meet the statutory duty. In October 2023, the UHB received additional allocations of approximately £72m which, together with additional savings of circa £8m, enabled a break-even position (£0.1m surplus) to be reported for 2023-24.
2.2.1	Audit Wales: Audit of the Financial Statements (ISA 260) Report (Including the Letter of Representation and Audit Opinion) – Verbal Update M. Jones provided a verbal update and highlighted key areas to Members attention. Members noted that the final report would be received at the Extra Ordinary Audit & Risk Committee on the 10th July 2024.
Resolution	The report was DISCUSSED and NOTED .
2.3	CTMUHB Audit Enquiries Letter G. Watts presented the report which had been jointly produced by Corporate Governance with Finance and Counter Fraud colleagues and had been shared with Audit Wales. The report also included the Emergency Ambulance Services Committee (EASC) and Welsh Health Specialised Services Committee (WHSSC) Audit Enquiries Letters as Appendices.
Resolution:	The Committee NOTED the Health Boards response to the Audit Enquiries letter included at Appendices
3.	GOVERNANCE AND RISK ACTIVITY
3.1	Organisational Risk Register

Resolution:	G Watts presented the report for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed. The Organisational Risk Register was DISCUSSED and NOTED.
3.2	Audit Recommendations Tracker G Watts presented an update to the Audit & Risk Committee on reported progress of audit report recommendations and actions in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module.
Resolution:	The report was NOTED and the assurances provided were AGREED.
3.3	Financial Control Procedure – Medical Variable Pay – Summary Authorised Breaches D. Hurford presented the report on the Financial Control Procedure Medical Variable Pay.
Resolution:	The report was NOTED.
4.	ANY OTHER BUSINESS There was no other business raised.
5.	DATE AND TIME OF NEXT MEETING Extra Ordinary Meeting - 10 July 2024 at 15:30pm to APPROVE the Annual Accounts and Accountability Report.

Agenda Item Number:

Unconfirmed Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Extra Ordinary Audit & Risk Committee Meeting Held via Microsoft Teams

10 July 2024 at 4:00 pm

Members Present:	
Patsy Roseblade Ian Wells Kath Palmer Geraint Hopkins	Independent Member (Chair) Independent Member (Vice Chair) Independent Member Independent Member
In Attendance:	
Jonathan Morgan Paul Mears Sally May Emma Samways Mark Jones Anthony Veale Steve Stark Abigail Harris Jacqueline Maunder- Evans Stacey Taylor Paul Worthington Owen James Gareth Watts Cally Hamblyn Emma Walters	Health Board Chair (In part) Chief Executive Officer Executive Director of Finance & Procurement NWSSP- Internal Audit & Assurance Audit Wales Audit Wales Audit Wales Interim Chief Commissioner Joint Commissioning Committee Committee Secretary and Associate Director of Corporate Services, Joint Commissioning Committee Director of Finance Joint Commissioning Committee Lay Member, Joint Commissioning Committee Head of Corporate Finance Director of Corporate Governance/Board Secretary Assistant Director of Governance & Risk Head of Corporate Governance & Board Business
1.	PRELIMINARY MATTERS
1.1	Welcome & Introduction P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the

	recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.
1.2	Apologies for Absence Apologies for absence were received from: Paul Dalton, Head of Internal Audit
1.3	Declarations of Interest There were no interests declared.
2.	ANNUAL REPORT 2023-2024
2.1	CTMUHB Annual Report and Annual Accounts 2023-2024 G. Watts presented the Annual Report incorporating the Accountability Report at Chapter 2, (Incorporating the Governance Statement, Statement of Directors Responsibilities and the Remuneration Report), in conjunction with the Annual Accounts that will be submitted to Welsh Government by the 15th July 2024 as a single unified document. G. Watts advised that the Draft Annual Report and Accounts had previously been received by the Committee at their June 2024 meeting. He advised that the purpose of the Extra Ordinary meeting today was to seek Endorsement from the Committee for Board Approval. G. Watts reminded the Committee that the Health Board's Annual Report and Accounts are produced to a prescribed format set out by the Treasury and Welsh Government. G. Watts outlined that the next stage of the process should the Committee endorse the Annual Report and Accounts, would be for Board approval on the 11th July 2024 and then certification by the Auditor General for Wales on the 12th July and then the document would be laid before the Senedd. G. Watts advised that there were a number of changes from the last time the Committee had received the Annual Report and Accounts and these were summarised in the cover report. G. Watts added that the most substantive changes were the insertion of the Auditor General for Wales' Certificate and his report. He advised that other minor changes were with regard to page numbering and timing issues with the random waste

	management performance monitoring data which had now changed from estimated to confirmed figures. G Watts recognised the efforts involved in the development of the Annual Report and thanked all colleagues involved. S May provided an update in relation to the accounts highlighting a small number of misstatements which were identified since the submission of the draft accounts. All the amendments had been processed to the satisfaction of Audit Wales. Other minor corrections were also identified and the Committee were assured that these had been resolved appropriately. K. Palmer raised a point of accuracy on the Accountability Report at Chapter 2 that stated that the Annual General Meeting would be held in July and was in fact now being held in September 2024. G. Watts confirmed that the date would be amended to reflect September 2024 in readiness for the Board Meeting on the 11th July 2024. J. Maunder Evans provided assurance that the Annual Governance Statements for the predecessor organisations, Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), and the Compliance Statement for the National Collaborative and Commissioning Unit (NCCU) had been approved by the new Joint Commissioning Committee as Legacy Documents on the 21 May 2024. P. Worthington advised the Committee that the WHSSC and EASC documents date had been amended to 2024 following a query at the last meeting. P. Worthington referred to paragraph 2.51 on the WHSSC report where it stated that the new JCC would continue to utilise the CTM Audit and Risk Hosted Bodies Committee. He advised that the JCC would be looking at its own Sub Committee structure which would include the JCC setting up its own Audit & Risk Committee. G. Watts, in response, advised that these arrangements had been approved as part of the governance work which took place in creating the JCC. The principles behind this were set out in the JCC approved Accountability Map. Any future changes with respect to governance and accountability arrangements would have to be approved by all Health Boards. J. Maunder-Evans clarified that the JCC were having discussions internally on the Sub Committee structure that would be the most appropriate for the JCC. The views of Health Boards would be sought before any changes would proceed. In response, A. Harris advised that the JCC were working through their governance structure and once completed, a proposal would be brought
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Resolution	to the Members of the JCC with options on how to progress. She added that the JCC Chair was mindful that there was a role of this Committee and it was important not to duplicate. The Audit & Risk Committee was asked to: ENDORSE FOR BOARD APPROVAL • The Annual Report & Accounts for 2023-2024 - Appendix 1 for onward approval by the Board. • The Letter of Representation (Included in the ISA 260 at Agenda item NOTE • The Governance Statements & Accounts received from the Health Board's Hosted Organisations (Agenda items 2.1.1 – 2.1.5). • The Proposed audit opinions in relation to true and fair view (Unqualified) and regularity of expenditure (Qualified) by Audit Wales following review.
2.1.1 Resolution	Welsh Health Specialised Services Committee (WHSSC) Annual Governance Statement 2023-2024 The Annual Governance Statement was NOTED.
2.1.2 Resolution	Emergency Ambulance Services Committee (EASC) Annual Governance Statement 2023-2024 The Committee NOTED the EASC Annual Governance Statement for 2023-2024.
2.1.3 Resolution	National Collaborative Commissioning Unit Governance Compliance Statement 2023-24 The Governance Compliance Statement for 2023-2024 was NOTED.
2.1.4 Resolution	National Imaging Academy for Wales Governance Compliance Statement 2023-24 The Committee NOTED the Governance Compliance Statement.
2.1.5	WHSSC and EASC Annual Accounts 2023-2024 S. Taylor presented the WHSSC and EASC Annual Accounts for 2023-2024 and highlighted key areas for the Committees' attention.

Resolution	S. Taylor provided a brief update on the WHSSC and EASC accounts and extended her thanks to S. May and O. James for their support during the accounts processing period. She advised that a paper has been drafted by way of an update and was included as part of the papers. The Committee NOTED the report.
2.2	Head of Internal Audit Opinion and Annual Report 2023-2024 E. Samways presented the Annual Report that sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. Members noted that a Reasonable Assurance opinion has been provided to the Health Board
Resolution	The report was NOTED.
2.3	Audit of the Financial Statements (ISA 260) Report (including the Letter of Representation and Audit Opinion) M. Jones and A Veale presented the report and updated the Committee on auditing, certifying and reporting on Cwm Taf Morgannwg University Health Board's financial statements for the year ended 31 March 2024. M. Jones highlighted the following key matters: • Audit Wales' Audit of Accounts Report sets out that it is proposing to give an unqualified true and fair opinion, however, a qualified regularity opinion on the accounts; • As previously highlighted to the Audit & Risk committee the opinion in respect of regularity of expenditure is qualified because the Health Board did not meet its revenue resource allocation over the three-year period ending 31 March 2024, due to the reported deficit that occurred in 2022/23, which has led to an overspend over the three year period 2021/22 to 2023/24 of £24.2m; • Recognised the success of the audit, which is reflected in the low number of corrections in comparison to the size of the organisation; • Noted that final checks will be made on the morning of the 12th July prior to certification by the Auditor General; • It is anticipated that the Annual Report and Accounts will then be laid by the Senedd either on the 12th July or the 15th July; • The Annual Report and Accounts will be submitted to Welsh Government no later than midday on the 15th July 2024; A Veale extended his thanks to the Finance Teams of both the Health Board and the JCC for producing the accounts in such a short time frame. He also thanked the Corporate Governance team for their assistance in supporting and pulling everything together.
Resolution	The report was NOTED.

3.	ANY OTHER BUSINESS There was no other business to report.
4.	DATE AND TIME OF NEXT MEETING 15 August 2024 at 10:30 AM



Agenda Item

2.1.4a

Audit & Risk Committee

AUDIT & RISK COMMITTEE ANNUAL REPORT 2023-24

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
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	Endorse for Board Approval
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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	
ARC	Audit & Risk Committee
CTMUHB	Cwm Taf Morgannwg University Health Board

1. Situation /Background

- 1.1 The purpose of this report is to highlight the activities and performance of the Audit & Risk Committee (ARC) during 2023-2024.
- 1.2 The Chair of the ARC is required to present an annual report outlining Committee business throughout the financial year to provide the Board with assurances on the monitoring and scrutiny undertaken in relation to those issues set out under the Terms of Reference (TOR) for this Committee.
- 1.3 The Committee's draft Annual Report for 2023-2024 is presented at **Appendix 1** for endorsing.
- 1.4 The revised Terms of Reference for the ARC Committee were last approved by the Board in May 2023 and are available on the Health Boards website via the following link: [Standing Orders - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](https://nhs.wales).
- 1.5 An annual self-assessment questionnaire is also required to be undertaken and this will be completed by members outside of the meeting, the results of which will be reviewed at the October 2024 meeting

2. Specific Matters for Consideration

- 2.1 The Committee is asked to approve the Audit & Risk Committee Annual Report for 2023-2024.

3. Key Risks / Matters for Escalation

- 3.1 The publication of the annual report demonstrates compliance with the Standing Orders, which stipulates that each Committee is required to submit an annual report to the Board through the Chair at the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

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:
	Not Applicable



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)	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable.
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i> <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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 are asked to **ENDORSE FOR BOARD APPROVAL** the Audit & Risk Committee Annual Report for 2023-24.

6. Next Steps

- 6.1 Members of the Committee to undertake its Annual Self Effectiveness Survey to be reviewed at the October 2024 meeting.

Audit & Risk Committee

Committee Annual Report 2023-2024

AUDIT & RISK COMMITTEE ANNUAL REPORT 2023-2024

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2023-2024.

I would like to recognise the significant commitment of all the officers of the Committee who have supported and contributed to the work carried out and for their continued dedication in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales and Local Counter Fraud Services.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long term aim to help further strengthen the governance arrangements of the Health Board.

Patsy Roseblade
Chair of the Audit & Risk Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The Committee's business cycle runs from the closure of the Annual Accounts in one financial year to the next. This reflects its key role in the development and monitoring of the Governance and Assurance framework for Cwm Taf Morgannwg University Health Board (CTMUHB), which culminates in the production of the Accountability Report including the Governance Statement.

The Terms of Reference for the Committee were reviewed and were formally approved by the Board in May 2023. As part of the wider review being undertaken in relation to the Effective Management of Board Business the terms of reference are being reviewed and will be reviewed by the Board in September 2024.

Members will be aware that all papers relating to the Committee (unless closed or 'in-committee') are available on the Health Board [website](#).

This report sets out the role and functions of the Audit & Risk Committee and summarises the key areas of business undertaken during the year. In addition, the report sets out some of the key issues, which the Committee will be focussing on over the next few years.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

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

The Organisation's system of internal control has been designed to identify the potential risks that could prevent Cwm Taf Morgannwg UHB achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur, and seeks to manage them efficiently, effectively and economically. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, the assurance framework may be strengthened and developed further.

The Committee's Terms of Reference are reviewed annually and are included within the Standing Orders for the Cwm Taf Morgannwg UHB.

3.2 MEMBERSHIP

The membership of the Audit & Risk Committee comprises of four Independent members, enabling the Committee to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2023-2024 is outlined in table 1 below:

Table 1 – Composition & Membership of the Audit & Risk Committee April 2023-March 2024

Name	Period
Members	
Patsy Roseblade (Committee Chair) Independent Member	April 2023 – March 2024
Jayne Sadgrove UHB Vice Chair/Independent Member	April 2023 – August 2023
Kath Palmer UHB Vice Chair/Independent Member	November 2023 – March 2024
Ian Wells Committee Vice Chair/ Independent Member	April 2023 – March 2024
Carolyn Donoghue Independent Member	April 2023 – July 2023
Geraint Hopkins Independent Member	July 2023 – March 2024

3.3 ATTENDEES

As Executive leads for the Committee the Executive Director of Finance and the Director of Corporate Governance/Board Secretary attend every meeting as do members and are often accompanied by members of the respective teams. The Committee's work is also informed by reports provided by Audit Wales, Internal Audit, Local Counter Fraud Services and CTMUHB personnel. Although they are not members of the Committee, auditors and other key personnel are expected to attend each meeting of the Audit & Risk Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed by the Audit & Risk Committee.

3.4 ATTENDANCE AT AUDIT & RISK COMMITTEE 2023-2024

During the year, the Committee met on seven occasions.

*Two Extra Ordinary meetings were held during this period - one of which was devoted to the draft Approval of the Annual Accounts (21 June 2023) and one of which was devoted to the Approval of the Annual Accounts and Annual Report (26 July 2023). All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

In Attendance	19 April 2023	21 June 2023	26 Jul 2023*	16 Aug 2023	24 Oct 2023	19 Dec 2023	22 Feb 2024	Total
Patsy Roseblade Committee Chair/Independent Member	✓	✓	✓	✓	✓	✓	✓	7/7
Jayne Sadgrove – Health Board Vice Chair/Independent Member (until August 2023)	✓	✓	X					2/3
Ian Wells – Independent Member/Committee Vice Chair	✓	✓	✓	X	✓	✓	✓	6/7
Carolyn Donoghue – Independent Member (until July 2023)	✓	✓						2/2
Kath Palmer Health Board Vice Chair/Independent Member (from November 2023)						✓	✓	2/2
Geraint Hopkins – Independent Member (from July 2023)			X	✓	X	X	X	1/5

4. AUDIT COMMITTEE BUSINESS

The Audit & Risk Committee provides an essential element of the Health Board's overall assurance framework. It has operated within its Terms of Reference in accordance with the guidance contained within the NHS Wales Audit Committee Handbook.

A Consent agenda approach was adopted across all Board and Committee meetings during 2020 and has continued to be used since. This enabled a number of reports to be received by Members for approval/noting, with an opportunity provided to Members to raise questions against these items in advance of the meeting.

The Audit & Risk Committee agenda broadly followed a standard format, comprising of specific sections, which are outlined below:

4.1 Main Areas of Audit & Risk Committee Activity – Part 1

The agenda for each meeting followed a standard format, broken down into the following 6 main parts:

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda for Approval/Noting

The following written reports were received by the Audit & Risk Committee and considered accordingly:

- Unconfirmed Minutes;
- Action Log;
- Committee Annual Cycle of Business;
- Forward Work Programme;
- Amendment to the Standards of Behaviour Framework Policy – Declarations of Interest Form;
- Declarations of Interest & Gifts and Hospitality Report;
- Clinical Audit Annual Plan and Clinical Audit Annual Report 2023-2024;
- Audit Wales – Annual Audit Enquiries Letter Response;
- Audit & Risk Committee Annual Report;
- Audit & Risk Committee Terms of Reference;
- Audit & Risk Committee Effectiveness Self-Assessment;
- Annual Report Timetable 2023-2024.

It is important to note any member of the committee can request that an item planned for the consent agenda can be moved to the main agenda for discussion.

3. Main Agenda

4. Sustaining Our Future

The following reports were received for discussion:

- Local Counter Fraud Report;
- Counter Fraud Annual Report;
- National Fraud Initiative Progress and Outcomes;
- Counter Fraud Annual Self Review;
- Counter Fraud Draft Work Plan;
- Procurement and Scheme of Delegation Report;
- Post Payment Verification Annual Report and End of Year Update;
- Draft Annual Report and Draft Annual Accounts 2022-2023;
- Losses and Special Payments Report;
- Medical Rostering Six Monthly Progress Report;
- Medical Variable Pay – Rates Agreed above Cap;
- Financial Control Procedure – Medical Variable Pay – Summary of Authorised Breaches;
- Changes to the Welsh Risk Pool Agreement;
- CTMUHB ISO14001 Certification Progress Report;
- National Commissioning Review and the Establishment of the New NHS Wales Joint Commissioning Committee (JCC) Progress Report.

5. Improving Care

The following reports were received for discussion:

- Audit Recommendations Tracker;
- Audit Tracker Automation Update;
- Annual Review - Risk Management Framework
- Consultant Job Planning – Six Monthly Progress Reports;
- Medical Rostering Progress Report;
- Organisational Risk Register;
- Internal Audit – Prince Charles Hospital Redevelopment Programme Integrated Audit Plan 2022-2023;
- Annual Internal Audit Plan and Internal Audit Charter;
- Learning from Events Report;
- Endoscopy JAG Accreditation Closure Report – Progress and Associated Risk Mitigation Verbal Report;
- National Review of Consent to Examination & Treatment Standards in NHS Wales – Final Welsh Risk Pool Report;
- Draft Annual Report and Annual Accounts 2022-2023.

Also received under this section were reports from:

- **Internal Audit**

NHS Wales Shared Services Partnership are the appointed Internal Auditors to the Health Board and provide an update on progress against the internal audit annual plan of business at each meeting together with finalised reports for each area that was subject to audit.

Each report contained an assessment on the level of assurance provided. Follow-up action was agreed for recommendations raised, which informed future audit plans.

- **External Audit**

The Auditor General for Wales (AGW) is the statutory external auditor for the Health Board. The AGW has a wide range of audit and related functions, including auditing the accounts of the Health Board, and reporting on the economy, efficiency and effectiveness with which the Health Board has used their resources. The AGW undertakes his work using staff and other resources provided by Audit Wales. The Engagement Lead and or the Financial Audit Manager from Audit Wales provide an Audit Position Statement at each meeting, summarising progress against its planned financial audit work. Additionally, the Performance Audit Manager will attend work to update the Committee on performance audit work in relation to local audit work, national studies and the Structured Assessment

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

During 2023/2024 The organisations hosted by the Health Board are the Welsh Health Specialised Services Committee (WHSSC), the Emergency Ambulance Services Committee (EASC) and the National Imaging Academy for Wales (NIAW). On the 1st April 2024, the NHS Wales Joint Commissioning Committee (JCC) was established in response to the findings of an independent review commissioned by Welsh Government into the national commissioning arrangements undertaken by the Emergency Ambulance Services Committee (EASC), the Welsh Health Specialised Services Committee (WHSSC) and the National Collaborative Commissioning Unit (NCCU). From April 01 2024, the JCC replaced EASC and WHSSC and has assumed responsibility for the services previously commissioned by these committees.

Regular, standing agenda reporting to the CTMUHB Audit & Risk Committee for Hosted Organisations include;

- Internal and External Audit Plans
- Internal and External Audit Reports with completed management action plans
- Progress reports against audit recommendations (Audit Tracker) NB - to be highlighted to Joint Committee and/or Lead Sponsor if progress is deemed unsatisfactory
- Assurance Framework Report and Risk Register
- Compliance and activity governed by CTMUHB Standards of Behaviour Policy (i.e. Declarations of Interest, Gifts & Hospitality)
- Single Tender Actions
- Breach or waivers to Standing Orders and/or Standing Financial Instructions

To support the Audit & Risk Committee requirements for EASC, WHSCC and the NIAW the Health Board's Audit & Risk Committee is separated into two parts, specifically Part 1 for Health Board business and Part 2 for the Hosted bodies. The relevant officers attend for the relevant components of the meeting.

The Director of Corporate Governance/Board Secretary for CTMUHB also attends both parts of the meetings. The CTMUHB Executive Director of Finance also commenced attending the Hosted Bodies part of the meeting from February 2023.

The WHSSC, EASC and NIAW have shared the same External and Internal Audit teams and Local Counter Fraud Services (LCFS) with CTMUHB. All these factors enable CTMUHB to take necessary assurances from the hosted bodies, particularly in relation to the Accounts and the Annual Governance Statement and vice-versa for areas carried out by CTMUHB as part of its hosting responsibilities.

4.3. WORK/ACTION LOG

In order to monitor progress and any necessary follow up action, in line with recognised 'house style' templates a work log is maintained to capture all agreed actions from the Audit & Risk Committee and Joint Committees. This provides an essential element of assurance both to the Committee and from the Committee to the Board.

5. INTERNAL AUDIT - OVERALL SUMMARY

In overall terms for the year 2023/2024, the Head of Internal Audit opinion provided **Reasonable Assurance** to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the relevant assurance domains. The full opinion report was presented to the Audit & Risk Committee in July 2024 and is available on the link [here](#)

A breakdown of the internal audits results presented to the Audit & Risk Committee and the Board in 2023-2024 is presented at **Appendix 1** for information.

A breakdown of the Audit results for the Hosted Bodies presented to the Audit & Risk Committee and the Board in 2023-2024 is presented at **Appendix 2** for information.

A number of follow up audits were also undertaken within key assurance areas, a list of which is detailed in appendix 1 & 2, together with the respective assurance ratings.

6. EXTERNAL AUDIT

6.1 Audit Wales Audit Wales provide a progress report at each meeting, covering both probity and performance audits. The audit strategy, audit letters and statements of responsibilities were received and the ISA 260¹ Report was approved as part of the Accounts approval process.

The following performance reports and management responses were also discussed during the year, with attendance from UHB Officers where considered appropriate:

- Audit Wales Audit & Risk Committee Update (at each meeting);
- Audit Wales Audit Plan 2023;
- Audit Wales Forward Work Programme 2023-2026;
- Audit Wales/Healthcare Inspectorate Wales Joint Review Follow Up Report;
- Audit Wales Structured Assessment;
- Audit Wales Audit of Accounts Report Addendum;

6.2 Approval of the Annual Accounts

A meeting of the Audit & Risk Committee was convened on 26 July 2023 to scrutinise the 2022-2023 Annual Accounts prior to approval by the Health Board including the letter of representation to Auditors and the Annual Governance Statement. The 2022-2023 Annual Accounts were scrutinised and approved by the Board on 27 July 2023. The meeting also scrutinised the Accounts and Statements for 2022-2023 from the Health Board's hosted organisations as appropriate. The 2023-2024 sign off accounts will be reported in the 2024-2025 Annual Committee Report.

7. PRIVATE MEETING WITH AUDITORS

In line with recognised good practice a private meeting between Audit Committee members, Internal Audit, External Audit and the Local Counter Fraud Specialist can be held as and when required. This provides an opportunity for free and frank discussion. The Audit & Risk Committee Chair also meets privately with Internal Audit and External Audit on occasions. This process will continue for 2024-2025.

8. LINKS WITH OTHER COMMITTEES

8.1 Other Sub Committees

The Audit & Risk Committee has close links with the Quality & Safety Committee and other Committees of the Board. Through either specific

¹ Auditors are required by International Standard on Auditing (ISA) 260 - Communication with those Charged with Governance - to communicate audit matters of governance interest to those charged with governance. It is important that those charged with governance have an understanding of all significant issues that have arisen from the audit process. In the UK and Ireland this must be done in a written format. The communication is done through the issuance of an Audit Completion Report known as the ISA 260 Report. This outlines the findings of the auditors and any other issues the auditor may wish to raise with management.

meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

During 2023-2024, a Committee Referral process continued to be adopted for all Committees where the following three questions were posed by the Committee Chair for each referral request:

- What are you referring?
- Why are you referring it?
- What is the outcome that you are anticipating for this referral?

The Chair of the Audit & Risk Committee provided a report to the Board after each meeting via the Committee Highlight Report.

9. LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Services is undertaken to help reduce and maintain the incidence of fraud (and/or corruption) within CTMUHB to an absolute minimum. Work is undertaken in accordance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures with adoption of Government Functional Standards: Counter Fraud NHS Requirements with which the Health Board is expected to comply.

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

The Health Board commissions its Counter Fraud service from Swansea Bay UHB via Service Level Agreement. The Health Board maintains an accredited counter fraud specialist resource of 2.6 FTE. This is in line with comparable sized Health Board's within NHS Wales.

The Counter Fraud Team received 50 new referrals for investigation in 2023/24 with 13 investigations carried over from 2022/23. 44 investigations were closed in 2023/24 which resulted in the application of 5 civil sanctions. This investigation work led to the recovery of £33,438 of Health Board funds and an overall identified fraud prevention figure of £46,446.

A review of compliance with Government Functional Standards: Counter Fraud NHS Requirements is undertaken annually. The Health Board was required to self-assess on a RAG rated basis against these Standards across 12 requirement areas. The Health Board achieved an overall Green rating following review with improvement identified as required in relation to Requirement 3 – Risk Assessment which was assessed as Amber rated and Requirement 1b – Accountable individual which was rated Red due to a lack of nominated Fraud Champion, following the departure of the Director of Corporate Governance during this self-assessment period. Work plan actions have been agreed to

improve these areas for 2024/25 and Green ratings are anticipated at the next review.

As part of its work, the Counter Fraud Department has a regular annual programme of raising fraud awareness within the Health Board for which a number of days are then allocated and included as part of an agreed Counter Fraud Work-Plan which is signed off, by the Health Board's Executive Director of Finance, on an annual basis.

In addition to this and in an attempt to promote an Anti-Fraud Culture within the Health Body, a quarterly newsletter is produced which is then made available to all staff on the Health Board's Intranet and all successful prosecution cases are also publicised in order to obtain the maximum deterrent effect. The Counter Fraud Team also deliver awareness sessions to staff, both general awareness aimed at all staff and bespoke sessions based on risks faced by staff assessed to be in roles at a higher level of potential exposure to fraud.

10. ASSURANCE TO THE BOARD

The Audit & Risk Committee provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the guidance contained in the NHS Wales Audit Committee Handbook.

10.1 Internal Control & Risk Management - In addition to the audit reports received by the Committee during the reporting period, a wide range of internally generated 'governance' reports/papers were produced for consideration by the Audit & Risk Committee.

10.2 Governance Statement - For the period 2023-2024 the Health Board produced its Governance Statement, which explains the processes and procedures in place to enable the Health Board to carry out its functions effectively. The Statement was produced following a review of CTMUHB's governance arrangements undertaken by the Board with the support of and the Board Secretary/Director of Corporate Governance. The Statement brings together all disclosures relating to governance, risk and control for the organisation. The Governance Statement is captured in the CTMUHB's Annual Report which is available via this [link](#)

10.3 Tracking of Audit Recommendations

The Committee has increased the focus on tracking the implementation of agreed audit recommendations and the clarity of reporting of this, which achieved improvement during the year and laid the foundations for the further improvements now being made in 2024/2025, in particular the transition to an automated system using AmAT.

10.4 Audit Committee Effectiveness Survey - A Committee Effectiveness Survey was undertaken in 2022-2023 to obtain feedback from Committee members on potential areas for development.

The statements used in the survey were devised in accordance with the guidance outlined within the NHS Audit Committee Handbook.

11. CONCLUSION AND FORWARD LOOK

The Audit & Risk Committee in discharging its scrutiny and assurance role on behalf of the Board considers that on the basis of the risk based work completed by the Committee during 2023-2024, that there are effective measures in place **and that there are no outstanding issues that the Audit & Risk Committee wishes to bring to the attention of the Board.**

The Directors have been held to account and have responded positively in dealing with any concerns raised by the Auditors and the Audit & Risk Committee.

This Annual Report will be supplemented by the annual self-assessment process, which will be undertaken via Microsoft Office Forms, which reviews the individual and collective function of the Committee against the NHS Audit Committee Handbook best practice guidance and helps to inform the work of the Committee going forward.

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2024-2025 in respect of:

- Reviewing audit outcomes and ensure actions are taken as a result of learning.
- The transition to an automated system for tracking audit recommendations and inspections, with the ambition to introduce trends and themes into reporting.
- Discharging effectively the Board approved Committee Terms of Reference, including the changes made in response to the Effective Management of Board Business Review.
- Increased reporting in relation to Declarations of Interest for the organisation.
- Ensuring all parties discharge their responsibilities appropriately as outlined within the Audit Charter.
- Continue to strengthen processes and resources in place to prevent and respond to fraud activity.

Appendix 1

List of Internal Audits Undertaken within Cwm Taf UHB 2023-2024 and Assurance Ratings

	Internal Audit Assignment	Assurance Rating 2023-2024
1	Arrangements for financial savings – centralised processes	Substantial
2	PCH – Quality – site supervisor role	Substantial
3	PCH – Validation of management actions	Substantial
4	Adult Mental Health CSG – Governance Arrangements	Reasonable
5	Adult Mental Health CSG – Risk Management	Reasonable
6	Adult Mental Health CSG – Workforce	Reasonable
7	Adult Mental Health CSG – Planning & Performance	Reasonable
8	Deprivation of Liberty Safeguards (DoLS)	Reasonable
9	Arrangements for financial savings – Enabling schemes	Reasonable
10	IT Infrastructure	Reasonable
11	IT service management	Reasonable
12	Leadership and management development	Reasonable
13	Management of controlled drugs	Reasonable
14	Risk management	Reasonable
15	Technical resilience	Reasonable
16	Welsh Risk Pool (Draft)	Reasonable
17	Follow up – Radiology workforce	Reasonable
18	Follow up – Medical variable pay (Draft)	Reasonable
19	Follow up – Digital operating model	Reasonable
20	Follow up – Reasonable offer (Draft)	Reasonable
21	PCH – Financial management and change control	Reasonable
22	PCH – Delivery of key project objectives (Draft)	Reasonable
23	Decarbonisation	Limited

24	Estates assurance (Draft)	Limited
25	Arrangements for financial savings – Care group processes	Limited
26	Gastro-Intestinal pathways – Demand management	Limited
27	Interventions Not Normally Undertaken (INNU)	Limited
28	Performance management of 4 hour target	Limited
29	Follow up – Patient pathway appointment management	Limited
30	Annual Governance Statement	Advisory & Non Opinion

	Substantial Assurance Rating	3
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	Reasonable Assurance Rating	19
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	Limited Assurance Rating	7
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	Advisory & Non Opinion	1
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	Total	30
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**NB – the above does not include the internal audit ratings for the reviews undertaken for the hosted bodies.*

List of Internal Audits Undertaken 2023-2024 and Assurance Ratings within

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

	Internal Audit Assignment	Assurance Rating 2023-2024
<u>Welsh Health Specialised Services Committee (WHSCC)</u>		
1	WHSCC – Welsh kidney network	Substantial
2	WHSCC – Integrated commissioning plan development process	Substantial
<u>Emergency Ambulance Services Committee (EASC)</u>		
1	EASC – Adult critical care transfer service	Substantial



Agenda Item

2.2.1

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
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
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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 2024 to 31 December 2024.
- 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 CTMUEB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUEB 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: Not applicable for this report
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Cydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

- 5.1 The Audit & Risk Committee are asked to **NOTE** the Annual Cycle of Business and the changes made in **red**.

6. Next Steps

6.1 There are no next steps required.

Audit & Risk Committee

Cycle of Business (1st January 2024 – 31st December 2024)

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 2024 to 31st December 2024.

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 **All Wales Joint Commissioning 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 2024 – 31st December 2024)

Item of Business	Executive Lead	Reporting period	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Consent Agenda														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Audit & Risk Committee Annual Cycle of Business	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Committee Forward Work Programme	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Audit & Risk Committee Annual Report	Director of Corporate Governance	Annually								R				
Audit & Risk Committee Annual Self-Assessment	Director of Corporate Governance	Annually				R								
Audit & Risk Committee Terms of Reference	Director of Corporate Governance	Annually								R		R		
Declarations of Interest and Gifts & Hospitality Report	Director of Corporate Governance	Quarterly				R				R				R
National Clinical Audit Annual Plan	Medical Director	Annually						R						
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		R		R		R		R		R		R
Annual Financial Accounts	Director of Finance	Annually						R Draft	R Final					
Accountability Report (Including the Governance Statement)	Director of Corporate Governance	Annually						R Draft	R Final					
Annual Review of the Risk Management Strategy / Board Assurance Framework	Director of Corporate Governance	Annually				R								
Sustaining our Future														
Losses & Special Payments Report	Director of Finance	Quarterly		R				R		R				R
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		R		R		R		R		R		R

Item of Business	Executive Lead	Reporting period	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Local Counter Fraud Report	Director of Finance	All Regular Meetings		R		R		R		R		R		R
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				R								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				R								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				R								
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				R								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										R		
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		R		R		R		R		R		R
Organisational Risk Register	Director of Corporate Governance	All regular meetings		R		R		R		R		R		R
Consultant Job Planning	Medical Director	Bi-Annually				R						R		
Medical Rostering	Medical Director	Bi-Annually				R						R		
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		R		R		R		R		R		R
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				R								
Internal Audit Reviews	Head of Internal Audit	All regular meetings		R		R		R		R		R		R
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually						R						
Audit & Risk Committee Update	Audit Wales	All regular meetings		R		R		R		R		R		R
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings		R		R		R		R		R		R
Audit Wales Annual Audit Report	Audit Wales	Annually				R								
Audit Wales Audit Plan	Audit Wales	Annually				R								

Item of Business	Executive Lead	Reporting period	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)	Audit Wales	Annually						✍						
Structured Assessment	Audit Wales	Annually				✍								
Audit of Financial Statements Addendum Report (if required)	Audit Wales	Annually								✍				
Hosted Bodies														
JCC Internal Audit Recommendations Tracker	JCC Director of Finance	All regular meetings		✍		✍		✍		✍		✍		✍
JCC Corporate Risk Assurance Framework including the risk register.	JCC Committee Secretary/Head of Corporate Services	All regular meetings		✍		✍		✍		✍		✍		✍
JCC Governance Statement	JCC Committee Secretary/Head of Corporate Services	Annually						✍						
JCC Annual Accounts	JCC	Annually						✍						
National Imaging Academy for Wales Hosted Compliance Statement.	Director of the National Imaging Academy	Annually						✍						
National Imaging Academy for Wales Risk Register	Director of the National Imaging Academy	Bi-Annually		✍						✍				

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
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Patient Pathway Follow Up	Internal Audit	Further work required so now scheduled for presentation to the 17 October 2024 meeting.
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy Accreditation Closure report - Progress and Associated Risk Mitigation JAG	Chief Operating Officer	13 February 2023 – Deferred to 19 April 2023 as per action log update. Deferred to August 2023 as per action log update. Verbal Update received at the August 2023 meeting. Written progress report to be presented to the meeting being held on 24 October 2023. Agreement given by the Chair outside the meeting for a report to be presented to the Committee in June 2024. On Agenda for August 23 Meeting.
Requested via email	Audit Wales Item	MIU follow Up Report	Audit Wales	15 August 2024



GIG
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NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item 2.2.2

Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – PCH Key Project Objectives	Internal Audit	15 August 2024
Deferred from August 2024 meeting	Deferred Item	Internal Audit Review – Quality Framework	Internal Audit	17 October 2024
Deferred from August (CLOSED) In Committee Meeting	Deferred Item	Financial Control Procedure – Medical Variable Pay	Medical Director	17 October 2024
Deferred from August 2024 Meeting	Deferred Item	Consultant Job Planning	Medical Director	17 October 2024
Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – Reasonable Officer	Internal Audit	17 October 2024
Deferred from June & August 2024 Meetings	IA Item	Patient Pathway Follow Up	Internal Audit	17 October 2024
Deferred from August 2024 Meeting	IA Item	Internal Audit Review – Supply Chain Partner	Internal Audit	17 October 2024
Annual Item (deferred from August 24 meeting)	Audit Wales	Audit of Financial Statements Addendum Report	Audit Wales	17 October 2024

Agenda Item 2.2.2

COMPLETED ITEMS

Deferred from April 2024 Meeting	Deferred item	Internal Audit Review - Mental Health Clinical Service Groups Review	Internal Audit	20 June 2024 – Completed
Requested via email	IA Item	Internal Audit Review – Risk Management	Internal Audit	20 June 2024 – Completed
Requested via email	IA Item	Internal Review – Medical Variable Pay Follow Up	Internal Audit	20 June 2024 - Completed
Requested via email	IA Item	Internal Audit Review – Revised Decarbonisation Audit	Internal Audit	20 June 2024 - Completed
Annual Cycle of Business – Deferred from April 24 Meeting	Annual Item (deferred)	National Clinical Audit Programme Update 2023 – 2024	Medical Director	20 June 2024 - Completed
Deferred from April 2024 Meeting	Deferred item	Financial Control Procedure – Medical Variable Pay (In Committee)	Medical Director	20 June 2024 - Completed
Email from Director of Strategy & Transformation	Additional Item	Progress update on Grant Thornton Recommendations	Executive Director of Strategy & Transformation	18 April 2024 – Completed
Email from Director of People	Additional Item	Workforce Management – Audit Wales Report	Audit Wales	18 April 2024 – Completed
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – PCH Financial	Internal Audit	18 April 2024 - Completed

Agenda Item 2.2.2

Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Controlled Drugs	Internal Audit	18 April 2024 – Completed
Requested via email	Additional item	Progress Update on Grant Thornton Recommendations	Executive Director of Strategy & Transformation	18 April 2024 – Completed



Agenda Item

2.2.3

Audit & Risk Committee

Declarations of Interest & Gifts, Hospitality and Sponsorship Register

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
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	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	05/08/2024	Reviewed

Acronyms / Glossary of Terms	

1. Situation /Background

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

2. Specific Matters for Consideration

- 2.1 The form in the Standards of Behaviour Framework policy or online via SharePoint should be used to declare interests and/or seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is submitted to the Corporate Governance Team.
- 2.2 In May 2024, all Board Members were formally asked to review and update, where appropriate, their declarations for the new financial year 2025-2025. A response from all Board Members was received and is captured in Appendix 1.
- 2.3 A targeted email was also issued by the Corporate Governance Team in May 2024 to 548 members of staff, which included all Consultants, Very Senior Managers and Staff at Band 8d and Band 9). It should be noted that some of the returns received to date and captured in Appendix 1 are from individuals that did not receive the targeted email as there is a responsibility for all employees to declare interests. This exercise will be repeated in May 2025 for the 2025-2026 reporting period.
- 2.4 As at 30th June 2024:
- 23 declarations of interest received from Board Members (Independent Members, Associate Members, Executive Directors and members of the wider Executive Team). Please see Appendix 1 – Sheet 1 – “Board Members”.
 - 172 declarations of interest received from staff (excluding Board Members / Executive Team colleagues). Please see Appendix 1 – Sheet 2 – “Non Board Members”.
 - To date there have been no declarations of gifts, hospitality and sponsorship received. It should be noted that some colleagues capture this information in their declaration of interest form.
- 2.5 Previous advice from Information Governance is that any information published on the register, which is then published in the public domain, excludes first and last names and includes job titles only (for non-Board Members). This has been actioned in terms of the appendices to this report.



3. Key Risks / Matters for Escalation

3.1 Please refer to the register for the Declarations of Interest included at Appendix 1.

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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
		Not required for this report



Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 entries on the register included at Appendix 1.

6. Next Steps

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

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes
New Starter Request	Jonathan Morgan	Chair	30/03/2023 Hard Copy Submission	Director of Insight Wales Consulting Limited (100% Share Ownership: Insight Wales Consulting Limited)	2012	Present	Dividend	Confirmed via O365 Forms 28.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 28.2.2024. No issues identified.	
				Associate with Practice Solutions Limited	2011	Present	Consultant fee			
				Wife employed as a Welsh Government Lawyer	2010	Present	Salaried			
09.05.2023	Dom Hurford	Executive Medical Director	06/11/2023 Hard Copy Submission	Nil Interests Declared	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
09.05.2023	Paul Mears	Chief Executive	09/05/2023 Online Submission	Director of Drake Consultancy Services (dormant company)	May 2018-present Amendment 17.11.2023 - declaration updated to confirm company dissolved 1st October 2023.		Nil	Confirmed via O365 forms 21.2.2024 - No longer interest as a Director of Drake Consultancy Services Ltd as the company has been dissolved on 10/10/23 - this had been noted but date from 1.10.2023. All other interests remain up to date.	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.	
			Email amendment received 17.11.2023.	Member of Advisory Board, Awen Cultural Trust	sep-22	Present	Nil			
				Observer Member, Board of Life Sciences Hub Wales	jun-22	Present	Nil			
09.05.2023	Dilys Jouvenat	Independent Member (Third Sector	10/05/2023 Online Submission	Chair of the Rhondda Cynon Taff Citizens Advice	jun-15	26th November 2023	Not applicable	O365 Form returned 21.2.2024 confirmed role change at the RCT Citizens Advice.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	Companies House registered as a Director when Dilys became a Trustee in these positions.
				Trustee Newport Citizens Advice	2 Years	Present	Not applicable			
				Trustee South East Wales Citizens Advice	1 Year	Present	Not applicable			
				Trustee Interlink	6 months	Present	Not applicable			
				Trustee Rhondda Cynon Taff Citizens Advice	27th November 2023	Present	Not applicable			
09.05.2023	Lauren Edwards	Executive Director of Therapies & Health Science	10/05/2023 Online Submission	Nil Interests Declared	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.	
			21/08/2023 - In Year Change (Online Submission)	Trustee and Director of Royal College of Speech and Language Therapists	Ongoing	Ongoing	Nil			
45055	Linda Prosser	Executive Director of Strategy & Transformation	12/05/2023 (Online Submission) Amendment email 26.2.2024	Director Altyn Tepe Ltd	Since 2019	Ongoing	Yes	Confirmed via email 26.2.2024 that Director Altyn Tepe Ltd remains unchanged however added two entries relating to family members.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
				Son (1) Chief Operating Officer Salisbury NHS Foundation Trust	Since Feb 2024 (previously RUH Bath)	Ongoing	Yes			
				Son (2) Service manager (Urology and Ophthalmology) Royal United Hospital Bath	Since 2021	Ongoing	Yes			
45055	Carolyn Donoghue	Independent Member (University)	18/05/2023 (Online Submission)	Welsh Wound Innovation Centre - Chair	9 Years	Ongoing	Payment for each Board meeting	Confirmed via O365 Forms 26.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	Companies House reference Carolyn Donoghue as a Director. It has been confirmed via email with Carolyn on the 28th March that she has been a Director of WWIC since 2014 and became Chair in 2020.
				Independent Governor University West of England	2 years	Ongoing	None			
				Magistrate - Newport Bench	3 Years	Ongoing	None			
				Chair South East Wales Student Mental Health Partnership	3 Years	Ongoing	Consultancy Fee-Hourly			
				Senior Professional Fellow - Cardiff University	3 Years	Ongoing	None			
				Son (ED) is employed by Seating Matters a company which supplies clinical seating to healthcare organisations. I am not involved in any way	1 Year	Not applicable	Not applicable			
			21/11/2023 - Update to current DOI noted. Additional Entry received via email notification	Appointed as Independent Member on the Welsh Health Specialised Services Committee (WHSSC)	1st July 2023	30th June 2025 31st March 2024	Remunerated	Confirmed via O365 Forms 26.2.2024 IM was appointed as an independent member of the Welsh Health Specialised Services Committee in June 2023. Anticipates this role will end on 31st March 2024.		
09.05.2023	Hywel Daniel	Executive Director for People	22/05/2023 (Online Submission)	Nil Interests Declared	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 23.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 23.2.2024. No issues identified.	
09.05.2023	Jayne Sadgrove (Term ended 31.8.2023)	Vice Chair	23/05/2023 (Online Submission) Confirmed 31.10.2023 that declaration did not change at date of	Director, Cardiff Union Services Ltd	2019	Ongoing	Voluntary/Unremunerated	Confirmed 31.10.2023 that declaration did not change at date of term ending.		
				Vice Chair of Trustee Board , Cardiff University Students Union	2019	Ongoing	Voluntary/Unremunerated			
				Director, home study courses ltd	1994	Ongoing	None stated			
				Director, Keyford Properties Ltd	2023	Ongoing	50 %			

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes
			not change of date or term ending.	Senior Professional Fellow, Cardiff University	2019	Ongoing	Honorary Title			
				IM (designate) HEIW	2023	Ongoing	Remunerated			
				Spouse: Director, home study courses ltd Director, Keyford Properties Ltd	1994 2023	Ongoing	50 %			
09.05.2023	Nicola Milligan	Independent Member (Trade Union)	12/07/2023 (Online Submission)	Royal College Of Nursing Wales Board member	Term completes December 2024	Term ends December 2024	Nil	Confirmed via O365 Forms 27.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
09.05.2023	Gregory Padmore-Dix	Executive Director of Nursing, Midwifery & Patient Care / Deputy CEO	12/07/2023 (Online Submission)	Trustee - Royal College of Nursing Foundation	September 2021	Ongoing	Voluntary role, travel / accommodation paid for by the charity	Confirmed via O365 Forms 27.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	Companies House reference Greg Dix commencing at Director at WWIC in April 2022. Email confirmation received 28.3.2024 confirms the following: That Greg Dix attended the WWIC Board meeting on 20/1/22 and were the nominated CTM representative. The notification however, in terms of the Director changeover and registration at Companies House, occurred in April 2022.
				Board Director - Welsh Wound Innovation Centre	jan-22	Ongoing	No financial or benefits in kind			
				Visiting Professor, University of South Wales	2020	Ongoing	Nil			
				Associate Professor, University of Plymouth	2015	Ongoing	Nil			
09.05.2023	Gethin Hughes	Chief Operating Officer	04/08/2023 Hard Copy Form	School Governor and Trustee Ditcham Park School	Since March 2015 (Confirmed via email 27th March 2024)	Ongoing	Not applicable	Confirmed via O365 Forms 5.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 5.3.2024. No issues identified.	Companies house registered as a director.
				Wife is Parliamentary Assistant to Natasha Ashgar MS	From 7th August 2023	Email update from Gethin Hughes 27th March 2024 confirming that this can be removed as wife no longer works for Natasha Ashgar	-			
09.05.2023	Sally May	Executive Director of Finance	04/08/2023 Hard Copy Form	Cousin is Director of DECIPHER; Professor in Social Interventions and Health, Cardiff University Ongoing Salaried position	Ongoing	Ongoing	Salaried	Office 365 form received 13.3.2024 confirmed an additional entry for daughter.	Confirmed continued eligibility via O365 Forms 5.3.2024. No issues identified.	
				Cousin is Regional Sales Manager South West Arthrex Ltd Ongoing Salaried position	Ongoing	Ongoing	Salaried			
				Cousin is Partner, Knight Frank Project and Building Consultancy Ongoing Salaried position	Ongoing	Ongoing	Salaried			
			Office 365 Form 13.3.2024	Daughter appointed to Lead Physiologist role for In Health South West Community Diagnostic Centre	Ongoing	Ongoing	Salaried			
09.05.2023	Stuart Morris	Director of Digital	04/08/2023 Hard Copy Form	Chair of Governors for Penyfai Primary School, Bridgend	2017	Ongoing	Nil	Confirmed continued eligibility via O365 Forms 4.3.2024. No issues identified.	Not applicable.	
09.05.2023	Lisa Curtis-Jones	Associate Member - Third Sector	17/08/2023 Hard Copy Form	Statutory Director of Social Services in MerthyrTydfil	apr-15	Ongoing	Member of the regional partnership board (RPB) – RIF funding to local authorities through RPB.	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
09.05.2023	Mel Jehu	Independent Member (Community)	17/08/2023 Hard Copy Form	Independent Member (Vice Chair) South Wales Police Crime Panel.	2012	Ongoing	Attendance Fee	Confirmed via O365 Forms 28.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Term ends 31.3.2024.	
				Trustee, Safe Merthyr Tydfil.	2008	Ongoing	Voluntary no financial gain			
				Independent Member - Merthyr Tydfil County Borough Council Standards Committee	24th February 2022	Ongoing	Attendance Fee			
				Deputy Lord Lieutenant for Mid Glamorgan	sep-21	Ongoing	No remuneration or benefits in kind			
								Mel Jehu's term comes to an end with CTMUHB on the 31st March so confirmed as accurate at point of leaving.		

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				Spouse is employed in CTMUHB in a part time role as Lymphoedema Nurse since 2012 and prior to that Breast Care Specialist Nurse	2012	Ongoing	Not applicable			
09.05.2023	Patsy Roseblade	Independent Member (Finance & Audit)	17/08/2023 Hard Copy Form	Non Executive Director Tennis Wales	2020	Ongoing	Voluntary	Confirmed via O365 Forms 12.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 12.3.2024. No issues identified.	
25.10.2023	Philip Daniels	Interim Executive Director of Public Health	30.10.2023 Hard copy form	Board Member / Welsh Chair - Faculty of Public Health	jun-23	Ongoing	Nil	Confirmed via O365 Forms 24.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 24.2.2024. No issues identified.	
				Partner is Director - The Performance Centres	2011	Ongoing	Owner / Chief Executive			
09.05.2023	James Hehir (Term ended 30.09.2023)	Independent Member (Legal)	Confirmed no change to declarations on term ending 30.09.2023. Email dated 27.10.2023 on file.	Non-Executive Director, Llandarcy Park Ltd.	14.06.2018	Present	None	Confirmed no change to declarations on term ending 30.09.2023. Email dated 27.10.2023 on file.		
				Trustee Neath Port Talbot Contact Centre.	01.05.2007	Present	None			
				Vice Chairman, Neath Port Talbot Group of FE Colleges.	29.03.2006	Present	None			
				Solicitor of the Supreme Court.	14.02.1984	31/8/2016.	None			
				Honorary Vice President, West Glamorgan Magistrates Association.	16.10.2017	life time appointment.	None			
				Associate member, magistrates Association.	01.06.1993	Present	None			
				Patron Neath YMCA.	apr-15	Present	None			
09.05.2023	Ian Wells	Independent Member (Digital)	8/11/2023 Hard Copy Form	Director of the Wales Institute of Digital Information which undertakes research with Digital Health and Care Wales/NHS Wales Informatics Service in collaboration of University of Wales Trinity St David and the University of Wales. Research projects also undertaken for various health boards including CTM.	3 days per week from 1/2/20	Present	Nil financial transactions or benefits in kind.	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.	
New Starter Request	Gareth Watts	Director of Corporate Governance / Board Secretary	13/09/2023 Hard Copy Form	Board Member of Coleg Gwent (Further Education College) Since 2015 onwards	2015	Present	Voluntary	Confirmed via O365 Form return that amendment made on 28 February to ensure that voluntary is against the Coleg Gwent role and not the Gwent Police role for which a daily rate is received.	Not applicable.	
				Voluntary-Member of the Joint Audit Committee of Gwent Police and the Police and Crime Commissioner for Gwent	2022	Present	Daily rate for meeting attendance and preparation			
09.05.2023	Geraint Hopkins	Independent Member (Local Authority)	, Saf	Llanharan Community Development Project Limited	10 years +	Present	Not applicable	Confirmed via O365 Forms 14.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
				Elected Member, Rhondda Cynon Taff County Borough Council	19 years	Present	Not applicable			
09.05.2023	Lynda Thomas	Independent Member (Corporate Business)	8/11/2023 Hard Copy Form	Chair of Norfolk Community Health and Care NHS Trust.	Since February 2023	Present	Remunerated.	Confirmed via O365 Forms 13.3.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 13.3.2024. No issues identified. Although identified that she has been Chair of Norfolk Community Health and Care NHS since 01/02/2023	Companies house have registered Lynda Thomas as a Director from February 2023. Confirmed via email with Lynda on the 28.3.2024 that she is a Trustee and commenced this role in January 2023.
				Trustee of Age UK	jan-23	jan-26	None			
09.05.2023	Anne Morris	Associate Member - Chair of SRG	7/11/2023 Hard Copy Form	Nil interests declared.	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 27.2.2024. No issues identified.	
09.05.2023	Sally Bolt	Associate Member - Chair of CAG	7/11/2023 Hard Copy Form	Nil interests declared.	Not applicable	Not applicable	Not applicable	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Not applicable	

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind	End of Financial Year Check	Annual Eligibility Form and Indemnity Check	Notes
New Starter - November 2023	Kath Palmer	Vice chair	23/11/2023 Hard Copy Form	Natural Resources Wales – Board member and Chair of Audit, Risk and Assurance committee.	feb-23	Present	Paid Position	Confirmed via O365 Forms 21.2.2024 that the declaration of interest returned for the period 2023-2024 remains up to date and there are no changes required.	Confirmed continued eligibility via O365 Forms 21.2.2024. No issues identified.	
				Interim CEO Cynon Taf Community Housing Group which has a Care and Repair subsidiary and Down to Zero subsidiary.	sep-23	November 2023 - with a handover period between November and December 2023. Handover with Cynon Taf Housing Association finished 8.12.2023.	Paid Position			
				Trustee of Crisis (national homelessness charity) and chair of the client services governance committee.	des-22	Present	Voluntary (Expenses Paid)			
				Member of the Residential Decarbonisation Implementation Group for Welsh Government.	sep-19	Present	Voluntary			
New Starter 2.1.2024	Helen Lentle	Independent Member - Legal	15/01/2024 Hard Copy Form	Non-Executive Director: CISWO (the Coal Trustee: Dyslecsia Cymru/Wales Dyslexia Charity	Since September 2022 Since August 2022	Present Present	Voluntary role - no salary Voluntary role - no salary	Confirmed via O365 Forms 3.3.2024 that the declaration of interest	Confirmed continued eligibility via O365 Forms	Email confirmation 2.4.2024 from Helen

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind
Change Declared April 2024 and New Financial Year request 20.5.2024	Jonathan Morgan	Chair	25.4.2024 - Via hard copy form.	Trustee and Director of the NHS Confederation	Since April 2024	ongoing	Travel Expenses reimbursed
				Director of Insight Wales Consulting Limited	Since 2012	ongoing	Nil
				100% Share Ownership of Insight Wales Consulting Limited	Since 2012	ongoing	Dividend
				Associate Consultant with Practice Solutions Ltd	aug-11	ongoing	Fees for work undertaken
				Wife employed as a Welsh Government Lawyer	Since 2010	ongoing	Salaried.
New Member - request on commencement and New Financial Year request 20.5.2024	Rachel Rowlands	Independent Member Community	30.04.2024 - via hard copy form.	Chief Executive / Company Secretary, Age Connects Morgannwg	2005	ongoing	Annual Salary
				Trustee / Director, Age Connects Wales	2017	ongoing	Nil
Change Declared April 2024 and New Financial Year request 20.5.2024	Carolyn Donoghue	Independent Member University	07.05.2024 - via hard copy form.	Chair, Welsh Innovation Centre	9 Years	31.05.2024	Payment for each Board meeting
				Independent Member of the Board of Governors, University West of England	2 Years	ongoing	None
				Special Advisor Joint Commissioning Committee	11th April 2024	30th June 2024	Remunerated position x1 day per month
				Chair, South East Wales Student Mental Health Partnership	4 Years	31.07.2024	Consultancy Fee
				Magistrate, Newport Bench	4 Years	31.05.2024	None
				Senior Professional Fellow, Cardiff University	4 Years	ongoing	None
				Member of Health and Care Research Wales Advisory Board	From May 2024	ongoing	None
				Son (ED) employed as a Business Development Manager for Seating Matters			
20.05.2024	Gethin Hughes	Chief Operating Officer	11.06.2024 - Via Email	Nil Interests declared. Gethin Hughes confirmed resignation from School Governor and Trustee Ditcham Park School on the 9th April 2024.	Not applicable	Not applicable	Not applicable
20.05.2024	Sally May	Executive Director of Finance	11.06.2024 - Via Email	Cousin is Director of DECIPHER; Professor in Social Interventions and Health, Cardiff University Ongoing Salaried position	Ongoing	Ongoing	Salaried

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind
				Cousin is Regional Sales Manager South West Arthrex Ltd Ongoing Salaried position	Ongoing	Ongoing	Salaried
				Cousin is Partner, Knight Frank Project and Building Consultancy Ongoing Salaried position	Ongoing	Ongoing	Salaried
				Daughter appointed to Lead Physiologist role for In Health South West Community Diagnostic Centre	1.5.2024	Ongoing	Salaried
20.05.2024	Paul Mears	Chief Executive	11.06.2024 - Via Email	Member of Advisory Board, Awen Cultural Trust	sep-22	Present	Nil
				Observer Member, Board of Life Sciences Hub Wales	jun-22	Present	Nil
20.05.2024	Nicola Milligan	Independent Member - Trade Union	11.06.2024 - Via Email	Board Member - Royal College of Nursing Wales	jan-16	Term ends December 2024	Nil
20.05.2024	Stuart Morris	Director of Digital	11.06.2024 - Via Email	Chair of Governors for Penyfai Primary School, Bridgend	jul-17	Ongoing	Nil
20.05.2024	Simon Blackburn	Director of Communications, Engagement & Fundraising	11.06.2024 - Via Email	Nil interests declared.	Not applicable	Not applicable	Not applicable
20.05.2024	Lauren Edwards	Executive Director of Therapies & Health Science	11.06.2024 - Via Email	Trustee and Director of Royal College of Speech and Language Therapists	08-nov-23	Ongoing	Nil
20.05.2024	Linda Prosser	Executive Director of Strategy & Transformation	11.06.2024 - Via Email	Director Altyn Tepe Ltd	Since 2019	Ongoing	Yes
				Son (1) Chief Operating Officer Salisbury NHS Foundation Trust	Since Feb 2024 (previously RUH Bath)	Ongoing	Yes
				Son (2) Service manager (Urology and Ophthalmology) Royal United Hospital Bath	Since 2021	Ongoing	Yes
20.05.2024	Anne Morris	Associate Board Member - Chair of the Stakeholder Reference Group	21.05.2024 - Via hard copy form.	Deputy Chief Executive of Interlink	2009	Ongoing	Yes - Salaried.
20.05.2024	Philip Daniels	Interim Executive Director of Public Health	11.06.2024 - Via Email	Board Member / Welsh Chair - Faculty of Public Health	jun-23	Ongoing	Nil
				Partner is Director - The Performance Centres	2011	Ongoing	Owner / Chief Executive
22.05.2024	Hywel Daniel	Executive Director for People	11.06.2024 - Via Email	Nil interests declared.	Not applicable	Not applicable	Not applicable
22.5.2024	Greg Dix	Executive Director of Nursing / Deputy Chief Executive	11.06.2024 - Via Email	Trustee - Royal College of Nursing Foundation	September 2021	Ongoing	Voluntary role, travel / accommodation paid for by the charity
				Board Director - Welsh Wound Innovation Centre	jan-22	Ongoing	No financial or benefits in kind
				Visiting Professor, University of South Wales	2020	Ongoing	Nil
				Associate Professor, University of Plymouth	2015	Ongoing	Nil
20.05.2024	Dilys Jouvenat	Independent Member - Third Sector	11.06.2024 - via email	Chair of the Rhondda Cynon Taff Citizens Advice	jun-15	26th November 2023	Not applicable
				Trustee Newport Citizens Advice	2 Years	Present	Not applicable
				Trustee South East Wales Citizens Advice	1 Year	Present	Not applicable
				Trustee Interlink	6 months	Present	Not applicable
				Trustee Rhondda Cynon Taff Citizens Advice	27th November 2023	Present	Not applicable

Targeted DOI Request Sent	Full Name	Designation	Date DOI Approved	Nature of Declaration	Period of Involvement "From"	Period of Involvement "to"	Financial Benefits /Benefits in Kind
28.05.2024	Kath Palmer	Vice Chair	11.06.2024 - via email	Natural Resources Wales – Board member and Chair of Audit, Risk and Assurance committee.	feb-23	Present	Paid Position
				Trustee of Crisis (national homelessness charity) and chair of the client services governance committee.	des-22	Present	Voluntary (Expenses Paid)
				Member of the Residential Decarbonisation Implementation Group for Welsh Government.	sep-19	Confirmed in declaration on the 28th May that this Group ceased in April 2024.	Voluntary
Email update 11.7.2024			12.07.2024	Board Member (Crisis Trustee) for Pathway UK (Subsidiary of Crisis)	8th July 2024	Present	Voluntary (Expenses Paid)
29.05.2024	Lynda Thomas	IM Corporate	11.06.2024 - via email	Chair of Norfolk Community Health and Care NHS Trust.	Since February 2023	Present	Remunerated.
				Trustee of Age UK	jan-23	jan-26	None - Voluntary role
03.06.2024	Lisa Curtis-Jones	Associate Member - Third Sector	5th June 2024 - via hard copy form.	Statutory Director of Social Services in Merthyr Tydfil Member of the regional partnership board (RPB) – RIF funding to local authorities through RPB.	apr-15	Ongoing	
03.06.2024	Gareth Watts	Director of Corporate Governance / Board Secretary	11.06.2024 - Via Email	Board Member of Coleg Gwent (Further Education College) Since 2015 onwards	2015	Present	Voluntary
				Member of the Joint Audit Committee of Gwent Police and the Police and Crime Commissioner for Gwent	2022	Present	Daily rate for meeting attendance and preparation
05.06.2024	Geraint Hopkins	Independent Member (Local Authority)	19.6.2024 - Via Email.	Llanharan Community Development Project Limited	10 years +	Present	Not applicable
				Clerk to Llantrisant Community Council.	okt-21	Present	Remunerated
				Elected Member, Rhondda Cynon Taff County Borough Council	19 years	Present	Not applicable
06.06.2024	Patsy Roseblade	Independent Member (Finance & Audit)	11.06.2024 - via email	Non Executive Director Tennis Wales	2020	Ongoing	Voluntary
10.06.2024	Ian Wells	Independent Member (Digital)	11.06.2024 - via email	Director of the Wales Institute of Digital Information which undertakes research with Digital Health and Care Wales/NHS Wales Informatics Service in collaboration of University of Wales Trinity St David and the University of Wales. Research projects also undertaken for various health boards including CTM.	From 1/2/20	Present	Nil financial transactions or benefits in kind.

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
02.04.2024	Education and Training and Paediatric Pharmacist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
02.04.2024	Pharmacist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
04.04.2024	Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
04.04.2024	Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
08.04.2024	Physiotherapy Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
09.04.2024	Community Pharmacy Facilitator	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Community pharmacist (and IP) without managerial responsibilities at Valleys Link Pharmacy Ltd (Cilfynydd and Gelli) Husband works as Placements Lead for Cardiff University School of Pharmacy, and is responsible for allocating students to placement sites across CTMUHB. I am not involved in the decision making and would be unlikely to benefit in any way from this association.	6 months (started October 2023) Approx 1 year in role	Permanent salaried role None	Any contractual or performance issues relevant to Valleys Link Pharmacies located in CTMUHB will be managed by Jason Carroll and/or Meinir Davies. Carys will avoid any circumstances which ,may present a conflict of interest.
15.04.2024	Consultant in Radiology	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Chief Medical Officer Adaptix Imaging Centre for Innovation and Enterprise Oxford University Begbroke Science Park Woodstock Road Oxford OX5 1PF	Since July 2021	Salaried half day/ week	None Identified.
18.04.2024	Senior Healthcare Science Practitioner	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
19.04.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
23.04.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Working with the Neurodevelopment Service. Noted as no conflict with current position held.	8 hours across the month of April	Not stated.	
23.04.2024	Clinical Technologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
23.04.2024	Planning Assistant	Planning & Partnerships Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
23.04.2024	Healthcare Science Associate	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
23.04.2024	Superintendent Radiographer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
24.04.2024	Speech & Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.04.2024	Academy Office and Events Manager	National Imaging Academy Wales	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.04.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
29.04.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
3.05.2024	Superintendent Radiographer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
6.5.2024	Deputy Ward Manager	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
7.5.2024	Primary Care Therapist	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
8.5.2024	Advanced Pharmacist for Cardiology and Anticoagulation	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
8.5.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
13.5.2024	Project Manager	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
14.5.2024	Rotational Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
16.5.2024	District Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
16.5.2024	District Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
16.5.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
21.5.2024	Academy Administrator	National Imaging Academy Wales	Nil Interests Declared	Not applicable	Not applicable	Not applicable
22.05.2024	Pharmacist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
26.05.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
28.05.2024	Information Analyst	Digital & Data Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
28.05.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
29.05.2024	Medicines Management Support Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
29.05.2024	Clinic Co-ordinator	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
29.05.2024	Head of Assets, Governance & Technical Services	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
31.05.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
03.06.2024	Medicines Management Support Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
05.06.2024	Consultant Old age Psychiatrist and Clinical Director for Older Adult Mental Health Services CTMUHB	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
05.06.2024	Lead Nurse - Angelton Clinic	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
05.06.2024	Nurse Director - MHL D Care Group	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Urologist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2026	Strategy Group Clinical Director	Planning & Performance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant ENT Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant General Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	LHP Infrastructure Programme Director	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Assistant Director Capital & Estates	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Microbiology Consultant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Haematologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Pathologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Haematologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Ophthalmologist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Care Group Service Director	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
06.06.2024	Directorate Manager	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Directorate Lead Psychologist OPMH/Consultant Clinical Psychologist OPMH	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
06.06.2024	Consultant Breast Surgeon and Clinical Director for Breast Services	Planned Care Care Group	1. Two Togethers Limited (undertaking my private practice) 2. Moondance Cancer Foundation Clinical Advisory Board 3. Medical advisor for ITV and Netflix 4. Raise Healthcare consultant	1. Since January 2021 Since June 2023 3. Since June 2021 4. Since August 2023	2. 1. Salary/Dividends and Shareholder 2. Unpaid 3. Paid Consultancy Rates 4. Paid Consultancy Rates	Not applicable
06.06.2024	Consultant Hepatologist/Clinical Director Gastroenterology and Endoscopy	Diagnostics, Therapies, Pharmacy and Sciences Care Group	1. Trustee of Brynawel Rehabilitation Centre, Llanharan, CF72 9RN 2. Member of the British Society of Gastroenterology clinical Standards Committee which drafts national policy and guidelines	1. 2 Years 2. 2 Years	1. No financial or benefits in kind 2. None	Not applicable
06.06.2024	Deputy Director Commissioning Ambulance and 111	Joint Commissioning Committee	1. Bank Paramedic Contract with the Welsh Ambulance Service 2. Acting corporal British Army Reserves 3. Spouse is advanced clinical practitioner Swansea Bay	1. Since February 2016 From October 2017 Since March 2018 2. 3.	1. Paid per shift 2. Paid per hours worked 3. Salaried Employee	Not applicable
06.06.2024	Consultant Child & Adolescent Psychiatrist	Mental Health & Learning Disabilities Care Group	1. Second Opinion Approved Doctor (SOAD), Health Inspectorate Wales 2. Sole Director of SL Healthcare Solutions Ltd	1. 2018-present 2. 2017- present	1. Remunerated at the nationally agreed rate plus expenses for SOAD visits undertaken 2. 2017- present	Not applicable
06.06.2024	Consultant Gastroenterologist	Unscheduled Care Care Group	Sponsorship 2023 by AbbVie drugs company for digital attendance at ECCO IBD conference.	2023	Paid conference fee.	Not applicable
06.06.2024	Consultant Intensivist and Clinical Director for ICU	Planned Care Care Group	1. School Governor - YGG Aberdare 2. Regional Clinical Lead for Organ Donation	1. February 2023 April 2022 2.	1. None 2. 1 PA (NHSBT Funded)	Not applicable
06.06.2024	Assistant Director of Facilities	Facilities Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Assistant Director of Governance & Risk	Corporate Governance - Central Function	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Consultant in Acute Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Advanced Pharmacist - Formulary and Interface	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Medical Director	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Consultant in Emergency Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Consultant	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Consultant	Medical Director Function	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Deputy Chief Operating Officer	Chief Operating Officer Function	Nil Interests Declared	Not applicable	Not applicable	Not applicable
07.06.2024	Consultant Cardiologist	Unscheduled Care Group	1. Trustees for Swansea Chinese Christian Church 2. Joint working project to run pharmacist led heart failure 3. Hold Cardiff University Honorary Lecturer Post clinic	1. Since 2011 2. 2023-2024 Since 2017 3.	2. 1. Nil 3. Pharmaceutical Company 3. 1 PA from HEIWs	2. Not applicable
07.06.2024	Consultant Physician	Unscheduled Care Group	Spouse is a Director of limited liability company		Nil financial transactions	Not applicable
07.06.2024	Consultant Anaesthetist/ Associate Clinical Director	Planned Care Care Group	School governor - Caldicot School, and Durand Primary School, Caldicot	Since 2018	Nil financial transactions	Not applicable
08.06.2024	Consultant Anaesthetist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Honorary Tutor title with Cardiff University, Medical School	Renewed 01/05/2024	Nil financial transactions	
10.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Radiology	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Assistant Director of Finance	Finance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
10.06.2024	Deputy Director for People	People Service Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Public Health Consultant	Public Health	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Committee Secretary / Deputy Director Corporate	National Collaborative Commissioning unit	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Stroke Consultant	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Assistant Director of Transformation	Planning & Partnerships Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Radiologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Deputy Director of Finance	Finance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Deputy COO	Chief Operating Officer Function	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Dermatologist	Medical Director Function	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Paediatrician	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Locum Consultant Radiologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Paediatrician	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Chief of Staff	Corporate Functions	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Locum Consultant in General and Acute Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant in Palliative Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Locum Consultant Maxillofacial Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Service Director	Mental Health & Learning Disabilities Care Group	1. Chair of West Wales Care & Repair Board Member ATEB 3. Spouse is a Clinical Nurse Specialist at Hywel Dda Health Board 4. Daughter is a nurse at Aneurin Bevan UHB	1. Since 20 March 20223 Since 1 April 2024 Since March 2023 Since September 2023	2. 1. Voluntary role 3. Salaried role 4. Not applicable Not applicable	2. Not applicable
10.06.2024	Head of Psychology	Mental Health & Learning Disabilities Care Group	1. Trustee at Adferiad Glamorgan Psychotherapy & Consultation Private psychotherapy and consultation	2. 1. Since 2021 Since 2013	2. 1. Voluntary private healthcare systemic organisational consultation	2. Not applicable
10.06.2024	Consultant Physician & Site Clinical Lead	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
10.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	1. Director of Minesh Gastro Ltd 2. Spouse is Director of Minesh Gastro Ltd 3. Works at Nuffield Hospital in Cardiff Bay to do a clinic and endoscopy	1. Since 2022 Since 2022 Since 2018	2. 1. Share options 3. 2. Share options	Not applicable
10.06.2024	Consultant Anaesthetist	Planned Care Care Group	1. Director Private Limited Company 2. Spouse is Director of Private Limited Company	1. Since October 2016 Since October 2016	2. 1. Receive dividends Receive dividends	2. Not applicable
10.06.2024	Consultant Anaesthetist	Planned Care Care Group	1. Deputy Regional Advisor Royal College of Anaesthetics 2. Examiner for the Royal College of Anaesthetist	1. Since April 2024 Since April 2024	2. 1. Nil financial transactions 2. Nil financial transactions	Not applicable
11.06.2024	Consultant General and Colorectal Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Anaesthetist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Respiratory and General Internal Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Locum Consultant Rheumatologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Urologist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Deputy Director of Strategy and Partnerships	Planning & Performance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant in Acute Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Cardiologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Anaesthetist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Physician	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Clinical Director	National Collaborative Commissioning unit	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant Gastroenterologist	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
11.06.2024	Consultant Anaesthetist	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Consultant in Community Paediatrics	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Assistant Director of Finance	Finance Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
11.06.2024	Care group medical director	Medical Director Function	1. Director of a limited Company Spouse is a Director of a limited Company	1. From October 2022 From October 2022	1. Dividends share Dividends share and monthly salary	Not applicable
12.06.2024	Head of Health Psychology Service	Diagnostics, Therapies, Pharmacy and Sciences Care Group	1. Spouse is Principal Solicitor / Private Law Practice Professor of Health Psychology (Honorary - unpaid)	1. 36 Years 10 Years	1. Not applicable Nil	Not applicable
12.06.2024	Director of Planning, Vaccination Programme Wales (currently on secondment)	Planning & Performance Directorate	1. Spouse is GP Partner, Afon Elai Partnership Spouse is Director, Cardiff Southwest Cluster Community Interest	1. Since August 2015 Since January 2022	1. Not applicable Not for profit organisation	Not applicable
13.06.2024	Consultant Oral Surgeon / Clinical Service Director	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
13.06.2024	Consultant Paediatrician	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
13.06.2024	Consultant Obstetrician & Gynaecologist	Children & Families Care Group	Honorary Professor Reproductive Medicine and Gynaecological Oncology Swansea University	Since 2018	Nil financial transactions	Not applicable
13.06.2024	Consultant Surgeon	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
13.06.2024	Speech and language admin	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
13.06.2024	Deputy Medical Director	Medical Director Function	Nil Interests Declared	Not applicable	Not applicable	Not applicable
14.06.2024	Consultant Anaesthetist	Planned Care Care Group	President of Society of Anaesthetists of Wales	March 2023 to present	None	Not applicable
14.06.2024	Consultant in Restorative Dentistry	Planned Care Care Group	1. Directorship in a limited company providing private dental care in Cardiff and Bristol 2. Spouse has Directorship in a limited company providing private dental care in Cardiff and Bristol	1. 2018 to present 2018 to present	1. Financial transactions 2. Financial transactions	Not applicable
17.06.2024	Consultant Radiologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
17.06.2024	Consultant in Sports Medicine	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
17.06.2024	Directorate Manager CAMHS and specialist services	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
17.06.2024	Energy Support Officer	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
17.06.2024	Emergency Medicine Consultant	Unscheduled Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
18.06.2024	Consultant Orthogeriatrician	Planned Care Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
18.06.2024	Consultant Gynaecologist	Children & Families Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
18.06.2024	Consultant Histopathologist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
18.06.2024	Consultant Paediatrician	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
18.06.2024	Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
18.06.2024	Pelvic Health Physiotherapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Private Practice Work	Since April 2024	Financial	Not applicable
18.06.2024	Registered General Nurse	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
18.06.2024	Director of Nursing	Unscheduled Care Group	1. Trustee in City Hospice Cardiff Spouse works in DTPS Directorate within Health Board	1. Since 2020	1. Not applicable Not applicable	Not applicable
19.06.2024	Family Psychotherapist	Mental Health & Learning Disabilities Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
19.06.2024	Responsible Office PCH Construction Programme	Estates Directorate	Nil Interests Declared	Not applicable	Not applicable	Not applicable
21.06.2024	Dietetic Support Worker	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Secondary employment through Direct Payment in Neath Port Talbot Council as a Personal Assistant in Care for an individual. Contract will only be on the weekend	Once a month until contract terminates	Paid role. Paid via Neath Port Talbot Council	Not applicable
24.06.2024	Physiotherapy Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not Applicable	Not applicable

Date Approved	Designation	Department	Nature of Declaration	Period of Involvement	Financial Transaction or Benefits in Kind	Management Action Taken
24.06.2024	Physiotherapy Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
24.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
24.06.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Soon to begin a second paid employment as a specialist speech and language therapist at a private company "Cardiff Speech Therapy" operating outside of the health board area only.	From 20th July 2024 - onwards	Paid employment	Not applicable
25.06.2024	Highly Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Community Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Highly Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interests Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Highly Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Professional Lead Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
25.06.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
26.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
26.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
26.06.2024	Staff Nurse	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
26.06.2024	Healthcare Support Worker	Primary Care and Community Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
26.06.2024	Speech and Language Technical Instructor	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
26.06.2024	Anaesthetics Consultant	Planned Care Care Group	Director of Bridgend Anaesthetists limited.	Current	None	Not applicable
27.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
27.06.2024	Specialist Speech and Language Therapist	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
27.06.2024	Speech and Language Assistant	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable
28.06.2024	Consultant Acute Medicine	Unscheduled Care Group	Nil Interest Declared	Not applicable	Not applicable	Not applicable



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ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at date papers were circulated)
3.1	June 2024	Action Log Query on when the Committee would receive an update on JAG Accreditation report or	Chief Operating Officer	August 2024	In Progress On Agenda for August 2024 meeting.
4.2	June 2024	Losses & Special Payments Report - To provide more context to the report for future meetings including comparators for year on year with regard to cash write offs.	Head of Corporate Finance	August 2024	Completed Report has been fully updated with revised layout and content and on agenda for August 24 meeting.
5.1	June 2024	Organisational Risk Register To provide further clarity and updates with regard to risks 5755 and 1183	Assistant Director of Governance & Risk	August 2024	Completed Response provided via email on 15.7.24
5.2	June 2024	Audit Recommendations Tracker To review the high level overdue tracker actions and bring an update back to the next meeting	Director of Corporate Governance/ Board Secretary	October 2024	In Progress Review underway. This has been extended to review where recommendations may need to be reviewed in conjunction with audit colleagues if significant time has passed since the recommendation was set



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					and in light of operational changes. Request to push timeframe back to the October 24 meeting.
5.5.	June 2024	Internal Audit Review – Technical Resilience Digital Team to provide a more robust update on the agreed management actions on 4.1 and 5.1 and provide an update to the next meeting	Internal Audit/Digital Team	August 2024	In progress Management Actions updated and on agenda for August 2024 meeting.
3.2	April 2024	Committee Annual Self-Effectiveness Survey Outcome & Improvement Plan – To provide an explanation of the Statement of Internal Control and Assurance Framework at the next meeting of the Committee in June 2024.	Director of Corporate Governance/ Board Secretary	June 2024	Completed Received by the Committee at the Extra Ordinary Meeting on the 10 July 2024 <i>This is an issue on terminology used in the self-effectiveness survey. The Statement of Internal Control was a precursor to the Annual Governance Statement, which the ARC will now review as part of the year end Annual Report and Accounts. The Assurance Framework should be referenced as the Board Assurance Framework for CTM. We will update the terminology in the next Annual Effectiveness Survey to ensure that ARC members and attendees have</i>



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					clarity on what is being referred to.
5.5.5	April 2024	Internal Audit Review – Decarbonisation - To review the management response on recommendation 4.1 and bring back to a future meeting.	Internal Audit/Deputy Director of Strategy & Partnerships	June 2024	Completed Received at the June 2024 meeting.

Completed Actions

4.1	April 2024	Local Counter Fraud Annual Report – Annual Report to be amended to reflect the red and amber components and brought back to the next meeting of the Committee.	Local Counter Fraud Officer	June 2024	Completed Annual Report revised and on Agenda June 2024
4.5	April 2024	Progress on the Grant Thornton Recommendations – To feedback the comments made by the Committee and to review the wording on 2.8 and 2.9 with regard to the Born Well Strategy	Deputy Director of Strategy & Partnerships	June 2024	Completed Document revised and circulated 23.4.24
5.2	April 2024	Organisational Risk Register – To review risks 5276 LIMS Software, 4103 Ophthalmology and 5417 Community Dental outside of the meeting.	Assistant Director of Governance & Risk	June 2024	Completed Risk ID 5276 – an update on the mitigating action for the Laboratory Information System has been captured in the May



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					iteration of the organisational Risk Register included on the agenda for this meeting. • Risk ID 4103 – updated mitigation provided by the Planned Care Group relating to the Ophthalmology risk which is included in the May iteration of the organisational Risk Register included on the agenda for this meeting. • Risk ID 5417 – Mitigating action has been reframed to ensure the action being taken around additional lists is clearer and this is reflected in in the May iteration of the organisational Risk Register included on the agenda for this meeting.
5.3	April 2024	Audit Recommendations Tracker – To review the Bridgend Transfer of Services	Director of Corporate Governance/	June 2024	Completed There was only one recommendation which remained open from this



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		closed recommendation outside of the meeting.	Board Secretary		audit review and we sought an update as follows which supported this action being closed and that closed the recommendation actions arisen out of that specific review: <i>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.</i> The update at the December 2023 meeting stated that - Risks are now reviewed at every Bridgend Transition Board and any risks raised with the Joint Executive Group and the Digital & Data Committee - Propose to close. Following the April 2024 meeting Cally Hamblyn shared the full report with Ian Wells and provided Ian
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Cwm Taf Morgannwg
University Health Board

Agenda Item 3.1

					with the explanation as above which addresses the query which Ian raised in the meeting.
4.2	22/02/2024	Procurement & Scheme of Delegation Report – To discuss agency non-receipting with the People Directorate.	Executive Director of Finance & procurement	18 th April 2024	Completed Raised with Director of People with proposal to undertake some joint Workforce and Finance work on agency processes
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	Completed Received at the February 2024 meeting.
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	Completed Propose to Close as captured in the Audit Tracker work programme included at agenda item 5.3b. This will be an ongoing action in the work programme as the process has moved to the AmAT inspection module where there is no current field to



Agenda Item 3.1

					capture this data, however a development request to the system provider has been made. ARC members will continue to receive the work plan indicating timeframes for completion. In the meantime, rationale will be asked of leads to include in the narrative update field.
4.4	24/10/2023	Changes to the Welsh Risk Pool Agreement - Report to be shared with the Planning, Performance & Finance Committee for information only.	Head of Corporate Governance & Board Business	27 February 2024	Completed Report received and noted by the Planning, Performance & Finance Committee at it's February 2024 meeting. .
4.1.1	22/02/2024	Local Counter Fraud Report Agreed that the report should be referred to the People & Culture Committee as the report raised a fraud risk in relation to fitness to practice.	Director of Corporate Governance	15 th April 2024	Completed Referral received and discussed at the People & Culture Committee held on 15 April 2024



Agenda Item

4.1

Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
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
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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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Cydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 noting and 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 – 15 August 2024

Counter Fraud Progress Report

Matthew Evans
Head of Local Counter Fraud Services

1. INTRODUCTION

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

2. BACKGROUND

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

3. RESOURCE UTILISATION

AREA OF WORK	Planned Days	Days to Date
Strategic Governance		
Ensuring that anti-crime measures are embedded at all levels across the organisation	48	22
Inform and Involve		
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.	100	20
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	148	39
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	310	159
TOTAL	606	240

4. STRATEGIC GOVERNANCE

A benchmark report highlighting Counter Fraud performance across key performance indicators in comparison to an All-Wales average is included at Appendix 1 for Committee members perusal.

5. INFORM AND INVOLVE

A revised reporting system for Counter Fraud Services is being explored. This will seek to update the existing manual process to utilise available applications to automate reporting process as well as make it easier to interrogate context behind

figures. A meeting has been held with Internal Audit colleagues who have developed a database and reporting suite, learning has been gained and ongoing support offered.

Widespread press coverage of the successful trial at Cardiff Crown Court has led to further opportunities for external NHS awareness raising. Early discussions with a local TV production company have been undertaken and ideas are being explored to highlight the work of Counter Fraud in the NHS.

A series of internal communications have been developed to seek to raise awareness in the counter fraud agenda following interest in the trial outcome. Ultimately this work seeks to drive increased attendance at counter fraud awareness training. Targeted training sessions have been identified as part of lessons learned review following conclusion of this investigation.

6. PREVENT AND DETER

Work has commenced on the NHS Counter Fraud Authority led national proactive exercise around procurement with a focus on due diligence and contract management. This will lead into more focussed local proactive exercise around the same area with particular focus on local and NHS Wales risks.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 to this report. A summary of basic investigation KPI data is presented at outset of the appendix.

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

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

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

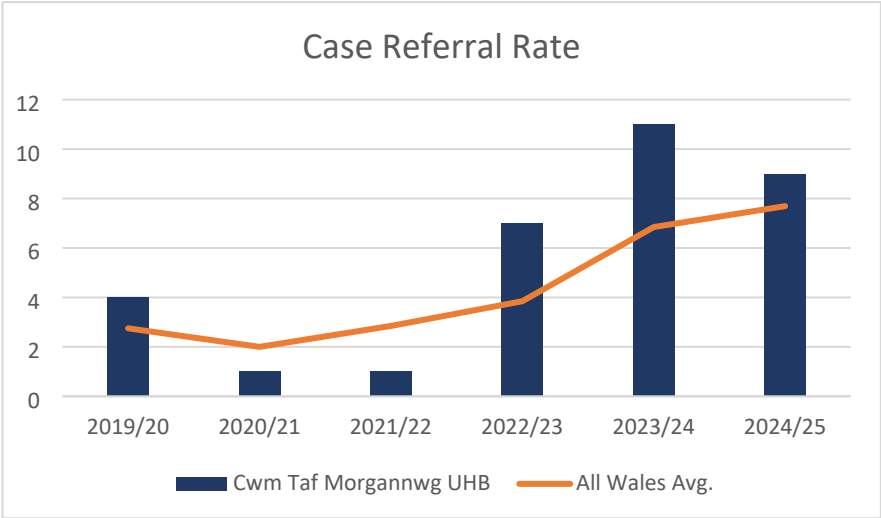


Item 4.1 – Appendix 1

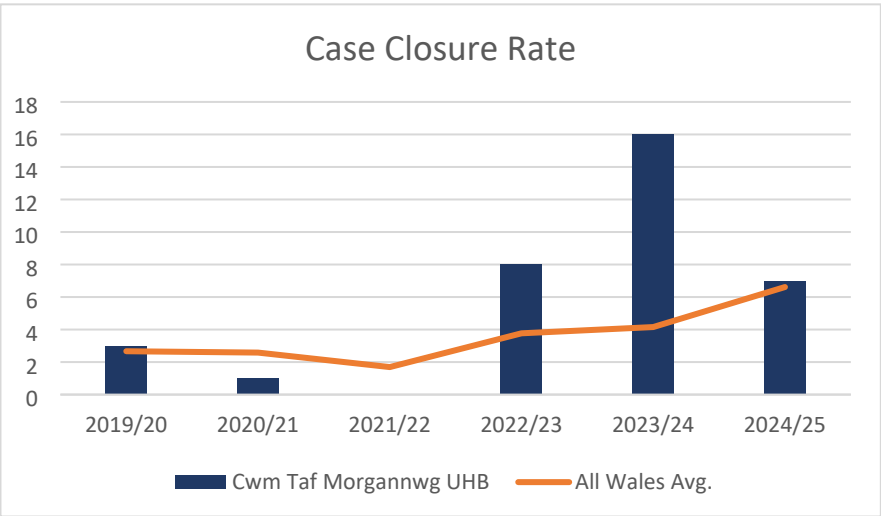
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Q1

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	4	2.8
2020/21	1	2.0
2021/22	1	2.8
2022/23	7	3.8
2023/24	11	6.8
2024/25	9	7.7



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	3	2.7
2020/21	1	2.6
2021/22	0	1.7
2022/23	8	3.8
2023/24	16	4.2
2024/25	7	6.6

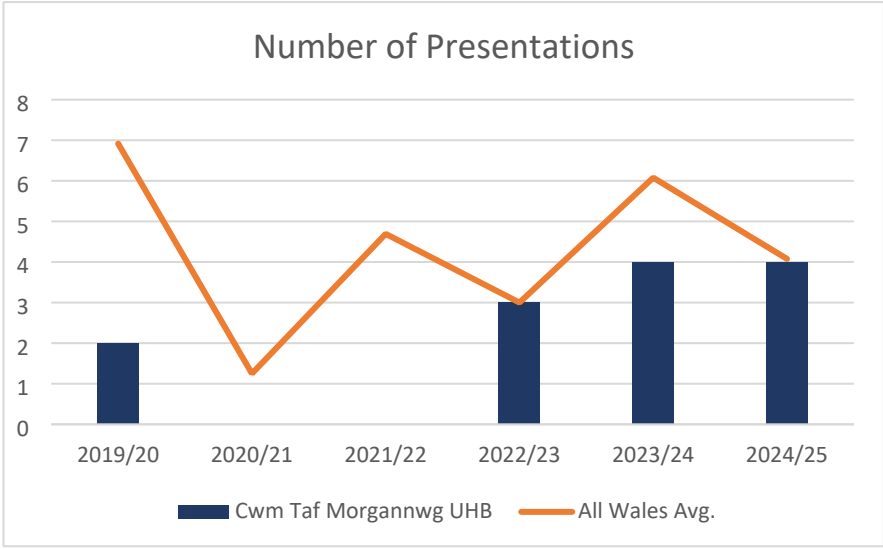


Counter Fraud Benchmarking Statistics – Q1

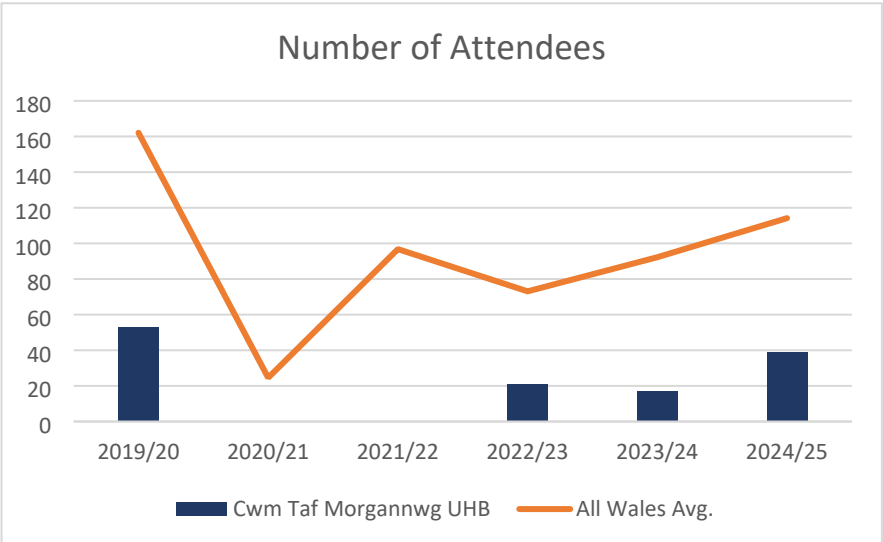
Sanctions	2021/22			2022/23			2023/24			2024/25		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	0	0	1	0	0	4	0	1	1	0	1	0
All Wales Avg.	0.1	0.3	0.5	0.1	0.4	1.2	0.7	2.9	4.9	0.7	2.9	4.9
All Wales Total	1	4	6	1	5	15	0	8	8	1	18	16

Counter Fraud Benchmarking Statistics – Q1

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	2	7
2020/21	0	1
2021/22	0	5
2022/23	3	3
2023/24	4	6
2024/25	4	4

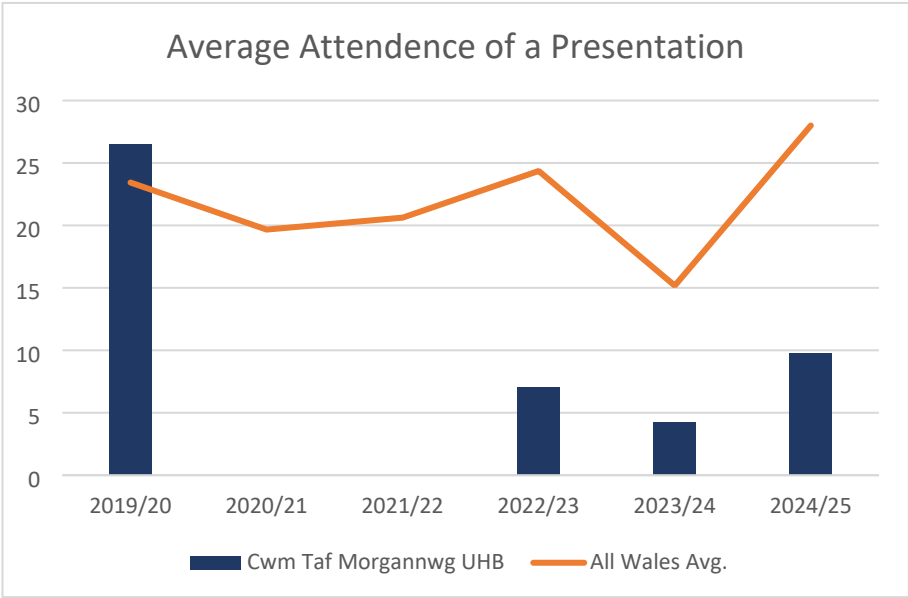


Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	2	7
2020/21	0	1
2021/22	0	5
2022/23	3	3
2023/24	4	6
2024/25	4	4



Counter Fraud Benchmarking Statistics – Q1

Average Attendance of a Presentation	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	27	23
2020/21	0	20
2021/22	0	21
2022/23	7	24
2023/24	4	15
2024/25	10	28





Item 4.1 – Appendix

Counter Fraud Investigations Update Report

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 2024/25
17	0	9
Case Rates		
Referrals Received 2024/25	Cases Under Investigation for Over 12 Months	
12	2	
Sanctions/Outcomes		
Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
1	0	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 has been found guilty in relation to 9 counts faced at Crown Court. Sentencing has been set for September 2024. A full report for members is available in the meeting folder in Admincontrol for members. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are awaiting outcome of criminal case.
INV/22/01136	18/08/2022	Unknown third party attending to complete an agency shift	Enquiries have corroborated referral information with witnesses with statements and documentation gathered. Digital forensics of mobile devices has been undertaken and evidence analysed. An interview under caution has been undertaken and an account gained. This investigation forms part of a wider investigative strategy with Home Office immigration and Police involvement. A case file is being prepared for CPS consideration of charges.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/02311	16/10/2023	Contractor Prescription Fraud	A dispensing GP Practice is alleged to have been dispensing cheaper medications but endorsing prescriptions for more expensive brands. Initial enquiries have established that CFS Wales have undertaken a previous investigation in this area. The case file from this previous investigation has been gained and was being reviewed in conjunction with new evidence. Following a case review meeting further meetings with CFS Wales and separately with NHS Counter Fraud Authority specialists in this area were held to inform investigative strategy. The assessment was that the drug tariff guidance and policy underpinning this matter is ambiguous. Visits to a sample of patients to verify that the medication dispensed matches claims has been undertaken with no concerns identified. A case conference has been undertaken to assess evidence. Weaknesses in the claiming guidance and procedure have been identified and these will be raised with Primary Care colleagues for input.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/02885	18/12/2023	Annual Leave Concerns	Information received from the Fraud and Corruption Reporting line that staff member records only half of annual leave take and works for 2 Health Boards. Enquiries have sought to identify secondary employer. A request for information to potential secondary employer has been issued to seek clarity on role fulfilled there. Annual leave records have been gathered from the ESR system and analysed. Subject's managers have been approached and information for use in further enquiries has been gained including car registration and system access details to request audit logs. Witnesses have been identified and will be approached to gain account and potential documentary evidence.
INV/23/02888	18/12/2023	Overpayment of Salary	Referral received from NWSSP Payroll stating that a Junior Fellow whose fixed term contract ceased 31/10/22 but salary continued to be paid until 31/10/23, causing an overpayment of salary of Gross £95,931.70, Net £61,334.42. Identified by Pensions when subject found to be being paid by two different NHS employers. CFS Wales to investigate as financial investigator powers are required under agreed criteria.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00157	23/01/2024	False NHS compensation Claim	Information received from the Fraud and Corruption Reporting line that a member of the public claims that they are unable to work and is in process of claiming against the NHS for issues linked to surgery but in fact does work regularly. Enquiries have established that compensation has been paid previously for the member of public linked to NHS treatment. Enquiries are being undertaken to ascertain the exact nature of that compensation and whether any dishonesty is present in the context of the allegation. Liaison with claim managers has been established and is ongoing.
INV/24/00220	29/01/2024	Fraudulently Obtaining Controlled Drugs	The partner of a patient currently serving a custodial sentence in prison, has been obtaining repeat prescriptions from the GP in the name of the patient, for controlled drugs (gabapentin), for a 6 month period, when the patient has been prescribed this medication through the prison. GP has been engaged as initial enquiries seek to corroborate allegation. Police are leading in this case and following enquiries have not established any evidence to support ongoing investigation. The Police Drugs Liaison Officer has been contacted for follow up.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00221	29/01/2024	Timesheet Fraud	Locum Doctor alleged to have been claiming incorrect rate and inflated hours. Allegation refers to claiming of on-site on call rate when actually absent. Additionally there appears to be inflation of hours claimed for weekends. Enquires have gathered timesheets and analysis is being undertaken. Further enquiries are being undertaken with the supplying agency seeking to corroborate and enhance current evidence.
INV/24/00223	29/01/2024	Timesheet Fraud	Locum Doctor alleged to have been claiming incorrect rate and inflated hours. Allegation refers to claiming of on-site on call rate when actually absent. Additionally, there appears to be inflation of hours claimed for weekends. Enquires have gathered timesheets and analysis is being undertaken. Further enquiries are being undertaken with the supplying agency seeking to corroborate and enhance current evidence.
INV/24/00224	29/01/2024	Non-Completion of Contracted Hours	Allegation that Consultant has not worked job plan sessions following a denied request to drop sessions. Enquiries have established communications confirming what expectations are in relation to sessions. Further enquiries undertaken assess how firm existing job plan arrangements are for this consultant and to attempt to clarify what actual sessions have been completed during the period of concern.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00465	23/02/2024	Authorisation of hours not worked	Concerns have been raised regarding bank staff submitting timesheets for hours beyond initially agreed shift hours and outside of hours of operation of unit worked at. Claims have been authorised by managers. Meetings have been held with senior managers and People Services colleagues to discuss concerns. Access has been gained to the allocate system and shift data gathered. Analysis is being undertaken. Enquiries established that staff identified had been uplifted in banding and hours authorised were intended to align with the pay of this higher banding. This appears to be a case of poor process rather than dishonesty. An ongoing disciplinary process is exploring the concerns and outcome is awaited to inform next steps.
INV/24/01164	07/05/2024	Falsified Sickness	Allegation that a staff member is absent due to workplace injury but has submitted photographs of injury which is believed to not be not them due to lack of a tattoo. Enquiries being undertaken to corroborate this allegation with parallel disciplinary ongoing.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/01324	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and various data sources have now been obtained for analysis. A further reference has been created to separate subjects into individual investigations. INV/24/01334 is the linked reference.
INV/24/01334	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and various data sources have now been obtained for analysis. A further reference has been created to separate subjects into individual investigations. INV/24/01334 is the linked reference.
INV/24/01512	14/06/2024	Overpayment of Salary	Staff member has continued to receive full pay whilst on a formal unpaid career break. Subject was traced and contacted they stated they have been out of country and travelling with no direct access to bank accounts. They subsequently confirmed that money was in their account and have agreed full repayment which is now being processed via Finance Dept.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/01873	23/07/2024	Overpayment of Salary	Staff member continued to receive salary payments following leaving Health Board employment. Intelligence checks have been completed and Financial Investigators engaged. An interview has been arranged with the subject.
INV/24/01883	26/07/2024	Prescription Misuse	A fraud and corruption reporting line report has been received alleging that a named patient has been obtaining NHS prescription medication before selling those prescribed medications in the community. South Wales Police have been engaged and the Counter Fraud Team are supporting with enquiries within the NHS.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
INV/24/00067	09/01/2024	Prescription Fraud	Allegation that Pharmacy contractor has been receiving fake prescriptions, not dispensing any items and then claiming reimbursement. Primary Care Prescribing Services colleagues have been contacted for advice and input. Claims data for the contractor has been gathered and is being analysed. Following analysis it was established that there was an anomaly due to late submission of relevant prescriptions for claim. No fraud was established and learning has been shared with Primary Care contacts.
INV/24/00789	25/03/2024	Pharmacy Contract Fraud	Allegation that a Community Pharmacy has provided false information on an application to be included on the Health Board's Pharmaceutical List. The potential false information relates to premises address and appears to be linked to a dispute around freehold/leasehold of the property. General Pharmaceutical Council have previously visited the contractor on two occasions and are satisfied with the operation of the pharmacy. The Pharmacy Team have sought legal advice on the matter from Legal and Risk. Following review this case was assessed as lacking any dishonesty and that the issues raised were technical

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			and administrative with no concerns around the behaviour.
INV/24/00859	05/04/2024	Working elsewhere in receipt of occupational sick pay	Allegation that subject has worked for own photography business whilst absent due to sickness. Enquiries have established one instance of work completed on a weekend day during absence period. This falls under the criminal threshold and information has been shared with manager and People Services for review and this has been actioned via Managing Attendance At Work and Standards of Behaviour Policies.



Agenda Item

4.2

Audit & Risk Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James - Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Approval
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

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



1. Situation / Background

1.1 Procurement Matters

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

- a) Engagement off contract of non-medical staff not paid via the payroll. The Director of People and the Head of Procurement would need to confirm agreement prior to any commitment.
- b) Waiver of competitive tenders, as authorised by the Director of Finance and Procurement.
- c) Contracts requiring Ministerial approval (over £1m)
- d) Summary of contracts over £500,000
- e) Free of charge services
- f) Retrospective orders and non-receipting areas
- g) Consultancy contracts
- h) No PO No Pay summary

This report provides details of any such transactions within the period 01.06.24 to 31.07.24

1.2 Purchase to Pay (PSPP)

In order to comply with the Public Sector Payment Policy, 95% of the number of non-NHS invoices must be paid within 30 days. This report provides an update on the Prompt Payment compliance for 2024-25.

1.3 Scheme of Delegation and Financial Control Procedures

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

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

2. Specific Matters for Consideration

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.06.24 to 31.07.24.

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 01.06.24 to 31.07.24

There were no Single Tender Actions for the period 01.06.24 to 31.07.24.

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

There were no contracts requiring Ministerial approval for this period.

d) Summary of contracts awarded over £500,000 –

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

retrospective summary of contracts awarded between 01.06.24 to 31.07.24

Reference	Title	Supplier	Value	Date Approval Received
STA1689	Specialist Orthadontic Services	Q Dental Care Ltd	£526,000	26/07/24

e) Free of Charge Services

Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer term commitment. Below is a summary of free of charge services that have been provided between 01.06.24 to 31.07.24:

There is currently a review being undertaken for People and OD for Retinue and KPMG-this is still ongoing

f) Retrospective orders and non-receipting areas

Below shows the trend of numbers of retrospective orders being placed across the Health Board and the main non-receipting areas:



Supplier	Areas	Value of retro order	Comments
Blue Arrow	544063_LLW DOM TOP B	£103,354.31	Agency Staffing
	559148_Houskeeping YCC		
	533912_RGH H'SEKEEP		
Boc Ltd	555100_PCH PHARMACY	£26,855	Industrial Gases and Equipment
	533044_DENTAL BRIDGEND CLINIC		
	533041_DENTAL SURGERY YNYSHIR		
Leda Orthopaedic	534102_POW THEATRES ORTHOPAEDICS	£11,528	Orthopaedic Equipment
	534116_POW THEATRES TRAUMA		
	555046_PCH THEATRE		

g) Consultancy Contracts

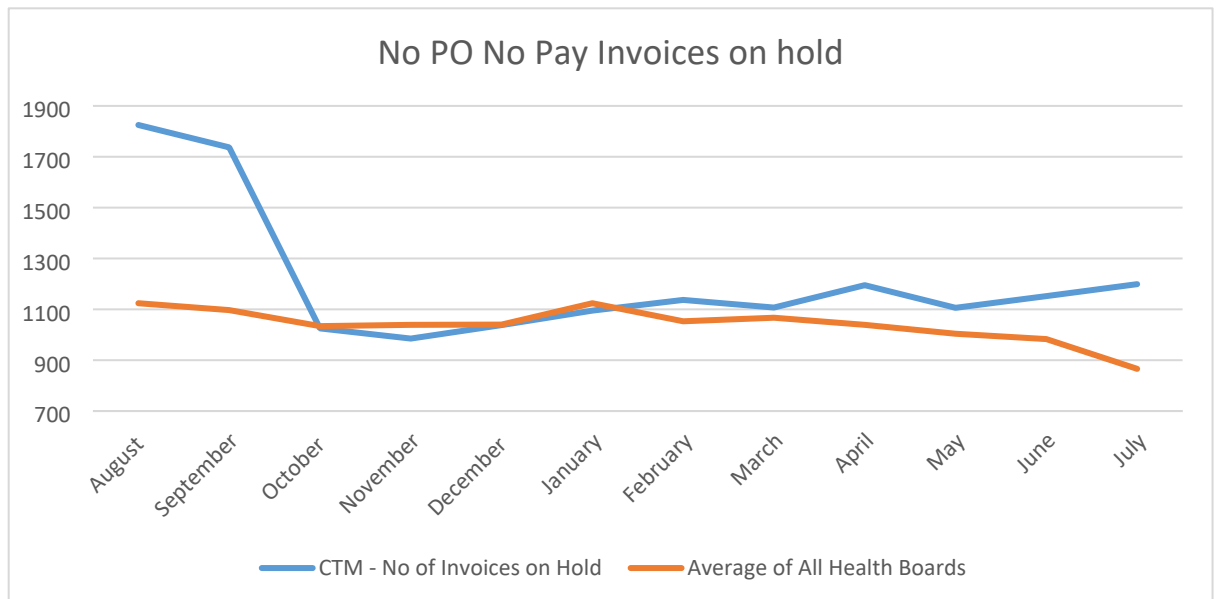
Below is a table detailing consultancy contracts that have been awarded between 01.06.24 to 31.07.24

None for this period

h) No PO No Pay Summary

Below shows the trend of number of No PO No Pay holds over the past 12 months.

The table below shows that the number of CTM invoices on hold have increased over the past two months, whereas the average across Wales has improved and the Health Board is above the average of invoices on hold. One large health board has significantly lower number of invoices on hold at 289 at the end of July, the financial accounts team will link in with their respective colleagues to gather best practice processes to implement within CTM.



2.2 Purchase to Pay (P2P)

The PSPP figures are reported for the 1st quarter to 30th June 2024.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 3 2024-25 achieving 94.6% (value 91.9%). This is below the target of 95%, however it is an improving position and it is projected the target will be met by the end of the financial year.

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-24	22,259	35,686,635	23,700	38,481,025	93.9	92.7
May-24	19,805	37,360,833	20,890	41,651,491	94.8	89.7
Jun-24	19,966	38,227,242	20,971	40,869,496	95.2	93.5
YTD	62,030	111,274,710	65,561	121,002,011	94.6	91.9

The NHS invoice position continues to be challenging and shows that 77.2% (number) and 94.6% (value) of invoices were paid within 30 days to month 3 2024-25.

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

There are four updated Financial Control Procedures for review and approval (**Appendices 1-4**), they are as follows:

- FP4 Cash & Banking – Limited changes following review, moved onto new template and update reference to WHSSC/EASC to Joint Commissioning Committee (JCC).
- FP5 Cash Management – No change to content following review, moved onto new template.
- FP7 Income & Debtors - Limited changes following review, moved onto new template and update reference to WHSSC/EASC to Joint Commissioning Committee (JCC).
- FP13 Requisitioning Goods and Services – It has been recognised that the financial limits table in Appendix 1 hasn't been updated to reflect a change which has already been implemented in the Scheme of Delegation to change the limits to be exclusive of VAT. The name of the Executive Director of Finance on the appendices have also been updated. A full review is still required on this FCP, and will be completed by December 2024.

Audit & Risk Committee are asked to approve the above updated FCPs (full FCPs appended to this report).

There are a still number of other FCPs that are over their review date, as reported to previous Audit & Risk Committee these will be updated by the end of December 2024.

3. Key Risks / Matters for Escalation

None to report.

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:
	Not Applicable



Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	Not Applicable
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
Dolen i Feysydd Ansawdd (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:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate):	If no, please include rationale below:



	POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Audit & Risk Committee is asked to:

APPROVE the updated following FCPs:

- FP4 Cash & Banking
- FP5 Cash Management
- FP7 Income & Debtors
- FP13 Requisitioning Goods and Services

NOTE the position on procurement matters for the period 01.06.2024 to 30.06.2024;

NOTE the update regarding Purchase to Pay and achievement of PSPP target for the first quarter of 2024/25;

6. Next Steps

6.1 If approved the updated FCPs will be distributed to the relevant areas and updated on the finance policies page on SharePoint.



Agenda Item

4.3

Audit & Risk Committee

Losses and Special Payments 01.04.24 to 01.06.24

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James – Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May - Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
NWSSP – legal services and Risk Pool	Click or tap to enter a date.	NOTED

Acronyms / Glossary of Terms	
WRP NWSSP VER DEL GMPI	Welsh Risk Pool NHS Wales Shared Services Partnership Voluntary Early Release Departmental Expenditure Limit General Medical Practice Indemnity



1. Situation /Background

- 1.1 This report advises the Audit & Risk Committee on the losses and special payments made by the University Health Board (UHB) for the 3 month period from 1 April 2024 to 30 June 2024, as required by in Standing Financial Instruction.
- 1.2 The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.
- 1.3 General Medical Practice Indemnity Scheme (GMPI) was introduced in recent years by the Welsh Government as a state-backed scheme within NHS Wales. Legal and Risk Services and WRP operates this scheme and cases settled under the scheme are presented to WRP for reimbursement.
- Scrutiny of the Learning from Events Report is conducted in the same manner as cases settled under NHS Indemnity or as part of the redress scheme.
 - Payments in relation to claims managed under GMPI are made by the defendant Health Board, and reimbursement by the WRP is made to the Health Board.
 - No excess in relation to reimbursement of cases settled under the GMPI will apply to the Health Board and all costs incurred are fully reimbursed.
- 1.4 In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.

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

- a) Losses & special payments recoded during the period, with details being provided within the appendices.
- b) Claims that have been identified as a provision on the balance sheet as they have been deemed as probable but have yet to be paid.
- c) The impact of these claims being recognised on the Health Boards in year revenue position.

2. Specific Matters for Consideration

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

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

a) Losses and Special Payments recorded during period

2.3 The losses and special payments recorded during this period totalled £2,172k, with the majority of this comprising of payments in respect of Clinical Negligence, Redress and Personal Injury.

2.4 It is important to note that the majority of these losses would have been recorded in the revenue position when the claim was deemed as probable, therefore this is showing the cash impact of the payments made during the period.

2.5 The total recovered from Welsh Risk Pool during the period is £1,115k, giving a net cash position for the period of £1,057k out.



2.6 The losses and special payments are detailed in Appendices 1 to 6 and are summarised in the table below.

	01.04.24 - 30.06.24 £000	Previous Periods	Total 2024- 25 £000
Medical Negligence Claims	574		574
Medical Negligence Costs	875		875
Medical Negligence Defence Fees	444	0	444
Medical Negligence Totals (Appendix 1)	1,893	0	1,893
Redress Medical Negligence Claims	26	0	26
Redress Medical Negligence Costs	25	0	25
Redress Medical Negligence Defence Fees	29	0	29
Redress Medical Negligence Totals (Appendix 2)	80	0	80
GP Indemnity Claims	35	0	35
GP Indemnity Defence Fees	11	0	11
GP Indemnity Totals (Appendix 3)	46	0	46
Personal Injury Claims	24	0	24
Personal Injury Costs	82	0	82
Personal Injury Defence Fees	29	0	29
Personal Injury Totals (Appendix 4)	135	0	135
Permanent Injury Benefit (Appendix 5)	0	0	0
Permanent Injury Benefit Totals (Appendix 5)	0	0	0
Other:			
Ex-Gratia	18	0	18
Debt Write Off	0	0	0
WRP Penalty Charge	0	0	0
Ombudsman	0	0	0
Employment Matter/Other	0	0	0
Other Totals (Appendix 6)	18	0	18
TOTAL	2,172	0	2,172
Recovered from Welsh Risk Pool	(1,115)	0	(1,115)
Net Cash Write-Off/(Recovery)	1,057	0	1,057

b) Provision as at 30 June 2024

2.7 As a claim is deemed probable a provision will be made on the balance sheet reflecting the estimated value of the claim. There will also be an estimate for the value recoverable from Welsh Risk Pool, leading to a net provision value on the balance sheet.

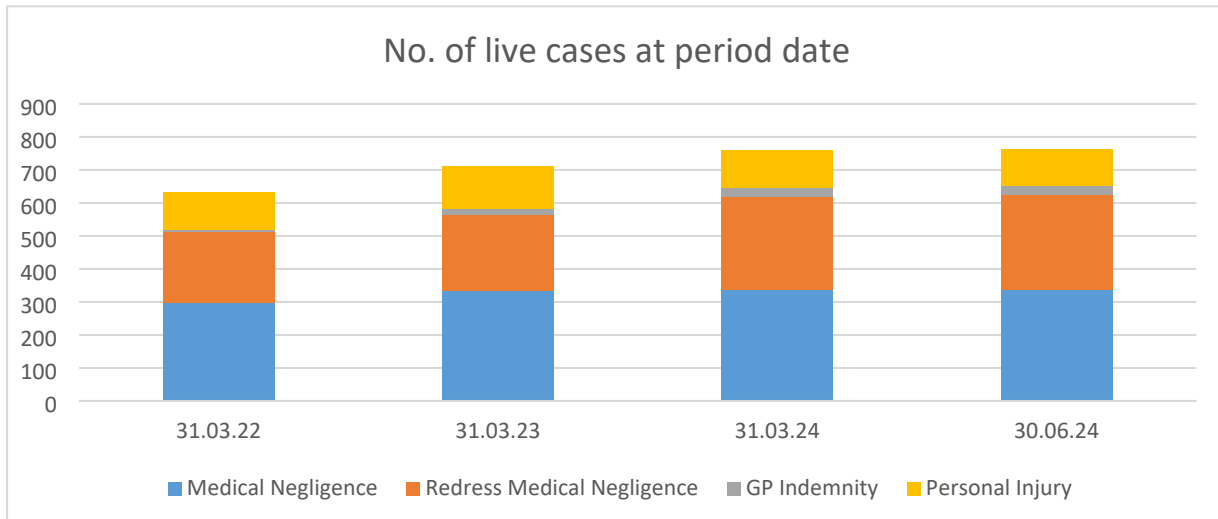


- 2.8 The table below shows the provision made for each type of claim as at the period stated and the amount recoverable from Welsh Risk Pool. It could be deemed the lower value the net claim provision the more efficient the health board are at recovering from Welsh Risk Pool i.e. payments have been made out and they have been recovered from Welsh Risk Pool in an efficient manner.
- 2.9 The total claims provision has increased by £6,042k since 31st March 2024, this is mainly due to an increase in value of medical negligence claims.
- 2.10 The net provision at the end of 30th June 2024 was £7,030k which is £714k higher than it was for the previous period.

	30.06.24	31.03.24	31.03.23	31.03.22
	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	100,544	94,478	72,198	65,127
Redress Medical Negligence claims/costs	424	372	385	235
GP Indemnity (Note 1)	585	612	0	0
Personal Injury claims/costs	868	917	701	611
TOTAL CLAIMS/COSTS PROVISION	102,421	96,379	73,284	65,973
Recoverable from Welsh Risk Pool	(113,243)	(106,450)	(83,623)	(93,074)
NET CLAIMS / COSTS PROVISION	(10,822)	(10,071)	(10,339)	(27,101)
Permanent Injury Benefit	3,792	3,755	4,077	6,201
NET PROVISION inc Perm Injury Ben.	(7,030)	(6,316)	(6,262)	(20,900)

Note 1: GP Indemnity provision is fully reimbursable by WRP as such no net impact to the Health Board's Budget.

- 2.11 The chart below shows the number of live cases as at period stated. You will note that the number of live cases have remained relatively steady over the last couple of years following an increase in cases after 2021/22.



c) Revenue impact for the year to date

- 2.12 As previously highlighted, the Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. The net impact of this value impacts the revenue account of the Health Board in the period the claim is recognised.
- 2.13 The table below shows the year to date position for each of type of claim. The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases.

	Year to
	30.06.24
	£000
Medical Negligence claims/costs	7,958
Redress Medical Negligence claims/costs	131
GP Indemnity	20
Personal Injury claims/costs	85
Recoverable from Welsh Risk Pool	(7,907)
Net claim expenditure (Note 1)	287
Permanent Injury Benefit	38
Other	18
Total Net expenditure	343

Note 1: The annual budget for net claim expenditure for 2024-25 is £1,785k, with a year to date budget of £446k, actual expenditure for the year is £287k, therefore an underspend of £159k to June 2024. It is important to note that these costs can fluctuate during the year. In previous years there has been a significant overspend at outturn against these costs.

WRP Risk Sharing Agreement

- 2.14 The Audit & Risk Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations, and is therefore an additional financial risk to those organisations.
- 2.15 At the time of reporting we are projecting the value to be on budget for 2024/25.

3. Key Risks / Matters for Escalation

- 3.1 During the period there have been 3 penalties imposed for late submissions, for which we have been imposed penalties of £2.5k each. They relate to the following:

Claim Ref	Reason	Due Date	Submitted Date	Directorate
CLA7A5-0063-DN	Late submission of deferred learning & further information need	22 nd May 2024	5 th July 2024	Planned Care
CLA7A5-0684-JB	Late submission of LFER	28 th November 2023	21 st May 2024	Children & Families
RED7A5-0434-CZ	Late submission of deferred learning	31 st May 2024	Information not submitted	Planned Care

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below:
	Growing Well Living Well Ageing Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:



150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)		
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective	
	If more than one applies please list below:	
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome for Equality Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15) POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable for this report



	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	
Cyfreithiol / Legal	Yes (Include further detail below)	
	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim	
Enw da / Reputational	Yes (Include further detail below)	
	As noted within Quality Impact Assessment section above, reputational risk is managed via the reporting hierarchy.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments	

5. Recommendation

5.1 The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 April 2024 to 30 June 2024.
- **NOTE** the penalties that have been imposed for submission of late information to the Welsh Risk Pool.

6. Next Steps

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

Medical Negligence Payments 01/04/2024 - 30/06/2024						Appendix 1	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RRSMN0039	75	13	0	0	88	139	227
09RVEMN0017	0	11	0	0	11	65	76
12RYLMN0004	0	6	0	0	6	477	483
12RYLMN0035	0	3	0	0	3	1 384	1 387
12RYLMN0037	0	7	0	0	7	331	338
12RYLMN0070	0	2	0	0	2	50	52
13RYLMN0005	0	8	0	0	8	24	32
13RYLMN0096	0	5	0	0	5	750	755
15RYLMN0049	50	1	0	0	51	417	467
15RYLMN0106	0	32	100	0	132	122	254
15RYLMN0143	12	3	-35	0	-20	1	-20
15RYLMN0199	0	1	0	0	1	9	10
16RYLMN0064	0	10	0	0	10	4	14
16RYLMN0086	0	1	0	0	1	3	4
16RYLMN0089	0	1	0	0	1	25	26
17RYLMN0081	0	0	0	-26	-26	51	25
17RYLMN0165	50	6	0	0	56	1	57
18RYLMN0016	0	0	0	0	0	3	3
18RYLMN0030	0	1	0	0	1	5	7
18RYLMN0072	0	0	0	0	0	4	4
18RYLMN0078	0	6	0	0	6	13	19
18RYLMN0106	0	11	0	0	11	20	30
18RYLMN0137	0	0	0	-25	-25	50	25
19RYLMN0024	0	0	0	-29	-29	54	25
19RYLMN0060	0	0	0	-46	-46	71	25
20RYLMN0007	0	0	0	-89	-89	114	25
20RYLMN0018	0	3	0	0	3	13	16
20RYLMN0033	125	9	0	0	134	20	153
20RYLMN0037	0	2	0	0	2	817	819
20RYLMN0099	37	1	0	0	38	74	112
20RYLMN0108	0	4	0	0	4	7	11
20RYLMN0109	0	5	0	0	5	244	249
20RYLMN0112	0	1	0	0	1	7	8
20RYLMN0116	0	0	0	-398	-398	423	25
20RYLMN0125	100	0	0	0	100	116	216
20RYLMN0129	0	6	0	0	6	1 214	1 220
20RYLMN0164	-3	0	20	0	18	9	27
20RYLMN0165	0	10	0	0	10	136	146
20RYLMN0170	0	8	0	0	8	12	21
21RYLMN0014	0	5	0	0	5	9	13
21RYLMN0016	0	1	0	0	1	78	79
21RYLMN0028	0	2	0	0	2	9	12
21RYLMN0032	0	0	0	-70	-70	95	25
21RYLMN0034	0	7	0	0	7	5	13
21RYLMN0035	0	0	100	0	100	9	109
21RYLMN0077	0	16	0	0	16	223	240
21RYLMN0099	0	0	0	0	0	76	76
21RYLMN0119	0	0	0	0	0	19	20
21RYLMN0134	0	2	0	0	2	20	21
21RYLMN0136	0	6	0	0	6	0	6
21RYLMN0140	0	0	78	0	78	0	78
21RYLMN0147	0	1	0	0	1	47	48
21RYLMN0148	0	1	0	0	1	9	9
21RYLMN0149	0	2	0	0	2	3	5
21RYLMN0154	0	1	0	0	1	4	5
21RYLMN0160	0	1	0	0	1	9	9
22RYLMN0007	35	3	0	0	38	139	176
22RYLMN0008	0	2	0	0	2	6	8
22RYLMN0012	0	3	0	0	3	68	71
22RYLMN0036	0	0	0	-98	-98	123	25
22RYLMN0039	-31	1	0	0	-30	28	-2
22RYLMN0067	0	2	0	0	2	7	9
22RYLMN0070	26	0	9	0	35	5	40
22RYLMN0072	7	0	25	0	32	0	32
22RYLMN0096	10	0	45	0	55	3	58
22RYLMN0099	0	4	0	0	4	0	4
22RYLMN0111	0	2	0	0	2	5	7
22RYLMN0154	0	1	0	0	1	4	5
22RYLMN0161	0	1	0	0	1	7	7
22RYLMN0164	30	0	0	0	30	2	32
22RYLMN0168	0	10	0	0	10	15	24
22RYLMN0182	0	0	0	0	0	10	10
22RYLMN0188	0	1	0	0	1	29	29
22RYLMN0190	0	2	0	0	2	30	32
22RYLMN0201	0	4	0	0	4	0	4
23RYLMN0033	0	4	0	0	4	3	7

23RYLMN0034	0	0	0	-58	-58	83	25
23RYLMN0037	0	0	0	-33	-33	58	25
23RYLMN0038	0	4	0	0	4	5	9
23RYLMN0040	35	0	0	0	35	13	48
23RYLMN0041	18	0	5	0	23	0	23
23RYLMN0042	0	1	0	0	1	3	4
23RYLMN0051	11	6	0	0	17	9	26
23RYLMN0052	1	1	16	0	18	3	21
23RYLMN0061	0	0	0	0	0	15	15
23RYLMN0064	4	1	25	0	30	1	30
23RYLMN0070	0	0	8	0	8	0	8
23RYLMN0071	0	1	0	0	1	59	60
23RYLMN0073	0	1	0	0	1	4	5
23RYLMN0075	0	0	0	-83	-83	63	-21
23RYLMN0079	0	0	0	0	0	126	126
23RYLMN0094	75	5	50	0	130	4	134
23RYLMN0100	7	1	0	0	8	85	94
23RYLMN0102	0	4	0	0	4	2	6
23RYLMN0103	0	3	0	0	3	2	5
23RYLMN0116	15	0	20	0	35	1	36
23RYLMN0122	15	0	16	0	31	2	33
23RYLMN0124	0	2	0	0	2	2	4
23RYLMN0136	0	7	0	0	7	0	7
23RYLMN0139	0	2	0	0	2	2	3
23RYLMN0143	0	17	0	0	17	8	25
23RYLMN0144	0	1	0	0	1	0	1
23RYLMN0153	0	1	0	0	1	4	5
23RYLMN0154	0	15	0	0	15	0	15
23RYLMN0156	0	2	0	-65	-63	86	23
23RYLMN0170	0	2	0	0	2	4	6
23RYLMN0177	9	1	0	0	9	5	14
23RYLMN0178	0	1	0	0	1	0	1
23RYLMN0202	0	1	0	0	1	16	16
23RYLMN0218	0	1	0	0	1	0	1
23RYLMN0219	0	2	0	0	2	0	2
23RYLMN0220	0	2	0	0	2	1	3
23RYLMN0222	0	2	0	0	2	5	7
23RYLMN0235	0	0	0	0	0	8	9
23RYLMN0236	0	3	0	0	3	0	3
23RYLMN0237	0	5	0	0	5	0	5
23RYLMN0239	75	1	0	0	76	11	87
23RYLMN0246	0	2	0	0	2	7	9
23RYLMN0247	25	0	0	0	25	0	25
24RYLMN0019	0	2	0	0	2	0	2
24RYLMN0025	0	0	9	0	9	0	9
24RYLMN0027	0	2	0	0	2	0	2
24RYLMN0030	0	1	0	0	1	3	4
24RYLMN0032	25	3	0	0	28	0	28
24RYLMN0057	0	2	0	0	2	0	2
24RYLMN0058	0	3	0	0	3	0	3
24RYLMN0062	0	1	0	0	1	0	1
24RYLMN0065	0	2	35	0	37	1	38
24RYLMN0080	0	9	0	0	9	0	9
24RYLMN0081	0	2	0	0	2	0	2
24RYLMN0082	18	0	0	0	18	0	18
24RYLMN0094	0	4	0	0	4	0	4
24RYLMN0098	0	0	0	0	0	0	0
24RYLMN0099	0	0	5	0	5	0	5
24RYLMN0099	0	4	0	0	4	0	4
24RYLMN0100	0	2	0	0	2	0	2
24RYLMN0102	15	9	15	0	39	0	39
24RYLMN0103	0	4	0	0	4	0	4
24RYLMN0112	0	3	0	0	3	0	3
24RYLMN0119	0	5	0	0	5	0	5
24RYLMN0124	0	2	0	0	2	0	2
24RYLMN0125	0	5	0	0	5	0	5
24RYLMN0134	0	2	0	0	2	0	2
24RYLMN0138	0	2	0	0	2	0	2
24RYLMN0139	0	5	0	0	5	0	5
24RYLMN0140	0	2	0	0	2	0	2
24RYLMN0142	0	3	0	0	3	0	3
24RYLMN0191	5	0	29	0	34	0	34
24RYLMN0195	0	5	0	0	5	0	5
24RYLMN0211	0	1	0	0	1	0	1
24RYLMN0216	0	0	0	0	0	0	0
24RYLMN0233	0	0	0	0	0	0	0
25RYLMN0005	0	0	0	0	0	0	0
Total 01/04/2024 - 30/06/2024	875	444	574	1 019	874		
Total						9 070	9 944

Redress Payments 01/04/2024 - 30/06/2024						Appendix 2	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimburseme nt £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLMN0124	0	0	0	-42	-42	42	0
19RYLMN0090	2	0	0	0	2	9	11
20RYLMN0069	0	4	0	0	4	0	4
20RYLMN0083	0	3	0	0	3	0	4
20RYLMN0085	0	1	0	0	1	0	1
20RYLMN0147	0	0	0	-2	-2	2	0
20RYLMN0183	0	0	0	0	0	3	3
21RYLMN0037	0	0	0	-3	-3	5	2
21RYLMN0046	0	2	0	0	2	2	4
21RYLMN0053	0	2	0	0	2	2	4
21RYLMN0091	5	0	0	0	5	3	8
21RYLMN0097	0	0	0	-3	-3	5	2
21RYLMN0107	0	6	0	0	6	0	6
22RYLMN0024	0	0	0	0	0	10	11
22RYLMN0026	0	0	0	0	0	14	14
22RYLMN0043	0	0	0	-3	-3	0	-3
22RYLMN0131	4	0	0	0	4	3	7
23RYLMN0001	0	6	0	0	6	0	6
23RYLMN0002	0	0	0	-27	-27	13	-14
23RYLMN0023	2	0	0	0	2	2	4
23RYLMN0027	2	0	15	0	17	0	17
23RYLMN0054	0	0	0	-2	-2	4	2
23RYLMN0082	0	0	1	0	1	0	1
23RYLMN0147	2	0	0	0	2	0	2
23RYLMN0167	0	0	0	0	0	-2	-2
23RYLMN0169	2	0	0	0	2	2	3
23RYLMN0173	0	0	0	-1	-1	1	0
23RYLMN0174	0	1	0	0	1	0	1
23RYLMN0213	0	0	0	-4	-4	6	2
24RYLMN0012	2	0	0	0	2	0	2
24RYLMN0026	0	4	0	0	4	0	4
24RYLMN0045	1	0	0	0	1	0	1
24RYLMN0054	0	0	4	0	4	0	4
24RYLMN0060	0	0	4	0	4	0	4
24RYLMN0073	0	0	0	0	0	0	0
24RYLMN0076	2	0	0	0	2	0	2
24RYLMN0078	0	0	0	0	0	0	0
24RYLMN0106	2	0	2	0	3	0	3
24RYLMN0128	2	0	0	0	2	0	2
24RYLMN0202	0	0	0	0	0	0	0
Total 01/04/2024 - 30/06/2024	25	29	26	87	8		
Total						125	117

GP Indemnity Payments 01/04/2024 - 30/06/2024						Appendix 3	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimburseme nt £000	Total £000	Previous Write Offs £000	Cumulative £000
22RYLMN0192	0	4	25	0	29	3	32
23RYLMN0204	0	3	0	0	3	1	4
23RYLMN0206	0	0	10	0	10	0	10
23RYLMN0233	0	0	0	0	0	4	
24RYLMN0104	0	0	0	0	0	0	
24RYLMN0197	0	4	0	0	4	0	4
Total 01/04/2024 - 30/06/2024	-	11	35	-	46		
Total						8	50

Personal Injury Payments 01/04/2024 - 30/06/2024						Appendix 4	
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimburseme nt £000	Total £000	Previous Write Offs £000	Cumulative £000
20RYLPI0053	0	0	10	0	10	5	15
21RYLPI0002	0	1	0	0	1	0	1
21RYLPI0007	34	5	0	0	38	75	113
21RYLPI0018	0	7	0	0	7	11	18
21RYLPI0025	0	6	0	0	6	1	7
22RYLPI0002	13	1	13	0	26	2	28
22RYLPI0005	0	0	0	-9	-9	34	25
22RYLPI0025	0	1	0	0	1	1	2
22RYLPI0030	20	0	0	0	20	27	47
22RYLPI0039	0	0	0	0	0	1	1
23RYLPI0004	0	0	0	0	0	1	1
23RYLPI0005	0	0	0	0	0	2	3
23RYLPI0014	1	0	0	0	1	1	1
23RYLPI0016	15	4	0	0	19	1	20
23RYLPI0047	0	1	0	0	1	1	2
23RYLPI0050	0	0	0	0	0	0	1
23RYLPI0052	0	0	0	0	0	1	1
24RYLPI0005	0	0	1	0	1	1	2
24RYLPI0011	0	1	0	0	1	0	1
24RYLPI0012	0	0	0	0	0	0	1
24RYLPI0029	0	1	0	0	1	0	1
24RYLPI0032	0	0	0	0	0	0	0
24RYLPI0035	0	0	0	0	0	0	0
24RYLPI0038	0	0	0	0	0	0	0
Total 01/04/2024 - 30/06/2024	82	29	24	9	125		
Total						167	292

Permanent Injury Benefit 01/04/2024 - 30/06/2024			
			Appendix 5
Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	0	260	260
02RVEPI0001	0	76	76
02RVEPI0003	0	191	191
02RVEPI0004	0	131	131
03RRSPI0020	0	930	930
03RVEPI0028	0	283	283
04RRSPI0009	0	254	254
04RRSPI0024	0	179	179
05RRSPI0020	0	88	88
05RRSPI0021	0	211	211
05RVEPI0033	0	323	323
05RVEPI0034	0	95	95
08RVEPI0009	0	210	210
10RYLPI0070	0	119	119
11RYLPI0065	0	278	278
12RYLPI0059	0	85	85
13RYLPI0020	0	44	44
13RYLPI0050	0	163	163
98RVEPI0005	0	8	8
19RYLPI0022	0	377	377
20RYLPI0032	0	55	55
20RYLPI0033	0	23	23
20RYLPI0034	0	34	34
20RYLPI0035	0	109	109
20RYLPI0036	0	75	75
20RYLPI0037	0	26	26
20RYLPI0038	0	61	61
20RYLPI0039	0	46	46
20RYLPI0040	0	114	114
20RYLPI0041	0	77	77
20RYLPI0042	0	37	37
Total 01/04/2024 - 30/06/2024	0		
Total		4 963	4 963

Other Payments 01/04/2024 - 30/06/2024			Appendix 6
Case Reference	Type	Details	Amount £000
25RYLEG0001	EG - Ex gratia payments	Lost Property	1,05
25RYLEG0002	EG - Ex gratia payments	Lost Property	1,20
25RYLEG0003	EG - Ex gratia payments	Lost Property	1,00
25RYLEG0004	EG - Ex gratia payments	Lost Property	0,23
25RYLEG0005	EG - Ex gratia payments	Retirement Vouchers	0,40
25RYLEG0006	EG - Ex gratia payments	Retirement Vouchers	0,27
25RYLEG0007	EG - Ex gratia payments	Retirement Vouchers	0,37
25RYLEG0008	EG - Ex gratia payments	Retirement Vouchers	0,29
25RYLEG0009	EG - Ex gratia payments	Retirement Vouchers	0,31
25RYLEG0010	EG - Ex gratia payments	Retirement Vouchers	0,31
25RYLEG0011	EG - Ex gratia payments	Retirement Vouchers	0,31
25RYLEG0012	EG - Ex gratia payments	Retirement Vouchers	0,24
25RYLEG0013	EG - Ex gratia payments	Retirement Vouchers	0,37
25RYLEG0014	EG - Ex gratia payments	Retirement Vouchers	0,24
25RYLEG0015	EG - Ex gratia payments	Retirement Vouchers	0,32
25RYLEG0016	EG - Ex gratia payments	Retirement Vouchers	0,22
25RYLEG0017	EG - Ex gratia payments	Retirement Vouchers	0,30
25RYLEG0018	EG - Ex gratia payments	Retirement Vouchers	0,43
25RYLEG0019	EG - Ex gratia payments	Retirement Vouchers	0,28
25RYLEG0020	EG - Ex gratia payments	Retirement Vouchers	0,24
25RYLEG0021	EG - Ex gratia payments	Retirement Vouchers	0,39
25RYLEG0022	EG - Ex gratia payments	Retirement Vouchers	0,22
25RYLEG0023	EG - Ex gratia payments	Retirement Vouchers	0,37
25RYLEG0024	EG - Ex gratia payments	Retirement Vouchers	0,30
25RYLEG0025	EG - Ex gratia payments	Retirement Vouchers	0,22
25RYLEG0026	EG - Ex gratia payments	Retirement Vouchers	0,30
25RYLEG0027	EG - Ex gratia payments	Retirement Vouchers	0,22
25RYLEG0028	EG - Ex gratia payments	Retirement Vouchers	0,29
25RYLEG0029	EG - Ex gratia payments	Retirement Vouchers	0,30
25RYLEG0030	EG - Ex gratia payments	Retirement Vouchers	0,35
25RYLEG0031	EG - Ex gratia payments	Retirement Vouchers	0,35
25RYLEG0032	EG - Ex gratia payments	Retirement Vouchers	0,29
25RYLEG0033	EG - Ex gratia payments	Retirement Vouchers	0,36
25RYLEG0034	EG - Ex gratia payments	Retirement Vouchers	0,20
25RYLEG0035	EG - Ex gratia payments	Retirement Vouchers	0,35
25RYLEG0036	EG - Ex gratia payments	Retirement Vouchers	0,32
25RYLEG0037	EG - Ex gratia payments	Retirement Vouchers	0,39
25RYLEG0038	EG - Ex gratia payments	Retirement Vouchers	0,36
25RYLEG0039	EG - Ex gratia payments	Retirement Vouchers	0,24
25RYLEG0040	EG - Ex gratia payments	Retirement Vouchers	0,20
25RYLEG0041	EG - Ex gratia payments	Retirement Vouchers	0,27
25RYLEG0042	EG - Ex gratia payments	Retirement Vouchers	0,22
25RYLEG0043	EG - Ex gratia payments	Retirement Vouchers	0,31
25RYLEG0044	EG - Ex gratia payments	Retirement Vouchers	0,23
25RYLEG0045	EG - Ex gratia payments	Retirement Vouchers	0,36
25RYLEG0046	EG - Ex gratia payments	Retirement Vouchers	0,20
25RYLEG0047	EG - Ex gratia payments	Retirement Vouchers	0,32

25RYLEG0048	EG - Ex gratia payments	Retirement Vouchers	0,36
25RYLEG0049	EG - Ex gratia payments	Retirement Vouchers	0,24
25RYLEG0050	EG - Ex gratia payments	Retirement Vouchers	0,37
25RYLEG0051	EG - Ex gratia payments	Retirement Vouchers	0,24
25RYLEG0052	EG - Ex gratia payments	Retirement Vouchers	0,20
25RYLEG0053	EG - Ex gratia payments	Retirement Vouchers	0,30
25RYLEG0054	EG - Ex gratia payments	Retirement Vouchers	0,15
Total 01/04/2024 - 30/06/2024			18,17



Agenda Item

4.4

Audit & Risk Committee

Standing Order Breaches

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
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	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval
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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 Under section 7.1 Preparing for Meetings as stated in the Standing Orders, it is noted that under section of "Notifying and Equipping Board Members":

"Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired."

- 1.2 In practice most Health Boards publish papers electronically 7 days prior to the meeting. The 10 day notice was drafted when papers were sent out in hard copy, however, given that the Standing Orders have not changed and are unlikely to do so in the near future the Audit & Risk Committee should note that all Board and Board Committee meeting publications are in breach of the 10 day publication period.

2. Specific Matters for Consideration

- 2.1 In the report presented to the August 2023 Audit & Risk Committee, it was advised that any other breaches would be reported in future updates to the Committee.
- 2.2 The following breaches are therefore reported:
- The agenda and papers for the Board and Board Committees are published 7 calendar days in advance of meetings which is a breach of the Health Board's Standing Orders which state publication should be 10 calendar days.
 - The papers for the Extra-Ordinary Audit & Risk Committee meeting that took place on 10 July 2024 to discuss and endorse the Annual Report and Annual Accounts, were not received until the 5 July 2024 and therefore papers were only published five days in advance of the meeting.
 - The papers for the Extra-Ordinary Public Board meeting that took place on 11 July 2024 to discuss and approve the Annual Report and Annual Accounts, were not received until the 5 July 2024 and therefore papers were only published six days in advance of the meeting.

3. Key Risks / Matters for Escalation

- 3.1 Later circulation of papers will leave Board Members with less time to review and scrutinise the position.



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))	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))	Timely
	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg	Yes: ☐	No: ☒



<i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

- 5.1 The Committee are being asked to **APPROVE** the Breach to Standing Orders being reported.



Agenda Item

5.1

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
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	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	June/July	RISKS REVIEWED
Operational Management Board	12 th June 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	15 th July 2024	MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee	23 rd July 2024	REVIEW OF ASSIGNED RISKS
People & Culture Committee	7 th August 2024	REVIEW OF ASSIGNED RISKS

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

Risk Review

- 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 and improve over the next 12 months.
- 2.2 The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.
- 2.3 The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.
- 2.4 Risks on the organisational risk register have been updated as indicated in red in Appendix 1.
- 2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 5th July 2024. Where review dates have passed and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

Training

- 2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.
- 2.7 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:
Risk Management Approach



Practical Approach to Managing Risk
Risk Assessment and Scoring
Datix Risk Management Module

- 2.8 To date **637** members of staff trained to date since training commenced in 2021.
- 2.9 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.
- 2.10 Feedback on the training continues to be positive, please see below:
- 2.11 47 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023).
- 70% (33/47) provided a score of 5/5 in terms of content of the session
 - 26% (12/47) provided a score of 4/5 in terms of content of the session
 - 4% (2/47) provided a score of 3/5 in terms of content of the session
- 2.12 100% of the 47 attendees providing formal feedback found that:
- The session provided the right amount of information.
 - They gained more confidence and knowledge in risk management having attended.
 - They would recommend this training to a colleague.
- 2.13 96% of the 47 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.
- 2.14 Some of the recent comments from the session in June, received through evaluation, have been included below:
- *"Useful to understand escalation processing more detail";*
 - *"Very well delivered with a lot of information included";*
 - *"I realised in the session that I don't have a good understanding of how risk is assessed in the organisation and potentially our team should be utilising this more so it initially started as confusing for me but is still very helpful";*
 - *"Right amount of information given in the presentations and well explained by the presenter"; and*
 - *"Good comprehensive information and resources to refer to".*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Diagnostics, Therapies, Pharmacy and Sciences Care Group

- Datix Risk ID 5730 – No Health Board MRI Pacemaker Service. New risk escalated to the Organisational Risk Register in June 2024. Risk score 20.

Facilities Directorate

- Datix Risk ID 5691 – CCTV System Failure in Prince Charles Hospital. New risk escalated to the Organisational Risk Register in June 2024. Risk Score of 16.

Unscheduled Care – Care Group

- Reinstated Datix Risk ID 1133 - Sustainability of the Emergency Department at the Royal Glamorgan Hospital. Risk Score of 15. Following discussion at Audit & Risk Committee the Unscheduled Care Senior Management Team agreed to reinstate this risk on the Organisational Risk Register until the Invest to Save Paper is approved at the Executive Leadership Group.

Strategy, Transformation, Planning and Commissioning Directorate

- Datix Risk ID 5821 - Provision of secondary care immunology services by external provider (this is a service that is not provided by CTMUHB). Risk Score of 20.

Public Health – Health Protection

- Datix Risk ID 5820 - Reduced Health Protection Funding allocation 2024-2025. Risk score of 12. Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register.

3.2 CHANGES TO RISKS

Risk Score Increased

No risks that had been escalated to the organisational risk register were increased in score in the July iteration.

Risk Score Decreased

Diagnostics, Therapies, Pharmacy and Sciences Care Group

- Datix Risk ID 2713 – Backlog of Reporting Radiology Examinations. Risk score reduced from a 16 to an 8 on the 20th May 2024. The risk score has decreased as numbers have reduced so the service is now at a more manageable level.

Additional capacity has been made available to support outsourcing arrangements. Risk will continue to be monitored via the DTPS Care Group.

- Datix Risk ID 5404 – Post Mortem Backlogs in Mortuary. Risk score reduced from a 16 to a 12. Risk score decreased as current demand has reduced and returned to seasonal normal and backlog has significantly reduced. It is anticipated that this risk may require re-escalation in winter period. Risk will continue to be monitored via the DTPS Care Group.
- Datix Risk ID 3131 – Mortuary Capacity. Risk score reduced from a 16 to a 12. Score decreased as currently capacity is being managed sufficiently although demand is higher than it normally is at this time of year (this is being noticed in other Health Board's), however there is no imminent threat of breach. It is likely that the risk will re-emerge as we move into winter months, and the risk will be increased and escalated accordingly as we review and monitor the demand on mortuary services. Risk will continue to be monitored via the DTPS Care Group.

Patient, Care and Safety Directorate

- Datix Risk ID 4906 - Failure to provide evidence of learning from events (Incidents and Complaints). Risk score reduced form a 16 to a 12. Status of all LFERs are regularly monitored in:
 - Quality & Safety Business meeting (weekly),
 - Executive Patient Safety Meeting (weekly),
 - Quality & Safety Committee (bi-monthly).

The Health Board has successfully implemented and maintained new systems and processes for managing Learning from Events Reports. These improvements have resulted in timely submission of LFERs to the Welsh Risk Pool panels on a consistent basis. As a consequence, the Health Board is now able to recover costs associated with personal injury and clinical negligence claims filed against it.

The punctual submission of LFERs has not only ensured cost recovery but has also helped the Health Board avoid penalties. At the most recent Welsh Risk Pool Committee (LFER Panel) meeting, no penalties were imposed due to the Health Board's compliance with submission deadlines. Ongoing collaboration and review with the Heads of Quality & Patient Safety continue. The Health Board links with the WRP Safety Learning Advisor for complex and challenging LFERs.

The proactive approach to LFER management has shown positive results. This strategy of active oversight and monitoring will be maintained going forward. Risk will continue to be monitored via the Patient Care and Safety Directorate.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

No risks that had been escalated to the organisational risk register were closed in the July iteration.

3.4 ORGANISATIONAL RISK REGISTER – VISUAL HEAT MAP BY DATIX RISK ID (RISK RATED 15 AND ABOVE)

Consequence	5			3337 3993 4080 1133	4664 5276 5755 5730		
	4			5820	4337 4152 3133 4809 4417 5374 4671 5254 4908 4907	5646 5579 5669 5658 5761 5417 5764 5765 5691	4491 4071 4103 3826 5590 5462 5821 4632
	3						4672 2808 4691 5040
	2						
	1						
	CxL	1	2	3	4	5	
Likelihood							

3.5 EMERGING RISKS

No emerging risks notified for inclusion in the July iteration Organisational Risk Register.

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:
	A Resilient Wales



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)	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	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 a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.



Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail captured for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail captured for each risk	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	See detail captured for each risk	

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	
	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequenc e X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	
1	5730	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	No Health Board MRI Pacemaker Service	IF there is no MRI pacemaker service THEN patients that require urgent imaging for serious conditions e.g. cauda equina, stroke and Unscheduled Care can not be imaged using the appropriate modality RESULTING IN poor patient outcomes, (life limiting conditions where alternative imaging (CT,US does not answer the clinical question)	Care Group director discussing situation with cardiac team to resource and support this service provision. Escalation to Clinical and Medical Directors as appropriate. Prince Charles Hospital site will offer the service as cardiac physiologist available.	Pacing defrib to be purchased - Capital Statement of Need ongoing.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	4 (C4xL1)		New risk escalated to the Organisational Risk Register in June 2024.	21.03.2024	17.06.2024	22.07.2024
2	5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business Interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	IF: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Establish short term contract with NHS provider for urgent referrals. Secure provision for routine cases. Work collaboratively with health boards across the SE Wales and SW Wales region to secure immunology provision in the longer term.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C4xL5	4 (C4xL1)		New risk escalated to the Organisational Risk Register in June 2024.	08.07.2024	11.07.2024	11.08.2024
3	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	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 July 2024 Risk reviewed by Unscheduled Care Senior Management Team, stroke services options appraisal has been submitted to Executive Leadership Group. The Stroke consultants within CTM cover Stroke services on two acute sites (Princess of Wales Hospital (POWH) and Prince Charles Hospital (PCH). They also provide a 1-6, seven-day stroke on-call advice service. However, due to vacancies within the consultant workforce the ratio for the on-call rota is currently 1:4 to mitigate gaps. There are currently 4.0 WTE stroke consultants and 4.8 WTE CNS in post across CTM, broken down as follows: • PCH – 2.0 WTE consultants with 1.0 WTE vacancy • PCH – 2 WTE Clinical Nurse Specialists • POWH – 2.0 WTE consultants with an additional 0.6 WTE agency locum Consultant • POWH - 2.8 WTE Clinical Nurse Specialist The Stroke consultants at POWH also have a GIM on call commitment on a 1:21 rota, comprising of weekday evening and full weekend day cover resident cover with non-resident overnight cover. The service becomes increasingly more fragile from September 2024 when one consultant at PCH will be commencing maternity leave for a 12-month period, from July they will also be coming off the on-call rota. This will leave just 3 substantive consultants undertaking a 1:6 rota with a 50% less workforce, as well as leaving just one consultant at PCH from September which will significantly impact being to deliver a safe and sustainable stroke service at PCH. Locum arrangements have been made, however, this risk remains under review in terms of mitigation and score. No change to the risk score is considered at this review. Next review date 02/08/24.	Quality & Safety Committee	20	C4xL5	12 (C4 x L3)	++	11.05.2021	02.07.2024	02.08.2024	
4	5755	Chief Operating Officer	Children and Families Care Group	Service Director - Children and Family Care Group	Improving Care	Environment /Estate/ Infrastructure	Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit	IF the Air handling unit or the electrical system backups fail for the labour ward and neonatal unit template in POW. Then we do not have assurance that our backup systems will maintain critical equipment including ventilators, anaesthetic machines, pumps etc. and key life preserving equipment during clinical procedures. Resulting in harm to patients and potential for life changing consequences for mothers and babies.	All equipment is being assessed for battery backup. Emergency scenario planning will be arranged with Strategy team as a priority. A Project plan is in place with support from Corporate Planning. Weekly planning meetings held with teams and external stakeholders including WAST, JSS, Network. Neighbouring Health Boards have been informed, meetings between Care Groups arranged. FAQs to staff are out, one to one meetings with affected colleagues taking place, meetings with community midwives / ANC staff underway. FAQs external to women and birthing people are out, drop in sessions underway for any one with any concerns.	Capital resource has been approved and allocated to support the infrastructure work from Welsh Government during this financial year. Plans are being drafted for the temporary decant of services for the period of estates work. Update June 2024: • Start date for the work (2nd September 2024). • Clinical pathways are being finalised.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	C3xL2	++	18.04.2024	25.06.2024	31.07.2024	
5	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety	Radiopharmaceutical Business Interruption	IF: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. THEN patients will not receive the necessary imaging RESULTING IN delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Update April 2024 - Swansea Bay University Health Board who supply CTMUHB's radioisotopes have instigated a brief firebreak in order to scale up their production. This would have had an impact on breast cancer surgery, however, the team have been able to use an alternative technique for this period, which has been used previously in Neath Port Talbot Hospital when part of the service was based there. Update June 2024 - risk reviewed on the 17th June 2024. No change to mitigation or risk score.	Quality & Safety Committee	20	C4xL5	4 C4xL1	++	23.10.2023	17.06.2024	22.07.2024	
6	5276	Director of Digital	Central Support 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 provision. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update May 2024 - CTMUHB have appointed internally into the 2 x fixed term band 7 clinical systems support roles for Pathology - once these posts have been backfilled these posts will be able to fully support LIMS implementation. The 1 x Ba fixed term clinical systems manager for Pathology has just gone out to advert, hoping to recruit externally - this post will provide project oversight and co-ordination. These posts will bring CTM in line with other Health Board's in terms of dedicated pathology IT support, however, Health Boards across Wales are looking for extra support in addition to this. Pathology continues to hold monthly LIMS deployment meetings with Digital Health Care Wales (DHCW) to facilitate progress. Update July 2024 - The Ba post is now filled and pathology/IT team is working on delivering the LIMS Project. No change to risk scoring due to resource limitations across Wales.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	++	26.10.2022	04.07.2024	31.08.2024	
7	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety	Failure to meet the demand for patient care at all points of the patient journey	IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Specialty 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 June 2024 Elective Demand- The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. The large-scale capital programme at Prince Charles Hospital will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. The current Fire enforcement notice at Princess of Wales hospital will reduce the number of operating theatres. Plans are ongoing for the temporary location of the theatres. Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service. Emergency Demand There has been some improvement against trajectories for emergency demand. Specifically in total reduction of lost ambulance hours. There remains a high number of clinically optimised patients in core capacity that is impacting on patient flow. The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. The conversion from locum to substantive and establishing COVID uncommissioned capacity remains a priority. Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	++	13.7.2023	09.07.2024	09.08.2024	
8	4071	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update July 2024 - risk ongoing, mitigation continues to be : ongoing increased scrutiny of pathways, focused work with urology, Gynaec and colorectal, enhanced monitoring with Velindre Cancer Centre.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	++	01.04.2014	04.07.2024	02.09.2024	
9																			

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
	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 & Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Sustainability of a safe and effective Ophthalmology service	IF: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. • Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). • On going monitoring in place with regards RTT impact of Ophthalmology. • In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. • Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. • Additional services to be provided in Community settings through ODTC (January 2020 start date). • Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enacted. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (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 W5 risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update April 2024 Previous high risk areas of the injection/macular clinic and the diabetic retinopathy service are now in a much better position with significant delays mostly eliminated. They remain vulnerable and work is ongoing to try and make them more robust and sustainable. CTMUH B did not have a substantive glaucoma consultant from 2017 to 2023. The glaucoma service is top of the list of services to fix but in the process of fixing it, we are going to come across many, many cases of avoidable vision loss. Aside from the human cost of avoidable blindness, there is a large financial and reputational risk to the Hb. The glaucoma service is currently at score of 25 on risk matrix - catastrophic consequences (blindness in high volume of patients) (5) x almost certain to occur (5). This needs to be the highest priority area in ophthalmology for the HB. Cataracts and eyes casualty are ongoing problem areas but are less urgent clinically than the risks outlined below. Major risks in ophthalmology at present 1) Glaucoma – glaucoma causes irreversible vision loss due to damage to the optic nerve. a. high volumes of long waiting patients. Many not seen for several years. Increasing Sis with severe harm as long-waiters finally being seen b. Large numbers of stage 4 glaucoma patients awaiting surgery, some for > 1 year. This is the highest risk glaucoma population. Patients are generally listed for surgery when medical treatment does not work – these patients are at high risk of vision loss with such long delays. Mitigating factors – we have 2 substantive glaucoma consultants, 1 locum consultant. Community glaucoma scheme and WGO54 will allow some low risk patients to be monitored in the community Immediate actions: meeting next week to formulate plan for stage 4 patients Need decision on funding for diagnostic hub to increase capacity in glaucoma service 2) Medical retina a. Long delay for new apt. Few dedicated medical retina appointments. 3) Inappropriate discharge by outsourcing company in April 2019. a. ~3000 patients discharged after notes review by outsource company in April 2019. b. Was noted that many of these patients had sight-threatening disease and should not have been discharged. Some patients with ocular cancer received a discharge letter. c. Sample of 350 records reviewed in 2021 - ~50% were appropriate discharge. 22% not appropriate. 23% uncertain. d. Initial plan was to review all notes of all discharged patients to ascertain if discharge was safe – this work still outstanding Update July 2024 - risk ongoing, no new updates in addition to those reported in April 2024, to be reviewed in September 2024.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01.04.2014	04.07.2024	30.09.2024
10	5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update July 2024 - All mitigating actions are in place, no further actions can be taken, demand continues to exceed service capacity. Business case to expand service is in development. Next rv due 22.7.24.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	05.07.2024	22.07.2024
11	4664	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Legal / Regulatory	Ransomware Attack resulting in loss of critical services and possible extortion	IF: The Health Board suffers a major ransomware attack. Then: there could be potential data loss and subsequent loss of critical services. Resulting in: Catastrophic service loss to all clinical and business services adversely impacting on population health management, patient care, business continuity, health and wellbeing of staff, organisational relationships, substantial financial risk and the UHB's other routine and improvement work - culminating in a culture of mistrust of the Health Board and all things digital leading to the likelihood of the opportunities that present from digital transformation being less likely to be achieved.	Update captured in Closed/Private Session papers due to business sensitivities									
12	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	Emergency Department (ED) Overcrowding	IF: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited to, significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting In: 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 July 2024 The Unscheduled Care SMT reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an SOP relating to fit2sit. We continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Quality statement baseline assessment has been completed, part of this work, will result in the development of an overcrowding score which should help reduce the risk of harm with overcrowding in the emergency department. 1. Currently developing a standardised approach to our huddle capture and reporting. 2. Proof of concept has been completed with engagement from operational and clinical stakeholders. 3. Move to development of software project. 4. This will support a consistent approach to recording and reporting escalation levels across all our acute sites. 5. USCC Dashboard which provides daily and ongoing trend data for performance metrics 1 Emergency Care 6. Developing data intelligence Emergency department acuity levels, including risk stratification and also clinical frailty score for all attendances in each of our Emergency Departments. 7. CTM HHTT describes development of a predictive data model to enhance current systems (we already have predicted attendance) This remains an ongoing risk for all 3 sites and is reviewed regularly as implementation of targeted improvement takes place. Noisy site wide safety meetings are being reviewed to ensure safe staffing. With sustained high level of escalation, risk rising to remain at 20. C4, likely hood 5. New review date 01/09/2024.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	2.7.2024	1.9.2024
13	5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety	CCTV System Failure in Prince Charles Hospital	IF: Major CCTV security management platform (SMP) headend and camera outage at PCH. Unable to live view live data images at the security control centre. NVR recording function is not available to record data images. The outage is also linked with the PCH site refurbishment scheme. The Capital Major Projects team advise that the new (SMP) headend server is not part of the PCH scheme as there is no funding for it. THEN: As a consequence this presents a site security with very limited site surveillance available to identify site incidents and provide evidence of criminal activity and crime. RESULTING IN: The ground floor, first floor and external site areas require the roll out of (124) new CCTV cameras as part of the PCH refurbishment scheme and the existing old (SMP) headend server does not have the functionality and capacity to accept these additional cameras therefore the contractor Tilbury Douglas are unable to roll out the new cameras on site until a new SMP is installed. Risks to the PCH site, patients and staff safety risk. Site risk of theft, property damage and personal injury/assault.	Incident meeting held by Facilities with Digital ICT, Estates, Open View the system contractor and Capital Major Projects team who are managing the PCH site Major project scheme to review the faults and aim to resolve the issue. Open View have managed to restore the security management system headend and power to the majority of existing site cameras. However there is further work to be undertaken and a risk of system failure remains. The outcome and recommendation from Open View the Capital Major Projects team and Tilbury Douglas is that the existing (SMP) headend system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced Tilbury Douglas will be unable to fully install the (124) new site CCTV cameras. Open View are providing a specification and estimate of cost of a new (SMP)headend so that a SON can be submitted for discretionary capital FY2024/25. System specification provided Capital SON ID 1251 submitted 17 May 24. Waiting for SON approval by ECG for funding.	Facilities have developed a case and tender spec for a suitable new CCTV head end in conjunction with ICT and estates and some discretionary capital combined with PCH scheme funding has been secured to cover the costs and is due out to Tender imminently (July 2024).	Health Safety & Fire Sub Committee Quality & Safety Committee Planning, Performance & Finance Committee	16	C4xL4	C3xL4 12	New risk escalated to the Organisational Risk Register in June 2024.	31.01.2024	24.06.2024	31.08.2024
14	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUIHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by CBV and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. As of March 2024, the update from DHCW is that they working on delivering the open architecture to support sharing documents and diagnostic results.	Quality & Safety Committee Digital & Data Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	01.07.2024	01.08.2024
15	5764	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to achieve the planned break-even position in 2024/25.	IF: The Health Board is not able to plan and deliver expenditure run rates that align with the available funding for 2024/25. THEN: The Health Board will not be able to deliver the planned break-even financial position for 2024/25. RESULTING IN: • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • Failure to deliver the financial plan for 24/25. • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 24/25. • Potential cash shortfalls in the latter months of 24/25	Financial Accountability letters issued from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	• Context: The Health Board has submitted a balanced financial plan for 24/25 but this plan includes significant risks, including the delivery of £26.3m of efficiency savings. The savings plans at the 26 March 24 total £23.0m with a RAG rating of £10.0m Green, £12.1m Amber and £0.9m Red. • M2 update: The M2 YTD position is a £2.3m deficit, which includes a £3.5m shortfall in savings delivery. The Health Board is continuing to forecast a break even position for 24/25. The key risks to the forecast are estimated at £11.2m and the main risk is savings delivery. The following actions are to support savings plan identification, development and delivery: • Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Develop the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.	Planning, Performance & Finance Committee	16	C4xL4	12 C4xL3	↔	30.04.2024	04.07.2024	31.08.2024
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	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 & Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	5765	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25	IF: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding for 2024/25. THEN: The Health Board may not be able to deliver a break-even financial position for 2025/26. RESULTING IN : • The Health Board not being able to increase investments in services and/or reduce savings targets from current levels. • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • WG not supporting the Health Board's plan for 25/26 • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 25/26. • Potential cash shortfalls in 25/26.	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	• M2 update: The M2 YTD position is a £2.3m deficit and this position presents a risk to both the In year forecast and the recurrent forecast. The forecast recurrent position at the end of 24/25 will be reviewed after Q1. • The main action is to develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25.	Planning, Performance & Finance Committee	15	C4xL4	12 C4xL3	↔	30.04.2024	04.07.2024	31.08.2024
17	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Paediatric Dentistry - General Anaesthetic (GA) theatre list Impact on the safety - Physical and/or Psychological harm	If... Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. Then... the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in... 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 8 wks from assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update April 2024 - The Care Group have explored the mitigating action required to manage and reduce this risk and identified that the main mitigation will be the allocation of the adhoc additional lists by secondary care, however, these additional sessions are not yet confirmed. Until these sessions are confirmed this risk remains high. The Care Group are working through a plan around demand and capacity with the Planned Care - Care Group for additional theatre sessions but as indicated this has not yet confirmed. Once additional sessions are secured the risk will be reduced and be mitigated through to the backlog being resolved. Update June 2024 - Additional PMBA lists have been added pre the GAA visit, it is hoped that these lists will reduce the numbers of children requiring a GA and will be treated in a different way. E.g. sedation or LA.	Quality & Safety Committee	16	C4xL4	9 C3xL3	↔	20.04.2023	02.07.2024	31.07.2024
18	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff /Public Safety	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care Impact on the safety - Physical and/or Psychological harm	If there is no dietetic service to POW critical care... Then this will impact on the safe and effective provision of nutrition and hydration to critically ill patients... Resulting in poorer nutrition provision and increased rated of malnutrition, which in turn lead to increased risk of infection, dependency on mechanical ventilation, poorer patient outcomes, increased length of stay and longer rehabilitation and recovery times following critical care. In addition to increased health utilisation costs, inequity of service provision across CTM critical care units, and non compliance with national standards and guidance as highlighted in critical care peer review.	At present there is no dietetic provision to POW critical care unit due to lack of specialist critical care dietitian on the POW site and lack of funding. Therefore the nutritional needs of critical care patients on the POW site are managed by the critical care Multi Disciplinary Team.	Update July 2024 - Operational Management Board updated 15.5.24. Actions will be taken forward by Planned Care Group. Next rv due 18.7.24.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	↔	19.12.2023	05.07.2024	18.07.2024
19	5669	Director of Digital	Central Support Function - Digital and Data	Assistant Director for Digital Delivery	Improving Care	Service / Business interruption	Increased cost of Citrix Subscription Impact on the safety - Physical and/or Psychological harm	IF the proposed increase in costs for providing thin client (Citrix) desktops to staff is not affordable or fully funded THEN Some or all of the staff that use Citrix will no longer be able to do so RESULTING IN Staff being unable to access local and national systems Citrix is used by staff to access Virtual Desktops from IGEL thin client devices - 4000 across. These devices only work with Citrix. Staff who access systems using Windows Laptops and PC's will be affected less severely, although many do use Citrix for certain functions. Aside from the CTM Local use and costs for Citrix - National applications that are delivered via Citrix are also in scope of the cost increase, and DHCW have indicated that any costs associated with this are likely to be passed on directly to the organisation.	Renewal costs will increase. Work underway with NHS Wales and Citrix to arrive at the best value licensing on an all Wales basis. CTM Renewal is March 2024, although an interim offer has been made which will take the renewal to December 2024 - allowing all NHS Wales organisations to align their renewals and for negotiations around licensing levels and quantities to be fully understood.	Update July 2024 - Progress continues to mitigate the risk. National conversations with Citrix are progressing which are led by DHCW. We have got a firmer understanding of the cost increases, and whilst the cost increase are not as much as initially anticipated they still present a cost challenge. DHCW are to write out to Directors of Digital and Directors of Finance with setting out the proposed position.	Digital & Data Committee	16	C4xL4	2 (C1xL2)	↔	12.01.2024	04.07.2024	02.08.2024
20	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	The impact of 'Right Care Right Person' approach. Impact on the safety - Physical and/or Psychological harm	If: South Wales Police (SWP) implement Right Care Right Person Then: In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. Resulting in: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register.	Update end of May 2024: Phase 2 of RCRP due to start August 2024 A national transportation group has been set up in preparation of phase 3 which is due to commence October 2024 A partnership meeting was held in April (notes attached) Health Board monthly meetings continue. Risk reviewed and remains unchanged.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3xL4)	↔	08.12.2023	29.05.2024	31.08.2024
21	5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes. Impact on the safety - Physical and/or Psychological harm	If there is no children and young person's weight management service Then the Health Board will be unable to support children and young people to manage their overweight and obesity Resulting in non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	Update April 2024 - Risk descriptor changed on this risk review. Business case finalised, and presented to Creating Health Steering Group 18.04.24. Proposal endorsed and the agreed next steps are to identify sources of funding. Next rv 25.7.24. Update July 2024 - no further changes to mitigation since April update. Review remains scheduled for the 25.7.2024.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	05.07.2024	25.07.2024
22	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance - Concerns & Claims	Assistant Director of Claims	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively	If: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update June 2024 Efforts to address the backlog of redress cases are ongoing. Additionally, to address the backlog, overtime arrangements now in place. The implementation of the Duty of Candour has led to a surge in redress cases. In response, team members have been reassigned to manage these cases. A trajectory of the redress cases is currently being developed and will be reviewed weekly in the Q&S Business meeting, as well as the Executive Quality & Safety meeting.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	08.07.2024	16.08.2024
23	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update July 2024 New reporting mechanisms have been implemented for Care Groups. Members of the Quality and Safety team now participate in governance meetings to review pending statements. A new grading system has been introduced to categorize inquests based on their risk level. This system utilizes a Red, Amber, and Green (RAG) rating to identify high-risk cases. There has been a significant upward trend in the number of inquests over recent years. Projections indicate that the volume of inquests in 2024 is expected to be twice that of the previous year. A future reviews will be undertaken in the Autumn to ascertain if the upward trajectory continues.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	08.07.2024	16.08.2024
24	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	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour Impact on the safety - Physical and/or Psychological harm	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 June 2024 Efforts to address the backlog of redress cases are ongoing. Additionally, to address the backlog, overtime arrangements now in place. The implementation of the Duty of Candour has led to a surge in redress cases. In response, team members have been reassigned to manage these cases. A trajectory of the redress cases is currently being developed and will be reviewed weekly in the Q&S Business meeting, as well as the Executive Quality & Safety meeting.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	08.07.2024	16.08.2024
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	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 & Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Estate/ Infrastructure	Fulfilling our environmental and social duties	If: the health board's decisions fail to reflect our values or consider the long term environmental or social impact Then: we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles Resulting in: negative environmental and social impacts and loss of trust and confidence among stakeholders	- Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. - CTM 2030' delivery focusses on community developments, employment and local procurement where possible. - CTM becoming established as an Anchor Organisation. - Decarbonisation Action Plan - Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda - CTM 2030' seeks to ensure that services take account of the impact on the environment - All-Wales approach to sustainable procurement - Green CTM Staff Forum - Fleet emissions reduction programme and trial of electric vehicles - Tree planting initiatives - Waste management – elimination of landfill for foodstuffs - Use of less environmentally impactful anaesthetic gases - CTM representatives attend the Welsh Government Green meeting - Update of the OAP by March 2024 - Board and Committee cover papers also now include environmental impact against SRs.	Update July 2024 - Mitigating action continues to undertake work to assess the environmental impact of projects and programmes that are not classed as "sustainability" projects/programmes. Timeframe is 30th April 2025. Currently score remains unchanged.	Population Health & Partnerships Committee	15	C4xL4	8 (C4xL2)	↔	21.2.2023	14.06.2024	31.08.2024
26	3133	Executive Director of Nursing / Deputy Chief Executive	Patient Care and Safety	Head of Clinical Education	Improving Care	Patient / Staff /Public Safety	Poor compliance with Medical Gas Safety Training - Impact on the safety – Physical and/or Psychological harm	If: Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. Then: Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). Resulting In: Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a training day that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update July 2024 - Ongoing discussion between the Assistant Director of Nursing and the Assistant Director of Clinical Education Venables Divisional Director of Facilities to establish the most appropriate lead for this risk as the next step is to monitor compliance with training to check what impact the actions taken so far have had on this risk. It is felt that this risk should now sit with Clinical Engineering for monitoring therefore, no update action for July other than the risk has been reviewed and discussions continue. The risk will be updated in August if not before.	Quality & Safety Committee. People & Culture Committee.	16	C4 x L4	8 (C4xL2)	↔	01.05.2018	08.07.2024	16.08.2024
27	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety	Back log for imaging in all modalities / areas and reduced capacity Impact on the safety – Physical and/or Psychological harm	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 and 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 (WCG) 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.	Update June 2024 Business case for CT in final draft, to be submitted this week. NOUS vacancies, 3.4 PCH, 1.8 RGH, recruitment issues - offering standard rate overtime and increased capacity with SRs. Rotate staff to PCH, explore PAAR rates to encourage staff to take overtime.	Quality & Safety Committee	15	C4 x L4	4	↔	01.06.2020	17.06.2024	22.07.2024
28	4337	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Digital Systems	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 - SBUHB Service Level Agreement - Bridgend disaggregation and the one-CTM aggregation plan - NHS Wales Control Agreement and data sharing agreements - Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. - 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	Update April 2024 - Progress is being made with consolidation/merger of the clinical systems to provide single departmental solutions across CTM to allow for better patient experience and help service redesign. The Welsh Patient Administration System (WPAS) merger is still on track for May 2025 this will deliver a single Patient Administration System (PAS) solution across CTM which is then the platform to look at how CTM delivers services. There is on going work with Digital Health Care Wales (DHCW) to ascertain the impact of the WPAS merger on the National suite of systems and how the changes will impact data and data flows. Update July 2024: Good progress is still being made and May 16th 2025 has been identified as the agreed merger weekend. DHCW are progressing national systems and local clinical systems for the merger.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	04.07.2024	30.08.2024
29	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Non Compliance with Mandatory Violence and Aggression Training Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	A 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.	Update June 2024 - A series of meetings have been set up with the V&A Team and Mental Health Service Group to look at means to ensure a suitable training provision from their Care Group. A paper highlighting the risks along with recommendations to ensure a separate contract is provided to the part time trainers is being considered.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	26.06.2024	30.09.2024
30	4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety	Management of Security Doors in All Hospital Settings Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	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: - Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. - For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. - Identify the measures needed to protect patients at risk - Record the significant findings. 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 July 2024 - Three acute Hospital sites all assessed against a criteria developed. Report due end of June extension given until July 12th July.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	08.07.2024	30.09.2024
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	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
1	4671	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects	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	Update captured in Closed /Private Session papers due to business sensitivities.									
32	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety	Failure to recruit sufficient medical and dental staff	IF: the CTMUHB fails to recruit sufficient medical and dental staff. Then: the CTMUHB's ability to provide high quality care may be reduced. Resulting in: a reliance on agency staff, disrupting the continuity of care for patients and potentially 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 June 2024 - The first Performance and Escalation Group, & Workforce Framework Group and Medical Workforce Productivity Board meetings have now taken place. Clear Key Performance Indicators have been drawn out and agreed at V&E. Care Groups are engaged and the programme is running to tackle the identified workforce issues. At the stage, risk remains at the same score.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	14.06.2024	30.08.2024
33	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Sustainability of the Emergency Department at the Royal Glamorgan Hospital	IF: the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH in line with other units within the area. Then: the Health Board will be unable to deliver safe, high quality services for the local population; Resulting in: compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update July 2024 - Following discussion at Audit & Risk Committee the Unscheduled Care SMT agreed to reinstate this risk on the Organisational Risk Register until the Invest to Save Paper is approved at the Executive Leadership Group. SMT risk reviewed, nurse establishment invest to save paper completed utilising the RCN BEST tool (same tool used to review the PCH nursing workforce 2021). To substantiate 2 additional registered nurse. This is ready to be presented to the executive team. In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff. Next review date is 30.08.2024.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	15	C5 x L3	10 (C5xL2)	Reinstated on Org Risk Register in July 2024	20.02.2014	02.07.2024	30.08.2024
34	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety	Waiting Times/Performance: ND Team	IF: The Neurodevelopmental 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 treated, risks associated with delays in medication monitoring	3.5 wte AHP/Nurses successfully appointed, starting June/July 2024 Demand and capacity modelling completed. Merging of Community and ND waiting lists to enhance capacity has taken place. Capacity available should meet demand following 3.5 wte commencing in post. However, this does not account for the average 20% increase in referrals accepted each year. This also doesn't address the backlog of patients already on W/L (SBAR developed and presented at OMB seeking 2.0 wte B7 AHP for 2 years to clear backlog. SBAR also submitted for PCR monies) NDIP funding for 24/25 awaiting final agreement (funds to include WLI clinics, additional overtime for A&C staff, medicine costs and ADOS training).	Update July 2024 - Consideration required for further non-recurrent/recurrent investment in service beyond 2024/5 to address backlog of longest waiters. Funding for 2024-2025 from WG confirmed (NDIP) and £313,000 agreed for ND services for CYP. Around £10k to be spent on CYP and assessments and the rest will be spent on locum SLT/CAMHS workforce, existing/overtime hours for A&C workforce and WLI for medical workforce. This investment will stabilise the longest waiting times and start to bring it closer to a maximum wait of 78 weeks by the end of March 2025 (WG target is 26 weeks although historic longest waiting times have been up to 150 weeks). Waiting list likely to rise again (or at best remain stable at 78 weeks without further improvement) after the end of March 2025 once NDIP funding stops without further investment in the service.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	08.05.2024	08.07.2024
35	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety	Fire Enforcement Notice - POW Theatres.	IF: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update July 2024 - Extension to the FEN in place until 1st January 2025, with the agreement the Health Board can apply for a further extension if necessary and noting that this will be required. Business case in development for Welsh Government funding, was due to be submitted by October 2024 however this has now slipped and will likely be early 2025.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	09.07.2024	30.09.2024
36	4672	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects	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 ontology server, WCP & E-forms etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days of maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update July 2024: Day forward scanning continues to be maintained to be within the agreed 48 hour turn around. A time in motion study is also underway to review what resource is required to destroy records at scales. A strategic approach for CTM's EPR proposal is being developed for consideration by the UHB board. FHR forms which enables structured data capture at source of clinical information are being prepared for UAT in Dermatology. WG funding below requisite levels which is resulting in numerous programmes for systems to capture information being delayed. CTM clinical data repository developing well. Clinical autocoder has been upgraded to incorporate over 400 additional coding standards.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	04.07.2024	30.08.2024
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	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
1	5040	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	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 Myrdin 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 July 2024 - The Digital SLG engaged with Ethical Healthcare, who are conducting a review of a national EPR requirements, we are expecting a report towards the end of June 2024. The Digital SMT also undertook a development session with the Director of Digital at BCUHB to gain a better understanding of the work they have carried out in this space. A strategic outline proposal is still planned for the July 2024 Board meeting.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	04.07.2024	30.08.2024
38	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	Use of Connecting Care (previously known as 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 June 2024 - risk reviewed, no change The Health Board are still pursuing alternative systems as WCCIS is no longer an option as an interim system while an all Wales solution is being progressed.	Quality & Safety Committee	15	C5xL3	6	↔	07.11.2018	20.06.2024	02.09.2024
39	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.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. 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 is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update March 2024 - Still Awaiting a feasibility review on Mental Health inpatient space that will support the mitigation for this risk. Care Group Director engaging with the Capital Team on progressing this at present. No change to risk score at this stage. Update May 2024 - risk mitigation remains as reported in March 2024. No change to risk score. Next review date set for the 01.07.2024. Update June 2024 - Risk reviewed - no further change as previously reported. Risk ownership will be transferred to the Service Director for MHLD Care Group.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	20.06.2024	09.09.2024
40	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety	Reduced Health Protection Funding allocation 2024-2025	IF the reduced allocation of Health Protection resource is insufficient to deliver a safe and sustainable service. THEN there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defense against infectious disease) in accordance with the NIP. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. RESULTING in avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection - Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register.	Population Health & Partnerships Committee Quality & Safety Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	New risk escalated to the Organisational Risk Register in July 2024.	01.07.2024	01.07.2024	01.09.2024
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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
2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	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.	Update April 2024 - Review monitoring of additional funding. Vacancies. See rationale for de-escalation.	Quality & Safety Committee Planning Performance & Finance Committee	8 Decreased from a 16 on 20 May 2024	4 C4xL1	Score decreased as numbers have reduced so the service is now at a more manageable level. Additional capacity has been made available to support outsourcing arrangements. Risk will continue to be monitored via the DTPS Care Group.
5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	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 April 2024 - Backlogs have improved with the use of medi-link. A bank APT has left however so we are short 1 APT, we are using a locum APT 1 day per week to support the Forensic service whilst UHW is undergoing re-furbishment. See rationale for de-escalation.	Quality & Safety Committee	12 Decreased from a 16 in June 2024	8 (C4xL2)	Score decreased as current demand has reduced and returned to seasonal normal and backlog has significantly reduced. Likely to require re-escalation in Winter period. Risk will continue to be monitored via the DTPS Care Group.
3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	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 April 2024 - Mortuary staff resource is currently unstable due to some bank staff leaving making it difficult to efficiently move bodies. We are currently at 67% occupancy however this is including Nutwells contingency storage. Could potentially be de-escalated from the organisational risk register, however approval and further information will be required from the service manager prior to any de-escalation. See rationale for de-escalation.	Quality & Safety Committee	12 Decreased from a 16 in June 2024	8 (C4xL2)	Score decreased as currently capacity is being managed sufficiently although demand is higher than it normally is at this time of year (this is being noticed in other Health Board's), however there is no imminent threat of breach. It is likely that the risk will re-emerge as we move into Winter months, and the risk will be increased and escalated accordingly as we review and monitor the demand on mortuary services. Risk will continue to be monitored via the DTPS Care Group.
4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	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.	Updated May 2024 - LFERs continue to be monitored in: Q&S Team Business meeting, and Weekly Executive Patient Safety Meeting and Quality & Safety Committee. See rationale for de-escalation.	Quality & Safety Committee	12 Decreased from a 16 in June 2024	8 (C4xL2)	Status of all LFERs are regularly monitored in: Q&S Business meeting (weekly), Executive Patient Safety Meeting (weekly), Quality & Safety Committee (bi-monthly). The Health Board has successfully implemented and maintained new systems and processes for managing Learning from Events Reports. These improvements have resulted in timely submission of LFERs to the Welsh Risk Pool panels on a consistent basis. As a consequence, the Health Board is now able to recover costs associated with personal injury and clinical negligence claims filed against it. The punctual submission of LFERs has not only ensured cost recovery but has also helped the Health Board avoid penalties. At the most recent Welsh Risk Pool Committee (LFER Panel) meeting, no penalties were imposed due to the Health Board's compliance with submission deadlines. Ongoing collaboration and review with the Heads of Quality & Patient Safety continue. The Health Board links with the WRP Safety Learning Advisor for complex and challenging LFERs. The proactive approach to LFER management has shown positive results. This strategy of active oversight and monitoring will be maintained going forward. Risk will continue to be monitored via the Patient Care and Safety Directorate.

	A	B	C	D	E	F	G	H	I	J	K
	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
1											
2	No risks that had been escalated to the organisational risk register were closed in the July iteration.										



Agenda Item

5.2

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	15/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

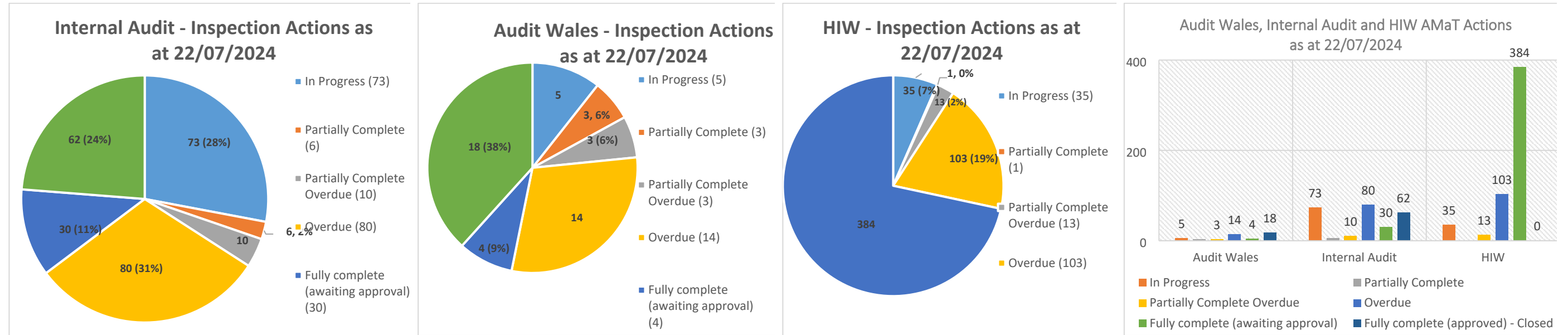
Pwrpas yr Adroddiad / Report Purpose	For Noting & Agreement as per recommendation at 5.1
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	5 th August 2024	Reviewed and Management Sign Off Received

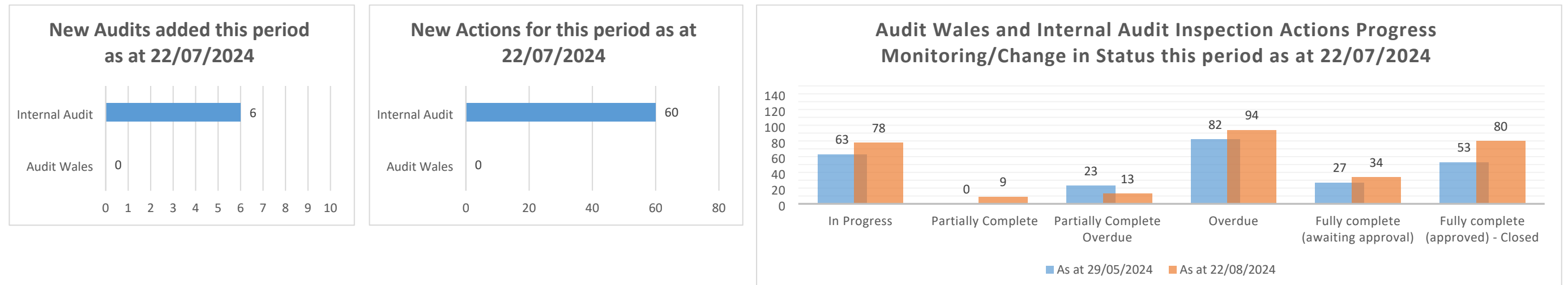
Acronyms / Glossary of Terms	
AMaT	Audit Management and Tracking
HIW	Healthcare Inspectorate Wales

Tracker Dashboard

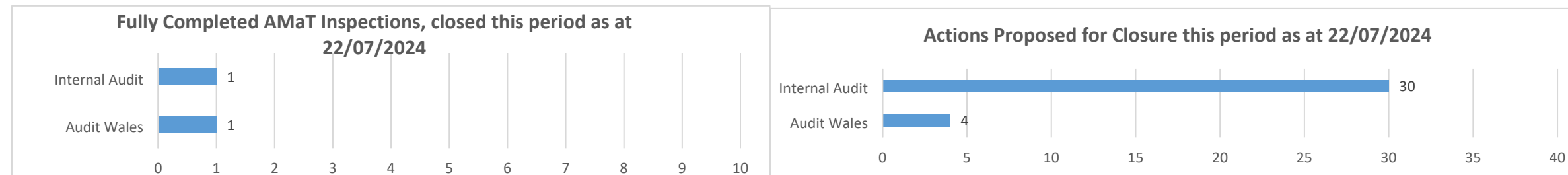
Status: Inspection Actions:



Inspections / Inspection Actions Added:



Closed Inspections:



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 following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module. Included in **APPENDIX 2** is a table of development requests made by CTMUHB that we are engaging with the software developers in order to improve the system for our assurance priorities. You may note that there has been some improvement in that there is now a function to record a revised due date. This will allow us to keep track of original due dates alongside revised due dates offering greater level of governance going forward.
- 1.2 The scope of this report relates to both internal and external audit review recommendations with information from HIW included for noting.
- 1.3 This report captures Health Inspectorate Wales (HIW) Improvement plans and Immediate Assurances inspections in terms of the dashboard infographic. Work is ongoing with Care groups to conduct a data cleanse of historic actions however due to competing priorities within the Care Groups this is taking longer than initially anticipated, however, remains an area of focus.

2. Specific Matters for Consideration

- 2.1 Please see the detailed dashboard and tracker with progress updates in **APPENDIX 1**.
- 2.2 The Committee are reminded that the report being presented is a transitioning process and will continue to evolve. Following on from collaboration with other Health Boards and the AMaT software Development team, there is now a function to add a revised due date whilst providing oversight of the original due date. The team continue to seek out opportunities to collaborate and share good practice with other Health Boards as well as working closely with the lead for AMaT within CTMUHB to ensure we are getting the best out of the system.
- 2.3 Following our Software development request there has started to be some progress in the developing of theming within the system as well as collaboration between the Assistant Director for Governance and risk and colleagues within Audit Wales and Internal Audit

The report at **Appendix 1**, remains a hybrid approach and has still required manual manipulation for some aspects. The Quality Assurance and Compliance Team continue to work with the system provider on further developments needed to fully automate and provide a robust and effective report as evidenced in **Appendix 2**.

2.4 Tracker Updates

2.4.1 Internal Audit (NWSSP) - Since the last meeting the following changes and updates are noted:

6 NEW Internal Audit Reviews have been added to the Audit Recommendations Tracker including **60 NEW** Inspections Actions:

- Internal Audit/2023/186- Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUHB-2223-07).
- Internal Audit/2024/187- Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01).
- Internal Audit/2024/188- Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14).
- Internal Audit/2024/189- Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20).
- Internal Audit/2024/190- Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17).
- Internal Audit/2024/192- Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)

30 Internal Audit recommendations have been completed and are proposed for **CLOSURE**.

- Internal Audit/2023/186
Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUHB-2223-07) R2.1.
- Internal Audit/2023/186
Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUHB-2223-07) R2.2a and 2.2b.
- Internal Audit/2024/173
PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06) R3.
- Internal Audit/2024/173
PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06) R4.
- Internal Audit/2021/76
Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03) R09.
- Internal Audit/2024/173
PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06) R3.

- Internal Audit/2024/173
PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06) R4.
- Internal Audit/2024/190
Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) R1.1.
- Internal Audit/2024/190
Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) R1.2.
- Internal Audit/2024/190
Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) R2.1b.
- Internal Audit/2024/190
Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) R3.1.
- Internal Audit/2024/190
Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) R4.2.
- Internal Audit/2024/190
Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17) R4.3.
- Internal Audit/2023/148
IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19) R6.1.
- Internal Audit/2023/73
Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22) R4.1.
- Internal Audit/2024/188
Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14) R2.1.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R4.1a.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R4.1b.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R5.1.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R5.2
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R8.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R8.

- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R8.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R9.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R9.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R10.1.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R13.1
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R13.1.
- Internal Audit/2024/192
Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09) R13.2.
- Internal Audit/2022/66
Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04) R8.4.
- Internal Audit/2023/151
Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07) R1.1.

2.3.2 **External Audit (Audit Wales)** Since the last meeting the following changes and updates are noted:

0 NEW External Audit Reviews have been added to the Audit Recommendations Tracker.

4 Audit Wales's recommendations have been completed and are proposed for **CLOSURE**, these are:

- Audit Wales/2021/144
Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017) R4.1.
- Audit Wales/2021/144
Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017) R6.1.
- Audit Wales/2023/150
CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023) R8.

- Audit Wales/2023/18
Structured Assessment 2022 – CTMUHB 2022_February 2023
(Document reference: 3313A2023) R10.

2.3.3 Health Inspectorate Wales (HIW) - reports from Healthcare Inspectorate Wales will be included in brief for noting and observation. The HIW tracker is included as **APPENDIX 3** however, the Committee should note that this was received by the Quality & Safety Committee at its meeting on the 23rd July 2024.

2 New agreed Improvement Plans added:

- Healthcare Inspectorate Wales (HIW)/2024/184
Appendix A - Ysbyty Cwm Rhondda Ward B2 (Ref: 03467)
- Healthcare Inspectorate Wales (HIW)/2024/185
Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024
(Ref: 03497)

384 Inspection actions fully **complete** and awaiting **approval**. As part of the ongoing cleanse these were presented to Executives and the Quality and Safety Committee for closure after which they can be closed on AMaT.

3. Key Risks / Matters for Escalation

- 3.1 The audit tracker will continue to be updated with a targeted focus on actions where the implementation date has passed. There has been an increased engagement with the team on some actions, however, there are still a number of actions under the remit of the Chief Operating Officer (Operational Services Teams), which has not been updated. Updates will continue to be sought and escalated as a matter of urgency in readiness for the next meeting.
- 3.2 Due to the change in the audit management and tracking process which is still a work in progress (please see table of software development requests (**Appendix 2**), there continues to be a requirement for extra manual inputting and management of the data in order to provide committee members with useable data. This continues to necessitate the requirement to adhere to a strict deadline for receipt of updates. Where updates are received after the deadline date these may be noted in the cover report however not included in the dashboard data.

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 a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
	Outcome for Welsh Language (delete as appropriate):	



	POSITIVE/NEUTRAL NEGATIVE	
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.

Code	Title	Date of Inspection	Executive Lead	Inspection Lead(s)	Function	Recommendations	Actions	Assurance Rating
Audit Wales/2021/144	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	01/08/2021	Greg Dix, Executive Director of Nursing & Deputy CEO	- Richard Hughes, Deputy Executive Director of Nursing - Nigel Downes, Assistant Director Quality & Safety - cc: Allison Thomas, Business Manager, Patient Care & Safety	Central Corporate Function - Patient Care & Safety	7	7	Not Applicable
Audit Wales/2021/7	Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 253A2021-22)	01/08/2021	Hywel Daniel, Executive Director for People	- Karen Wright, Assistant Director of Workforce and OD - cc: Nerys Heightley, Business Support Manager, People Services	Central Corporate Function - People	1	1	Not Applicable
Audit Wales/2022/12	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 293A42022)	01/08/2022	Linda Prosser, Executive Director of Strategy & Transformation	- Victoria Wallace, Deputy Director of Strategy and Partnerships - Sarah Mills, Head of Regional Commissioning Unit - cc: Beverley Howell, Executive Assistant - Strategy & Transformation	Central Corporate Function - Strategy & Transformation	5	5	Not Applicable
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	01/10/2023	- Gareth Watts, Director of Corporate Governance & Board Secretary - Linda Prosser, Executive Director of Strategy & Transformation - Stuart Morris, Director of Digital	- Cally Hamblyn, Assistant Director of Governance & Risk (Governance actions) - Linda Prosser, Executive Director of Strategy & Transformation (Performance related actions) - Stuart Morris, Director of Digital (Digital and Performance related actions)	Central Corporate Function - Corporate Governance	6	6	Not Applicable
Audit Wales/2023/150	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	01/11/2023	Sally May, Executive Director of Finance	Carolyn Blockley, Capital Finance Manager	Central Corporate Function - Finance	9	9	Not Applicable
Audit Wales/2023/18	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3118A2023)	01/02/2023	- Gareth Watts, Director of Corporate Governance & Board Secretary - Sally May, Executive Director of Finance - Linda Prosser, Executive Director of Strategy & Transformation - Stuart Morris, Director of Digital	- Cally Hamblyn, Assistant Director of Governance & Risk (Governance actions) - Sarah Mills, Deputy Director of Finance (Finance actions) - Linda Prosser, Executive Director of Strategy & Transformation (Performance related actions) - Stuart Morris, Director of Digital (Digital and Performance related actions)	Central Corporate Function - Corporate Governance	8	8	Not Applicable
Audit Wales/2023/23	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	01/03/2023	Gethin Hughes, Chief Operating Officer	- Tarek Alousi, Director of Operations - Planned Care - Sharon O'Brien, Director of Nursing Planned Care - Stephen Sarasin, Medical Director Planned Care & Consultant Orthopaedic Surgeon - cc: Clair Briggs, Personal Assistant, Planned Care	Care Group - Planned Care	3	3	Not Applicable
Audit Wales/2024/168	Review of Workforce Planning Arrangements – Cam Taf Morgannwg University Health Board (Document reference: 4157A2024)	01.02.2024	Hywel Daniel, Executive Director for People	- Nicola Evans, Head of Workforce Planning - Karen Wright, Assistant Director of Workforce and OD - cc: Nerys Heightley, Business Support Manager, People Services	Central Corporate Function - People	6	6	Not Applicable
Internal Audit/2020/120	Health & Safety Management_Final Internal Audit Report August 2020 (Review reference: CTMU-1920-16)	03/08/2020	Hywel Daniel, Executive Director for People	- Chris Beadle, Assistant Director of Health Safety and Fire - Linda Arroyo, Department Administration Manager, Health, Safety and Fire - Karen Wright, Assistant Director of Workforce and OD - cc: Nerys Heightley, Business Support Manager, People Services	Central Corporate Function - Health Safety & Fire	1	1	Reasonable
Internal Audit/2020/65	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-15)	29/07/2020	Gethin Hughes, Chief Operating Officer	Emergency & Acute Medicine Directorate - Lee Collins – Directorate Manager - Sean Thomasson – Service Manager - Ruth Morrissey – Service Manager	Care Group - Unscheduled Care	2	2	Reasonable
Internal Audit/2020/74	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU-1920-45a)	24/01/2020	Gethin Hughes, Chief Operating Officer	- Jim Venables, Divisional Director Of Facilities - Russell Hoare, Assistant Director OSS (Facilities) - Wayne Goodfield, Head Of Clinical Engineering - Paul Jones, Medical Electronics Engineering Manager	Corporate Central Function - Facilities	1	1	Reasonable
Internal Audit/2021/76	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_09)	06/08/2021	Sally May, Executive Director of Finance	- Julie Denley, Deputy CDO Mental Health, Primary Care and Community Services - Sarah Bradley, Service Director of Nursing, Safety & Fire - James Chambers, Primary Care & Community Estates Development Manager - Danrell Clarke, Interim Clinical Service Group Manager, Primary and Community Care - Tim Burns, Assistant Director of Planning (Capital and Estates) - Carolyn Blockley, Capital Finance Manager	Corporate Function - Capital and Estates	15	15	Reasonable
Internal Audit/2022/161	Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36)	14/02/2022	Greg Dix, Executive Director of Nursing & Deputy CEO	- Stan Lewis, Lead Nurse for CHC and NHS Funded Care - Ana Llewellyn, Nurse Director (Primary Care, Community & MHLd) - cc: Allison Thomas, Business Manager, Patient Care & Safety	Corporate Function - Patient, Care and Safety	1	1	Reasonable
Internal Audit/2022/25	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTMU-2122-15)	15/06/2022	Gethin Hughes, Chief Operating Officer	All Care Groups Initially to establish lead - Carl Verrechia, Service Director (DTPS, Children & Families) - Sarah Bradley, Service Director (Primary Care and Community) - Sarah Follows, Service Director (Unscheduled Care) - Elaine Lorton, Service Director (Mental Health and Learning Disabilities) - Tarek Alousi, Service Director (Planned Care)	All Care Groups	8	8	Limited
Internal Audit/2022/40	Fire Safety Management_Final Internal Audit Report February 2022 (Review reference: CTM_2122_01)	07/02/2022	Hywel Daniel, Executive Director for People	- Tim Burns, Assistant Director of Planning (Capital & Estates) - Chris Beadle, Assistant Director of Health, Safety & Fire - Carl Edwards, Senior Fire officer - Linda Arroyo, Department Administration Manager, Health, Safety and Fire - Karen Wright, Assistant Director of Workforce and OD - cc: Nerys Heightley, Business Support Manager, People Services	Corporate Function - Health, Safety & Fire	2	2	Limited
Internal Audit/2022/43	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	29/07/2022	Linda Prosser, Executive Director of Strategy & Transformation	- Tim Burns, Assistant Director of Planning (Capital & Estates) - Ian Phillips, Service Project Manager, Capital Planning - Bernard Carter, Senior Projects Manager, Capital Planning - Carolyn Blockley, Capital Finance Manager	Corporate Function - Capital and Estates	13	13	Limited
Internal Audit/2022/66	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	15/06/2022	Sally May, Executive Director of Finance	- Mark Thomas, Deputy Director of Finance - Owen James, Head of Corporate Finance - Andrew Jones, Assistant Director of Finance - Financial Planning & Reporting - cc: Jayne Maggs, Executive Assistant - Finance	Corporate Function - Finance	4	4	Reasonable
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-05)	24/10/2022	Gethin Hughes, Chief Operating Officer	- Carl Verrechia, Service Director DTPS - Sally Ball, Medical Director DTPS - Brownyn Baldwin, Radiology Service Manager - Paul Johnston, Superintendent Radiographer, - Sharon Donovan, Superintendent Radiographer	Care Group - Diagnostics, Therapies, Pharmacies & Specialities	5	5	Reasonable
Internal Audit/2022/89	Follow-up: Consultant Job Planning_Final Internal Audit Report May 2022 (Review reference: CTM-2122-16)	12.05.2022	- Dom Hurford, Executive Medical Director - Hywel Daniel, Executive Director for People	- Natalie Price, Assistant Director, Strategic Workforce Planning - Nicholas Price, Senior HR Manager - Medical Workforce - Sally Davies, Deputy Executive Medical Director - Karen Wright, Assistant Director of Workforce and OD - Nicola Evans, Head of Workforce Planning - cc: Abbie Jenkins, Business Manager - Medical Director - cc: Nerys Heightley, Business Manager - People Services	Corporate Function - People	1	1	Reasonable
Internal Audit/2022/95	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM-2122-31)	15/06/2022	- Dom Hurford, Executive Medical Director - Hywel Daniel, Executive Director for People	- Natalie Price, Assistant Director, Strategic Workforce Planning - Nicholas Price, Senior HR Manager - Medical Workforce - Sally Davies, Deputy Executive Medical Director - Karen Wright, Assistant Director of Workforce and OD - Nicola Evans, Head of Workforce Planning - cc: Abbie Jenkins, Business Manager - Medical Director - cc: Nerys Heightley, Business Manager - People Services	Corporate Function - People	1	1	Reasonable
Internal Audit/2022/97	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	10/10/2022	Stuart Morris, Director of Digital	- Matthew Swarfield, Head of Clinical Administration Transformation - Diane Chick, Medical Records Manager - Matthew Marsh, Clinical Records Modernisation Project Manager,	Corporate Function - Digital & Data	1	1	Reasonable
Internal Audit/2023/100	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	- Nigel Downes, Assistant Director Quality & Safety - Stephanie Muir, Assistant Director of Concerns and Claims - Liisa Davies, Deputy Executive Medical Director - Kellie Jenkins Forester, Head of Concerns & Business Intelligence - Carla Snook, Legal Services Manager - cc: Allison Thomas, Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	3	3	Reasonable
Internal Audit/2023/107	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	- Richard Hughes, Deputy Executive Director of Nursing - Bethan Cradle, Lead Infection Prevention & Control Nurse - Sarah Morgan, Deputy Lead Infection Prevention Control Nurse & Decontamination Officer - cc: Allison Thomas, Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	5	5	Reasonable
Internal Audit/2023/113	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	- Nigel Downes, Assistant Director of Quality & Safety - Liisa Jenkins, Clinical Lead, Serious Incidents and Complex Concerns, - Kellie Jenkins Forester, Head of Concerns & Business Intelligence - cc: Allison Thomas, Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	8	8	Reasonable
Internal Audit/2023/117	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	28/07/2023	- Linda Prosser, Executive Director of Strategy & Transformation - Stuart Morris, Director of Digital	- Linda Prosser, Executive Director of Strategy & Transformation - Stuart Morris, Director of Digital	Corporate Function - Performance	2	2	Reasonable
Internal Audit/2023/124	Follow-up: Conforms_Final Internal Audit Report May 2023 (Review reference: CTM-22/23-29)	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	- Nigel Downes, Assistant Director Quality & Safety - Stephanie Muir, Assistant Director of Concerns and Claims - Kellie Jenkins Forester, Head of Concerns & Business Intelligence - cc: Allison Thomas, Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	4	4	Reasonable
Internal Audit/2023/146	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	11/10/2023	Gethin Hughes, Chief Operating Officer	- Tarek Alousi, Director of Operations - Planned Care - Sarah James, Deputy Chief Operating Officer (Acute) - cc: Clair Briggs, Personal Assistant, Planned Care	Care Group - Planned Care	8	8	Limited
Internal Audit/2023/147	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022-23-42)	16/10/2023	Gethin Hughes, Chief Operating Officer	- Jim Venables, Divisional Director Of Facilities - Russell Hoare, Assistant Director OSS (Facilities) - Carre Masters, Facilities Manager	Corporate Central Function - Facilities	7	7	Limited
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2124-09)	09/10/2023	Stuart Morris, Director of Digital	- Paul Chirkett, Lead Infrastructure and Security Architect - Steve Macdonald, Assistant Director for Digital Delivery	Corporate Function - Digital & Data	5	5	Reasonable
Internal Audit/2023/151	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	28/11/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	- Richard Hughes, Deputy Executive Director of Nursing - Carie O'Keefe, Head of Safeguarding - Nadine Long, Deputy Head of Safeguarding - Anthony Zibekile, DoLS and Mental Capacity Act Team Leader - cc: Allison Thomas, Business Manager - Patient Care & Safety	Corporate Central Function - Patient, Care and Safety	8	8	Reasonable
Internal Audit/2023/186	Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUHB-2223-07)	27.11.2023	- Sally May, Executive Director of Finance - Gethin Hughes, Chief Operating Officer	- Elaine Lorton, Service Director (Mental Health and Learning Disabilities) - Sarah Follows, Service Director (Unscheduled Care) - Michael Dickie, Head of Change Hub	Care Group - Mental Health and Learning Disabilities / (Unscheduled Care) Programme Management Office (Change Hub)	2	2	Limited

Code	Title	Date of Inspection	Executive Lead	Inspection Lead(s)	Function	Recommendations	Actions	Assurance Rating
Internal Audit/2023/17	Arrangements for Managing Service Level Agreements, Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	06/06/2023	Linda Prosser, Executive Director of Strategy & Transformation	- Elizabeth (Elle) Beadle, Assistant Director of Transformation, Strategic and Operational Planning - cc Beverley Howell, Executive Assistant - Strategy & Transformation	Corporate Central Function - Commissioning	5	5	Limited
Internal Audit/2023/17	Reasonable Offer Process, Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	03/04/2023	Gethin Hughes, Chief Operating Officer	- Sarah James, Deputy Chief Operating Officer (Acute) - Tarek Alkousi, Director of Operations - Planned Care - Gavin Owen, Acute Services General Manager - Sandra McConnell, RTT Manager, Information Systems - Diane Chick, Medical Records Manager - Sandra Lloyd, WPAS Compliance, Training & System Manager - cc Clair Briggs, Personal Assistant, Planned Care	Care Group - Planned Care	4	4	Limited
Internal Audit/2024/73	Follow-up: Radiology Workforce, Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	08/08/2023	Gethin Hughes, Chief Operating Officer	- Carl Verrecchia, Service Director DTIPS - Sally Bolt, Medical Director DTIPS - Bronwyn Baldwin, Radiology Service Manager	Care Group - Diagnostics, Therapies, Pharmacies & Specialities	4	4	Reasonable
Internal Audit/2024/162	4-hour Emergency Department Performance Reporting, Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	06.02.2024	Gethin Hughes, Chief Operating Officer	- Sarah James, Deputy Chief Operating Officer (Acute Services) - Sarah Follows, Service Director (Unscheduled Care) - Emma James, Nurse Director (Unscheduled Care)	Care Group - Unscheduled Care	15	15	Limited
Internal Audit/2024/163	IT Service Management, Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	08.02.2024	Stuart Morris, Director of Digital	- Steve Macdonald, Assistant Director of Digital Delivery - Brett Thomas, Head of End User Computing - Paul Chikcott, Lead Infrastructure and Security Architect	Central Corporate Function - Digital & Data	11	12	Reasonable
Internal Audit/2024/169	Management of Controlled Drugs, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	11/04/2024	Dom Hurford, Executive Medical Director	- Hannah Wilton, Chief Pharmacist - Andrew Davies, Lead Nurse/Adjuvant Medicines Management and Medication Safety - Huw Carson, Principal Pharmacist - Quality and Safety & Medication Safety Officer	Care Group - Diagnostics, Therapies, Pharmacies & Specialities	17	18	Reasonable
Internal Audit/2024/170	Gastro-Intestinal Pathways - Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	12.04.2024	Gethin Hughes, Chief Operating Officer	- Tarek Alkousi, Director of Operations - Planned Care - Gareth Bradford, CSC Manager Surgery/T&O, Theatres - Diane Chick, Medical Records Manager - cc Clair Briggs, Personal Assistant, Planned Care	Care Group - Planned Care	7	7	Limited
Internal Audit/2024/171	Decarbonisation Internal Audit Report April 2024 (Review reference: CTMUHB-2324-13)	09.04.2024	Linda Prosser, Executive Director of Strategy & Transformation	- Victoria Wallace, Deputy Director Strategy and Partnerships - cc Beverley Howell, Executive Assistant - Strategy & Transformation	Central Corporate Function - Strategy & Transformation	9	9	Limited
Internal Audit/2024/172	Follow-up: Digital Operating Model Final Internal Audit Report April 2024 (Review reference: CTM-2324-34)	02.04.2024	Stuart Morris, Director of Digital	Steve Macdonald, Assistant Director of Digital Delivery	Central Corporate Function - Digital & Data	2	2	Reasonable
Internal Audit/2024/173	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report April 2024 (Review reference: CTM-SSU-2324-06)	03.04.2024	Sally May, Executive Director of Finance	- Tim Burns, Assistant Director of Planning (Capital & Estates) - Jeremy Halford, Responsible Officer PCH Construction Programme	Corporate Central Function - Capital and Estates	4	4	Reasonable
Internal Audit/2024/187	Leadership and Management Development Programme Internal Audit Report June 2024 (Review reference: CTMUHB-2324-01)	06.06.2024	Hywel Daniel, Executive Director for People	(Vacancy), Deputy Director for People - George Shouler, Strategic Lead for People Development - Karen Wright, Assistant Director of Workforce and OD - cc Nerys Heightley, Business Manager - People Services	People	4	7	Reasonable
Internal Audit/2024/188	Welsh Risk Pool Claims Final Internal Audit Report June 2024 (Review reference: CTMUHB-2324-14)	11.06.2024	Greg Dix, Executive Director of Nursing & Deputy CEO	- Nigel Downes, Assistant Director Quality & Safety - Stephanie Muir, Assistant Director of Concerns and Claims - Kellie Jenkins Forrester, Head of Concerns & Business Intelligence - Bahar Chowdhury, Head of Claims and Inquest - Carla Snook, Legal Services Manager - cc Allison Thomas, Business Manager - Patient Care & Safety	Patient Care and Safety	5	9	Reasonable
Internal Audit/2024/189	Technical Resilience Final Internal Audit Report June 2024 (Review reference: CTM-2324-20)	07.06.2024	Stuart Morris, Director of Digital	- Paul Chikcott, Lead Infrastructure Architect - Steve Macdonald, Assistant Director of Digital Delivery	Digital & Data	6	6	Reasonable
Internal Audit/2024/190	Risk Management Final Internal Audit Report June 2024 (Review reference: CTMUHB-2324-17)	03.06.2024	- Gareth Watts, Director of Corporate Governance & Board Secretary - Greg Dix, Executive Director of Nursing/Deputy Chief Executive - Gethin Hughes, Chief Operating Officer	- Cally Hamblin, Assistant Director of Governance and Risk - Kellie Jenkins Forrester, Head of Concerns & Business Intelligence - Lisa Lowe Gould, Clinical Director DTIPS - Carl Verrecchia, Service Director DTIPS - Sally Bolt, Medical Director DTIPS - Suzanne Hardacre, Director of Midwifery	- Corporate Governance & Risk - Patient Care and Safety - Care Group - Diagnostic, Therapies, Pharmacy and Specialities - Care Group - Children and Family	9	9	Reasonable
Internal Audit/2024/192	Adult Mental Health CSG review Final Internal Audit Report June 2024 (Review reference: CTMUHB-2324-09)	04.06.2024	Gethin Hughes, Chief Operating Officer	- Julie Denley, Deputy Chief Operating Officer for Primary Care, Community and Mental Health - Elaine Lorton, Service Director (Mental Health and Learning Disabilities)	Care Group - Mental Health and Learning Disabilities	15	27	Reasonable

Audit Recommendations Tracker
Actions - Status Key

In progress	Inspection action is in the process of being completed and has not yet reached the deadline.
Partially complete	Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.
Partially complete (Overdue)	Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.
Overdue	Inspection action deadline has been reached and no recommendations have been completed.
Fully complete (Awaiting approval)	Inspection actions have been fully completed and are waiting to be approved to be closed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current/ Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Audit Wales/2021/144	01.08.2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A20217)	Audit Wales/HIW Quality Governance Follow Up Review R3.5 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	Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILP performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBS.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.10.2021	31.10.2024	High	Partially complete	July 2024 Update - CTMUHB has successfully recruited to over 80% of the Clinical Director roles as of March 2024. Four posts remain vacant at present for Pathology, Radiology, Respiratory, and Diabetes and Endocrine, with plans in place to complete recruitment within the next three months. However, in the interim, the relevant Care Group Medical Directors are managing these posts to ensure effective oversight. Emergency Medicine has an interim appointment for a period of six months, with an aim to appoint substantially at the end of that period. Whilst Audit Wales are assured with the plans in place to complete the recruitment process, they are currently unable to close the recommendation until all remaining vacancies have been filled, particularly given the importance of the clinical areas they cover. May 2024 Update - Complaints and Concerns compliance is remains at 88% (Jan-Mar 2024); real time data and learning continues to be shared with the Care Groups in a timely manner. LFERs compliance continues to improve. Patient Experience data is being reported to the QSC. Following completion of the OCP process internal Care Group Quality & Safety Governance frameworks is complete, which supports clarity of the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the Care Groups. The structure now clearly outlines the quality and safety responsibilities of both Medical and Nurse Directors. This is now embedded at directorate and service level leadership, with established governance reporting mechanisms. The corporate function has also been designed to ensure quality and safety support to individual care groups whilst ensuring corporate oversight and reporting to triangulate learning and data collection. OCP Phase 2 is now complete and the result is that quality and safety responsibilities have been fully embedded at an operational level across the Health Board, therefore action is complete.			
Audit Wales/2021/144	01.08.2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A20217)	Audit Wales/HIW Quality Governance Follow Up Review R4.1 The roles and function of the QSGC 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 QSGC 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 QSGC 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	Meeting structure to sit under Management Board being developed to support the operational oversight and Health Board wide co-ordination and learning.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.12.2021	01.12.2021	High	Fully complete (Awaiting approval)	July 2024 Update - CTMUHB has continued to make progress in this area, with terms of reference in place for the operational quality and safety groups. Whilst some still require review CTMUHB has provided assurance that these will be updated within the next three months, and then receive an annual review. CTMUHB has also provided assurance that adequate support is provided to ensure the effective administration of the quality and patient safety groups. Audit Wales have considered this recommendation to be fully implemented. May 2024 Update - All operational quality and governance patient safety groups have clear and defined Terms of Reference which relate to the specific Care Group. Administrative support is utilised to ensure that actions can be logged and monitored and minutes are completed and circulated in a timely manner. Bi monthly QSGE meetings take place within the care groups. These are chaired by the Nurse Director/ Medical Director within the care group. A governance agenda includes an overview of governance within the care group with a focus on NRI/ DOC incidents, LFER status and any key learning from incidents. Heads of Nursing provide an overarching presentation for their sites which includes incidents and themes and trends, with an element around pressure and fall incidents as well as clinical effectiveness and mortality KPIs. Fortnightly governance meetings are held within the care groups where open/ overdue NRI/ LFER/ DOCs are discussed. LFERs & Risks are also highlighted here. These meetings are attended by lead nurses, senior nurses and service managers and medical representation when they are able to attend with clinical commitments. An example of TOR for children and families governance meeting is also attached. Overarching Health Board Pressure Ulcer and Falls Steering Groups are currently awaiting establishment. Tools have been developed and are awaiting approval.			
Audit Wales/2021/144	01.08.2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A20217)	Audit Wales/HIW Quality Governance Follow Up Review R6.1 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.	Health Board purchased CIVICA (captures population feedback using a patient insight software platform).	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.07.2021	31/12/2024 when Civica contract ends	High	Fully complete (Awaiting approval)	July 2024 Update - CTMUHB has continued to make progress in this area and has extended the Patient Advice and Liaison Service (PALS). Patient experience also features more prominently in the routine performance and quality reports to Board. Audit Wales have considered this recommendation to be fully implemented. May 2024 Update - Unsuccessful recruitment of R2 apprentice role which continues to cause delays in collecting and entering Have Your Say onto the Civica system. Agreed with Civica and NWSPS to extend the contract for 1 year with the option of +1 if required. Work is ongoing to create a daily automated data flow from Civica to CTM warehouse team for all patient experience data. Once this link is established the team will be linking up with the performance team to start creating internal dashboards. SMS in Neonatal and Gynae has now gone live. Currently testing SMS in Physiology/Pediatric, if successful further rollout within Paediatrics will progress. March 2024 Update - v8 of system has been released. Scoping out SMS across CTM. Still awaiting R2 Apprentice job approval from workforce. Awaiting copy of CTM Civica contract from NWSPS to be reviewed by Finance and procurement internally before agreement can be made on renewal of contract to 2027 or not. Meeting with the NHS Executive Quality & Safety Manager for performance and Assurance to be organised and discussed on the future of Civica within CTM.			
Audit Wales/2021/144	01.08.2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A20217)	Audit Wales/HIW Quality Governance Follow Up Review R14.5 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.	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	01.09.2021	30.06.2024	High	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - People's Experience Forum has been established and the inaugural meeting was held on 03 April 2024. Awaiting CEDAR and WG to approve and release the new set of core and optional questions that all Welsh HB should adopt- these have not been definitively agreed yet. Discussion will take place at the EDOF on 24th May with regards to the new People's Experience FRAMEWORK. Work continues to review and agree the scoring of each question to ascertain a benchmark on an all Wales basis enabling a clear, standardised, systematic approach. Discussions are required to map out the new set of questions against the old version. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Audit Wales/2021/7	01.08.2021	Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	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.	There is a context to the DoHYS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	People Executive Director for People	31.08.2021	31/05/2024 Unable to provide a revised date (see July 2024 update)	High	Overdue	July 2024 Update - The Welsh Partnership Forum has still not released the All Wales Pension Policy to NHS Wales organisations to approve and implement across their organisation. No date has been confirmed regarding when this policy is due to be released to NHS Wales Organisations. The Health Board is unable to take any action until the All Wales Policy has been received, approved and implemented. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - The Health Board was instructed by the NHS Wales Confederation to withdraw our draft Retire and Return Procedure which was being consulted upon internally during December 2023. They advised this matter had been raised with them by a Full-time Trade Union Officer as the new All Wales Pension Policy will set out the process and procedure in respect of this matter. The NHS Wales Confederation were not able to indicated when the All Wales Policy would be ready for Welsh Partnership Forum approval, noting they had previously advised it would be published to the Service by the autumn of 2023. Completion of this action is now dependent on the progress made by Welsh Partnership Forum and at this time no revised timescales have been advised.			
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R1 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: 1) taking a longer-term approach to its planning beyond five years, 2) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and 3) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to RPB 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.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Discussion paper outlining the opportunities and challenges with formal partnership working arrangements including examples and opportunities open for binding joint working presented to Integrated Leadership Board. Paper explored both the maximum potential of a section 33 structure and the practicalities of a formal public sector joint venture agreed as the best options for further exploration as part of the enablers within the integrated pathways implementation programme. March 2024 Update - Following an initial pilot in 2020/21 the Welsh Government have developed a self assessment exercise for Regional Partnership Boards. The purpose is to give RPBs a chance to reflect on how they operate, how effectively they carry out their statutory duties. The survey was issued to all RPB members for completion by 7th March 2024. A summary of the results will be provided by independent facilitators (CJW and HIW). Workshop planned for 18th April to feedback results and provide opportunity for discussion. The online assessment covered the following areas - Governance structures and arrangements, Workforce strategies (development and practice), outcome measurement and Frameworks, resources and progress in developing integrated models of care.			
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R4 Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated.	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Regional Integration Fund plan agreed for 2024/25. A number of projects provided initial 6 months funding to align with any changes required lined to community pathway development. Funding likely to be extended until the end of the financial year. Funding within the wider programme identified to take forward a number of priorities under the children and young peoples board that historically has seen less Rf investment.			
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R5 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 over reliance on a small team."	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.12.2022	31.01.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Additional Capacity secured. Director for Integration post commenced November 2023, Capital Planning Officer October 2023 (plus 3x capital Project Manager roles being interviewed for May 2024), NEST Co-ordinator commenced in post March 2024. March 2024 Update - NEST Co-ordinator now appointed to commence early April. 3 capital programme manager currently out to advert, Additional programme Management to support the integration Director agreed, to be advertised in April.			
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R6 Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core.	Agreed. The development of the Rf 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.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Rf budgets agreed for 2024/25. Programmes will be realigned in year in line with community pathways modelling. March 2024 Update - Through the regional Integrated Community Care Services Program the Director for Integration is supporting the region to jointly define and implement a target service and management model for our community services across the region. Regular meetings scheduled with Chief Executives to update on progress.			
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R7 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 deliver its priorities"	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Review of all Rf funded post has commenced to support urgent and emergency care pathways. As part of development work teams will be reviewed and aligned against the agreed pathways once agreed. March 2024 Update - The priority for the Integrated Community Care Services program is the development of robust pathways. As part of this work exploration of organisational forms will be explored as to how they can best support integration. Section 33 agreements are being reviewed and memorandum of understanding being drafted.			
Audit Wales/2023/149	01/10/2023	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	Structured Assessment 2023 R3 Enhancing transparency of committee business Draft committee meeting minutes are produced quickly and reviewed by the relevant chair; however, they are not made publicly available until the papers of the subsequent meeting are published. Furthermore, committee meetings are not livestreamed or recorded for public use. The Health Board, therefore, should consider putting appropriate arrangements in place to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. (Medium Priority).	The Corporate Governance Team will be reviewing how it can further enhance transparency around its Board Committee Business e.g. sharing a summary of planned business on the website ahead of publication of papers, publishing shared listening and learning videos (linked to R2) etc.	Corporate Governance Director of Corporate Governance/Board Secretary	01.03.2024	30.09.2024	Medium	In progress	July 2024 Update - this recommendation will be built into the programme of work being undertaken in relation to the Effective Management of Board Business Proposal which will be completed circa July 2024. There is a specific focus in this work on the commitment to openness and transparency. Listening and Learning stories received at the Public Board and Quality & Safety Committee meetings are now shared on the Health Boards website where appropriate to improve transparency. May 2024 Update - The Assistant Director of Governance & Risk is undertaking a review of the Committee structure with the new approach to be implemented following approval by the Board in September 2024. As the Committees will be changing it is proposed that this recommendation is addressed in terms of the new Committee Structure and the new effectiveness plans that this will be in place from 1st October.			
Audit Wales/2023/149	01/10/2023	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	Structured Assessment 2023 R6 Performance Management Framework The Health Board has appropriate arrangements in place to manage operational performance; however, it lacks a documented performance management framework. In order to enhance its arrangements further, the Health Board should prepare a written framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at service, management, committee, and Board levels (High Priority).	The Health Board has developed a working version of the Performance Framework, however it does require updating to reflect the new organisational structure and the latest Welsh Government performance framework. This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27 February 2024), for approval.	Performance Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	01.02.2024	01.02.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested. February 2024 Update - This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27th February 2024), for approval.			
Audit Wales/2023/150	01/11/2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	This detail is captured in the closed session due to business sensitivities.										
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R1 Improving administrative governance arrangements We found opportunities for the Health Board to improve its administrative governance arrangements to enhance public transparency and support Board and committee effectiveness. The Health Board, therefore, should: a) publish the agendas of private Board and committee meetings; b) publish the papers for all public Board, committee, and advisory meetings on its website in a timely manner; c) update report cover sheets to enable authors to better link their reports to the requirements of the Well-being of Future Generations (Wales) Act 2015; and d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.	a) In the exceptional circumstances where the Health Board is required to hold a Private Board meeting or Board Committee it will endeavour to highlight the agenda items covered on the Public Agenda for transparency. b) Due to capacity constraints within the Corporate Governance Function it is accepted that the timely publishing of papers maybe impacted. Discussions are underway with the Web Development Team to consider if they can provide interim support over the next 3-6 months. c) Report covers 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.	Corporate Governance Director of Corporate Governance/Board Secretary	30.10.2023	30.09.2024	High	Partially complete	July 2024 Update - As reported in May 2024 - Actions a, c and d are completed. Action B update is that as part of the Effective Management of Board Business review underway consideration will be given to the publication of papers received at the Advisory Groups and Sub Committees of the Board. Benchmarking has been done but it is difficult as not all Health Boards are operating the same Advisory Groups or Sub Committee meetings. The Health Board is also introducing two new Sub Committees which need to be taken into consideration. It is therefore proposed that recommendations in this regard are captured in the submission to Board in September for Approval. May 2024 Update - Actions a, c and d are completed. Action B update is that as part of the Effective Management of Board Business review underway consideration will be given to the publication of papers received at the Advisory Groups and Sub Committees of the Board. Benchmarking has been done but it is difficult as not all Health Boards are operating the same Advisory Groups or Sub Committee meetings. The Health Board is also introducing two new Sub Committees which need to be taken into consideration. It is therefore proposed that recommendations in this regard are captured in the submission to Board in September for Approval.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R3 Strengthening performance management arrangements The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable 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.	Performance Executive Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	30.09.2023	31.12.2023	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R4 Establishing measurable outcomes for strategic priorities Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.	We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter". In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation (Performance Framework)	01.09.2023	01.09.2023	High	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Workforce a key workstream within the urgent and emergency care pathway development programme. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current/ Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUH 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R9 Maximising the benefits of digital technologies and solutions There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	The themes identified in the existing Digital Strategy continue to be aligned to the NHS Wales Digital Strategy and are embedded and will continue to evolve with the CTM2030 strategy in relation to digital activity. The Health Board has performed an analysis and identified a minimum set of resources (staff and capital/revenue) required over the next 3 years. Aligned to this work, during 2022 the Health Board completed a functional map of services required from a Digital and Data perspective. The next stage in the process is to align staffing resources to the functions, which will be achieved by following organisational change process. For significant Digital and Data changes (i.e. projects/programmes) the Health Board has developed a process of creating business cases to support service transformation. These business cases indicate the resources (staffing & infrastructure) required to implement service 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.	Digital Director of Digital (Performance Information)	31.12.2023	31.12.2023	High	Overdue	July 2024 Update - Digital and the UHB have made a significant investment into developing and increasing the Digital Senior Leadership Team (SLT). This has included developing a cyber security team to face the ever present cyber challenges. An expanded Information Governance team, improving our IG response; as well as Digital Clinical resources, supporting the large number of clinical systems we have. We have also seen the successful approval of the ePMA business case, this will bring much needed digital transformation to medicine prescribing and well as further increasing our Digital capacity. We also undertook a Board development session in March 2024 to develop a greater awareness and identify potential approaches to Digital Transformation coalescing around a proposed way forward to developing a modular EPR approach. Thinking on this will be furthered in a Board meeting in July 2024. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUH 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R5 We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring: a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	a) 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.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation Director of Digital	30.06.2023	30.06.2023	High	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Added back onto the Tracker December 2023. No update has been received on this recommendation. 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.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUH 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R7 Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions - NOT COMPLETED	a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance. b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is Chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas. c) A review of all the outdated Financial Control Procedures is underway.	Finance Executive Director of Finance	31.12.2023	31.12.2024	High	Partially complete	July 2024 Update - A number of FCPs are being brought to August ARC as part of first tranche of updating the FCPs, all others are in line for update by the updated completion date of December 2024. May 2024 Update - c) Due to staff shortages on the team, there remains a number of FCP reviews outstanding. We anticipate these reviews to take place over the summer once vacant posts have been recruited to, for approval by the end of the calendar year.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUH 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R10 Strengthening Board-level oversight of estates issues and risks Structured Assessment 2022 R10: There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should: a) ensure there is regular reporting on estates related performance indicators and risks to the Planning, Performance, and Finance Committee NOT COMPLETED; b) update the committee's Terms of Reference to reflect these responsibilities; and c) establish a clear process for ensuring appropriate cross referral of estate issues which may have a significant health and safety impact with the Quality and Safety Committee NOT COMPLETED	On publication of Welsh Government's annual Estates, Facilities Performance Management System data, the findings are reported to the Planning, Performance and Finance (PPF) Committee. The report includes the Health Board's performance measured against the national estates key performance indicators which are Physical Condition, Statutory and Safety compliance, fire safety, functional suitability and space utilisation. In addition the report includes the estates operational planned and reactive performance data for statutory and mandatory jobs and also captures helpdesk request data, the reported data is compared against previous years so that trends can be analysed. The report also includes the organisations' energy performance and Carbon Dioxide (CO2) emissions which is measured and reported against the Welsh Government performance targets. At all of the Health Board's Health, Safety and Fire Sub Committees there is a standard agenda item for an Estates Safety and Compliance report and a fire safety report. These reports cover the critical infrastructure systems such as high and low voltage electricity, medical gases, ventilation and water. The Estates and Capital Directorate has its own risk register which is reported quarterly to the Estates / Capital Governance Board, the risks identified with a score above 15 are subsequently reported to Corporate Governance for inclusion on the Health Board's Organisational Risk register. The Health Board is also considering its approach to developing an Estates Strategy within the Health Board and how this will align with other key strategic documents and plans. The Planning, Performance & Finance Committee Terms of Reference will be reviewed to reflect the responsibility to receive Board level oversight of estates issues. The Health Board has a defined Committee Referral process which will be used if there are matters considered at either the PPF Committee or HS&F Sub Committee that require consideration at the Quality & Safety Committee. The HS&F Committee will also ensure any estates issues will be notified to the Q&S Committee through the Committee Highlight Report.	Finance Executive Director of Finance	31.10.2023	31.10.2023	High	Fully complete (Awaiting approval)	July 2024 Update - Action C COMPLETE. There is an established cross-referral process in place for Committees. The review of Committees is currently underway which is giving due consideration to where Estates matters are discussed. May 2024 Update - Key performance indicators and backlog maintenance costs were reported to PPF in February 2024, to be reported to Board July 2024. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Audit Wales/2023/23	01/03/2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R3 The Getting It Right 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 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.	The Health Board will undertake the following in order to maintain oversight 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 GIRT 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 GIRT 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.	Planned Care Chief Operating Officer	01.05.2023	01.05.2023	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 - An update has not been provided against this recommendation on this occasion. 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 GIRT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMUH HB 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.			
Audit Wales/2023/23	01/03/2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	The Health Board will undertake the following in order to ensure the recommendations are achieved: • The fragility of a small CMATS team was recognised within physiotherapy. Since the merger with Bridgend the UHB has invested training and development into the band 7 clinical specialist team in order to increase the number of staff working at the advanced practice level, to meet the demand across CTM. • In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialities, 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 Cydon 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.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting. August 2023 Update - An update has not been provided against this recommendation on this occasion.			
Audit Wales/2023/23	01/03/2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMs) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	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 single CD for performance and governance structure across CTMUHB.	Planned Care Chief Operating Officer	01.04.2024	01.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting. August 2023 Update - An update has not been provided against this recommendation on this occasion.			
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cern Taf Morgannwg University Health Board (Document reference: 4157A2024)	To address the absence of clear workforce plans, the Health Board should prepare sustainable and balanced short-, medium-, and long-term workforce plans with measurable goals and clear timelines aligned to the CTM2030 Strategy. As part of this, the Health Board should ensure that its intent to reconfigure services focusing more on prevention, population health, and digitally enabled health services is appropriately built into long term service workforce design and transformation plans.	Work has begun on the development of the CTM SWP, approach underpinned by the KPMG action plan, next steps are: • Using workforce data and wider information to develop high level workforce plans by staff group to enable the development of short, medium and long-term goals, with action plans, aligned to CTM 2030, in partnership with key stakeholders. Build into the plans:- • Agreed priorities aligned to the Acute Clinical Services Plan • To agree SWP actions for Llantrisant Health Park • Identify opportunities from regional working and other programmes e.g. Accelerated Cluster Working, Six Goals, HEW workforce Plans	People Executive Director for People	01.03.2025	01.03.2025	High	In progress	July 2024 Update - aligned to the actions in 26.30 below to develop the high level plans. Shape and Supply Group developed in July 2024 to discuss and plan to identify key supply pipelines, timescales and numbers across staff groups. May 2024 Update - The new Retention and Workforce Planning Lead commenced in post in April 2024. The Heads of People are cascading and embedding the CTM Strategic Workforce Planning approach to align to Care Group Service Plans. The next step is to develop data and information packs for Care Groups to help enable Care Groups to create their local Workforce Plans.			
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cern Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board should assess and agree its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually.	• Annual budget setting with Care Groups in place with alignment to Heads of People. • Establishment Control options appraisal underway to consider and agree preferred option to progress.	People Executive Director for People	01.05.2024	01.05.2024	High	Overdue	July 2024 Update - work still underway with Data/Digital, People and Finance to align ledger with ESR staff in post to identify baseline establishment information. It is anticipated this is will be available early August to inform action plans. Agreed to review medical workforce establishments by November 2024. Due Date - May 2024 for decision on options appraisal, with revised assessment of timeline for implementation. May 2024 Update The People Directorate is working with Finance to review processes and develop an option paper for implementation of establishment reporting to enable full establishment control.			
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cern Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board should review its operational workforce planning capacity and capability and then ensure it is sufficient to support their operational workforce planning requirements within the new Care Group model.	• Develop SWP skills within People Directorate to promote into the organisation. • Working with Care Groups and Heads of People, assess current SWP capacity and capability. • Explore opportunities to embed SWP methodology in CTM Leadership Development programmes. • Develop workforce planning materials and toolkits to support workforce planning delivery.	People Executive Director for People	01.09.2024	01.09.2024	High	In progress	July 2024 Update - SWP training being reviewed for Care Groups and opportunities to align to Leadership Development Programmes. Resources in development. May 2024 Update The team is working with Heads of People to undertake a baseline assessment of SWP capabilities. Working with L&D colleagues around opportunities to include SWP in the new leadership programmes.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current/ Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To help determine the extent that the action it is taking to mitigate workforce risks is having an impact, the Health Board should set trajectories and timescales to meet their target risk ratings and more clearly assess the impact of the actions that it is taking.	• Develop a workforce baseline assessment based on risk linked to the UHB risk register to identify key workforce priority areas. • Agree actions, targets and trajectories for improvement with outcome measures. • Agree reporting arrangements and monitor progress (including escalations and improvements) through quarterly reviews of the risk register and at Inspiring People Board to assess any impact of the SWP actions on managing risks.	People Executive Director for People	01.10.2024	01.10.2024	High	In progress	July 2024 Update - Update on SWP at People and Culture on 7 August 2024 using the BAF risk 3 Sufficient workforce to deliver the activity and quality ambitions of the organisation to identify priorities and agree actions for next steps. May 2024 Update - Development of a baseline assessment of our workforce challenges based on risk, using the Risk Register as a guide to identify potential current and future opportunities.			
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board needs to reinforce arrangements to both oversee progress and then assess the impact of the recommendations set out in the recent strategic workforce planning review via its People and Culture Committee.	• Assessment of progress and impact of recommendations to be on the agenda for PCC June 2024. • Regular progress updates to the relevant Board Committee.	People Executive Director for People	01.06.2024	01.06.2024	High	Overdue	July 2024 Update - Update on SWP at People and Culture on 7 August 2024 using the BAF risk 3 Sufficient workforce to deliver the activity and quality ambitions of the organisation to identify priorities and agree actions for next steps. Due Date - June 2024, with further updates to future PCCs May 2024 Update - Provide update to PCC in June 2024 and update to Board in July 2024.			
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To inform the development of its medium-term plans for workforce redesign and service transformation, the Health Board should use its workforce benchmarking to adopt best workforce practice and workforce models, ensuring similar system conditions, demographics, and population characteristics.	• Development of a horizon scan to support strategic workforce planning and to inform potential changes and/or impact to people/population/services which include: – Census analysis – Population Needs Assessments – Evidenced based practice – Use the benchmarking data and information e.g. HEIW People analytics tools and dashboards/NHS England and wider sources – Case studies and lessons learned – Changes to Policies/Standards, education and training – New roles, advanced and extended practice – Labour market changes and generational changes	People Executive Director for People	01.10.2024	01.10.2024	Medium	In progress	July 2024 Update - Plans in place to develop the horizon scan and in progress. May 2024 Update - Initial scoping of relevant evidence and research is underway.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2020/120	03/08/2020	Health & Safety Management_Final Internal Audit Report August 2020 (Review reference: CTMU-1920-16)	Health & Safety Management 06 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.	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.	Health, Safety & Fire Executive Director for People	01.01.2021	30.06.2024	Low	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - The Health and Safety Team are now using M5 Forms to undertake their audit work and are currently undertaking a COSHH Audit using this system. Reports will be provided to the Health Safety and Fire Sub Committee once completed (September 2024). March 2024 Update - The 2 trial audits using the new software are planned for April and June 2024 and a further evaluation of the software will then be undertaken.			
Internal Audit/2020/65	29/07/2020	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	Directorate Review Acute Medicine & A&E 13 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.	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.	Unscheduled Care Chief Operating Officer	01.04.2021	31.07.2024	High	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers February 2024 Update - Position remains the same. December 2023 Update - position remains the same as a consequence of staffing resource. It is hoped that the resolution of the OCP process will mitigate this situation. Too early to make a commitment - so update will be available for the meeting in February 2024.			
Internal Audit/2020/65	29/07/2020	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	Directorate Review Acute Medicine & A&E 04 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."	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.	Unscheduled Care Chief Operating Officer	01.12.2020	30.04.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers February 2024 Update - Position remains the same. December 2023 Update - situation remains the same as a consequence of lack of resource in staff. Anticipated that the OCP process will resolve this - but too early to make any commitment in this area. Update will be available in January 2024.			
Internal Audit/2020/74	24/01/2020	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU-1920-45b)	Medical Equipment and Devices Follow Up 03 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.	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. SCM 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.	Facilities Chief Operating Officer	01.04.2020	31.01.2024	Medium	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Switchover to new server environment pending a final data backup and quality assurance software application checks for complete switch over. Await some outstanding quotes for some infrastructure cabling to install hardware purchased as could not be completed last financial year - small amount of capital fund request made for this. Additional server request made to ICT as required for new fixed readers purchased. IoT Wi-Fi @ PCW still to be resolved. Data migration and Kiosk 2 app to be completed by July 2024. WG 21-05-2024.			
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 12 A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	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.	Capital and Estates Executive Director of Finance	01.11.2021	31.07.2024	Medium	In progress	July 2024 Update - Awaiting costed risk register from Expedite. May 2024 Update - no further update. A costed risk register is maintained by Expedite, the Employer's Agent and Contractor Administrator, and will be reviewed at monthly progress meetings but evidence of this cannot be provided until further into the programme.			
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 13 Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Capital and Estates Executive Director of Finance	01.09.2021	31.07.2024	Medium	In progress	July 2024 Update - Awaiting costed risk register from Expedite. May 2024 Update - No further update. This will be actively monitored and managed as an integral part of the above action once project starts on site.			
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 18 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	The Primary Care lead will continue to work with NWSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Capital and Estates Executive Director of Finance	01.01.2022	30.06.2024	Medium	Overdue	July 2024 Update - Lease is with the GPs for signing. Should be complete by next reporting period. May 2024 Update - discussions ongoing with GPs however progress being made and agreement expected soon.			
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 19 Management should confirm an agreed service model with measurable outcomes for front line and support services.	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.	Capital and Estates Executive Director of Finance	01.03.2022	30.06.2024	Medium	Overdue	July 2024 Update - Recommendation will not be complete until service model is agreed. Significant amount of work in this area over the past few months by PC to confirm exact services that will transfer but work ongoing. May 2024 Update - no further update. Recommendation will not be complete until service model is agreed. March 2024 Update - no further update. Recommendation will not be complete until service model is agreed. January 2024 Update - Recommendation will not be complete until service model is agreed.			
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 20 Objectives at the business case should be measurable.	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	29.02.2024	Medium	Overdue	July 2024 Update - no further updates. Benefits will be periodically reviewed as part of the Project Board agenda moving forward but have not yet been reviewed. May 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward.			
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 21 Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	29.02.2024	Medium	Overdue	July 2024 Update - no further updates. Benefits will be periodically reviewed as part of the Project Board agenda moving forward but have not yet been reviewed. May 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward.			
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 09 Performance of relevant parties should be monitored appropriately	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable although there will be a delay with the appointment of a new contractor.	Capital and Estates Executive Director of Finance	01.09.2021	29.02.2024	Low	Fully complete (Awaiting approval)	July 2024 Update - Marked as complete. Performance of the main contractor is being managed and monitored via the HB's recently appointed Clerk of Works (DRAC), the Employer's Agent and contract Administrator (Expedite) and via regular progress meetings and reports. May 2024 Update - no further update. Ongoing. Performance of the main contractor will be managed and monitored via the HB's appointed Clerk of Works (DRAC), the Employer's Agent and contract Administrator (Expedite) and via regularly progress meetings and reports. These in turn will be reported up to Project Board and its sub-groups.			
Internal Audit/2022/161	14/02/2022	Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36)	CHC and FNC 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.	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. As part of an internal review of CHC we have identified the need for a policy to outline the principles of CHC commissioning and the financial control procedure can be incorporated.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.05.2022	30.04.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - This work will now be reviewed and amended as an action in the forthcoming CHC Board. March 2024 Update - As part of an internal review of CHC we have identified the need for a policy to outline the principles of CHC commissioning and the financial control procedure can be incorporated.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.1 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.	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.	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.3 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.	ILGs will ensure that they undertake this action.	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.5 Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	All Care Groups Chief Operating Officer	01.09.2022	30.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.1 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.	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.2 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.	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.3 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.	ILGs will ensure that they undertake this action	All Care Groups Chief Operating Officer	01.08.2022	30.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.4 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.	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	All Care Groups Chief Operating Officer	01.09.2022	30.04.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 3.1 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.	This will be addressed by the ILG with colleagues from Performance	All Care Groups Chief Operating Officer	01.09.2022	30.04.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.			
Internal Audit/2022/40	07/02/2022	Fire Safety Management_Final Internal Audit Report February 2022 (Review reference: CTM_2021_01)	Fire Safety Management 2.1 Local procedures will be reviewed and updated within specified review periods – and associated uniform approval arrangements applied.	Agreed. A review is in progress to align and standardise procedures.	Health, Safety & Fire Executive Director for People	01.03.2022	30.06.2024	Medium	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - 90% of site specific procedures for sites are complete and the Team are on course to complete the remainder by June 2024.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 3.1 The Health Board should ensure timely completion of contacts.	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.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	31/09/2025 (from January 2025)	Medium	Overdue	July 2024 Update - cannot be evidenced until business case approved and contracts signed. May 2024 Update - as per March below, is likely to be in January 2025. March 2024 Update - As per Dec 2023, this is scheduled to be in January 2025.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.1 The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	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.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	31.03.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - to confirm the design team appointment was subject to a competitive process. Construction tenders will also be subject to competitive process. March 2024 Update - Tender has been completed & returned for the design team, preferred bidder informed w/c 18 March. Discussions started with NHS England re: S&S framework, likely to be a mini competition rather than a direct award. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Preferred option now agreed by the project board. Tender will be completed for the design consultants, discussion to be held with NWSSP SES regarding appropriate procurement process for appointment of modular theatre supplier as Framework is available for direct award. October 2023 Update - Please see note above this action will be addressed once there is an approved business case in place.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.2 The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March below. March 2024 Update - As per Dec 2023, this is likely to be in January 2025.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.3 The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March below. March 2024 Update - As per December 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 8.1 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.	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.	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	29.02.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - A new design team has been appointed, a PO is being issued for their costs and other costs (specialist consultants, surveys etc) are being compiled with an update so far to ECMG on 23 May. Costs will be reported regularly to Project Board and ECMG once they commence being invoiced. March 2024 Update - Progress has been reported to Project Board and costs will start being incurred from April now that a new design team has been appointed.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 9.1 Pending the outcome of the options appraisal, in the circumstance that Theatres reprieve remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Agreed. This will be undertaken at the future procurement.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	30.11.2024	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March below. March 2024 Update - Procurement for modular supplier is under discussion, procurement of a building contractor for works will be by competitive tender to inform the BJC costs, if and when the BJC is approved we can enter into a works contract.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.1 A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March, a new risk register to reflect the new design solution is being compiled, it will be reported to Project Board and be part of the BJC. March 2024 Update - As it is a different way forward for the scheme the risks will be costed as part of the BJC process in Summer 2024.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.2 Management should actively monitor and report the value of residual risk v remaining contingency.	Agreed	Capital and Estates / Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as reported at March. March 2024 Update - As above will be within BJC process and once contract has commenced.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.3 Risks should be individually assigned to those best placed to control them, with time parameters for action.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.12.2023	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - this will be part of the BJC. March 2024 Update - As per Dec 2023, this is likely to be in January 2025. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Key has been agreeing preferred way forward and pulling together a timeline for the project to present to the fire service , now this has been agreed the risk register will be fully reviewed and updated to address the recommendation.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.4 An exception report should be published of targeted risk mitigations not achieved.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.12.2023	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as per March below. March 2024 Update - Exception reporting will form part of regular risk monitoring.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 2.1 The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	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.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	31.10.2024	Low	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - internal resource costs will be submitted as part of the BJC cost form, have been adequate to date but now entering a busier phase. March 2024 Update - As per December 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Preferred option now agreed by the project board and programme updated. Business case is due for submission to WG October 2024. Adequate resources will be factored into the fees requested.			
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 7.1 The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2024	Low	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - as the new design team have been appointed this will form part of the discussions with NWSSP-SES on design & tender process in the summer. March 2024 Update - As per Dec 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - This will be discussed with NWSSP in advance of tendering for the works and modular hire.			

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Internal Audit/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	Financial Systems 8.4 Documentation to support all orders should be retained made available if required	Documentation will be made available via SharePoint.	Finance Executive Director of Finance	01.03.2023	30.11.2023	Medium	Fully complete (Awaiting approval)	July 2024 Update - Following review of the recommendation, as part of the training and education to the facilities team, they were instructed that verbal/email orders were not permitted, and all orders were to be raised via the Oracle system through requisitions. Following this process would mean that all orders and relevant documentation is included within the system. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - No further update since February 2024. February 2024 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 P2H information including virtual training guides. 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.			
Internal Audit/2022/67	24/10/2022	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	Radiology Service Review 12.1 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.	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.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	30.11.2022	31.12.2023	High	Partially complete (Overdue)	July 2024 Update - CT workforce paper and NIOUS staffing BC submitted for additional resource. Awaiting formal outcome for both papers. Workforce meeting required following the outcome of the papers to inform next steps. May 2024 Update - Departmental Core Mandatory training compliance is 73.35%. All M&D staff have been contacted regarding compliance. Ongoing inhouse training. March 2024 Update - All 3 groups have met in relation to short/medium/long term workforce plans. Meeting needed with Sally Bolt and Sam Britton to consolidate work and strategy going forward.			
Internal Audit/2022/89	12.05.2022	Follow-up: Consultant Job Planning_Final Internal Audit Report May 2022 (Review reference: CTM 2122.16)	Consultant Job Planning Follow Up 5.1 Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	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.	People / Executive Director for People / Executive Medical Director	01.12.2022	20/06/2024 (Revised Due Date Spring 2024)	Medium	Partially complete (Overdue)	July 2024 Update - Consultant rate card has been launched. May 2024 Update - Consultant Rate Card Paper is ready and is going to ELG. Upon approval, the AMD for Workforce will launch the rate card in a similar way to the launch of the non-consultant rate card.			
Internal Audit/2022/95	15/06/2022	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 2122-31)	Medical & Dental Rostering Follow Up Review 2.1 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.	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.	People Executive Medical Director Executive Director for People	01.11.2022	30.04.2024	Medium	Partially complete (Overdue)	July 2024 Update - The policy has now been sent to the LNC for review and will be discussed at the next meeting (10 September 2024). May 2024 Update - The policy is currently being updated and will submitted back to the LNC for approval. March 2024 Update - The Policy has been submitted to LNC and has received comments have been received; the policy is currently being updated and will submitted back to the LNC for approval.			
Internal Audit/2022/97	10/10/2022	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	Medical Records Management 1.1 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.	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.	Digital & Data Director of Digital	01.07.2024	01.07.2024	Medium	Overdue	July 2024 Update - Ongoing work to standardise the PAS continues, as per previous update there are a number of Health Records/ Patient Contact functions that do not sit within core Medical Records. In order to continue the sharing of best practice guidelines across these areas the quarterly Health Records Group is still active, with the most recent meeting being in June. There was a key focus on the CTM process for destruction of records now eligible under the guidelines and the sharing our processes to undertake this work, as well as continued notes storage pressures across all areas that manage health records. A key factor highlighted was the limitation of resource to be able to start destruction in a timely manner across all areas. We are also starting conversation with Therapy colleagues on the processes we use for management and booking of patients through our centralised Patient Contact teams in Medical Records. May 2024 Update - The standardisation work of the PAS will allow to support this, there are a number of health records and patient contact functions that sit outside of core health records including Mental Health, Therapies and some Community records. These are all managed within their own directorates, but we as core record managers share openly our processes and procedures. This includes the recent updates to the retention and destruction of records in line with national guidelines. I also chair the HB health records group which meets quarterly and include records managers from across the HB, this is due to meet again in June to review pressures, share good practice and process.			
Internal Audit/2023/100	31/05/2023	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	Welsh Risk Pool 1.1 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 on the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported.	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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	31/06/2024 (from 30/04/2024)	Medium	Partially complete (Overdue)	July 2024 Update - Meeting with BI team in respect of Redress Audit tool has been undertaken. BI team working on redress report and dashboard. May 2024 Update - a preliminary claims audit tool has been developed by the Business Intelligence (BI) team. A meeting has been arranged with BI and Legal team to review the audit tool and develop a similar tool for Redress. March 2024 Update - Inquest audit tool completed, with weekly reports produced by the Business Intelligence team. The development of Claims and Redress dashboards have been delayed due to system issues and the need to prioritise more urgent matters.			
Internal Audit/2023/100	31/05/2023	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	Welsh Risk Pool 2.2 Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	31/06/2024 (from 30/04/2024)	Medium	Partially complete (Overdue)	July 2024 Update - Meeting with BI team in respect of Redress Audit tool has been undertaken. BI team working on redress report and dashboard. May 2024 Update - a preliminary claims audit tool has been developed by the Business Intelligence (BI) team. A meeting has been arranged with BI and Legal team to review the audit tool and develop a similar tool for Redress. March 2024 Update - Inquest audit tool completed, with weekly reports produced by the Business Intelligence team. The development of Claims and Redress dashboards have been delayed due to system issues and the need to prioritise more urgent matters.			
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 1.0 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.	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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.11.2023	Revised Due Date 1a October 2023 Out for Comment / 1b December 2023 to Decontamination Committee/ IPC/ March 2024 / 1c March 2024	Medium	Partially complete (Overdue)	July 2024 Update - The policy was approved in the April IPC Committee meeting. The policy has been added to the agenda for the next Operational Board Management meeting for final approval. May 2024 Update - The Decontamination Policy has been reviewed in Decontamination and IPC Committee. The policy will be ratified in the next Q&S Committee meeting.			

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Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 3.0 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.	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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	Revised Due Date 3a July 2023 / 3b October 2023 / 3c March 2024	Medium	Overdue	July 2024 Update - No further update. May 2024 Update - A consultant has been asked to review the current Service Level Agreement (SLA) for laboratory services and microbiology cover in CTM. The review will take place this year. March 2024 update - Strategic review of IPC service ongoing. Led by Richard Hughes, Deputy Executive Director of Nursing.			
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 5.0 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.	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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - Audit program ongoing. The USS probe decontamination audit tool was agreed in the July Decontamination Committee meeting. There is one remaining audit tool left to be developed; dental services. This will be presented in the next Decontamination Committee meeting (September 2024). May 2024 Update - Audit program ongoing. An additional audit tool has been developed for USS probe decontamination. This will be circulated for comment and added to the next Decontamination Committee meeting agenda (04/06/24).			
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident Framework 2.1 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.	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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.11.2023	31.10.2024	Medium	Partially complete	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme. March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024.			
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident Framework 2.2 In the meantime, it should be ensured that at least one member of the investigation team on cases is RCA trained.	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 updated to Datix and feedback will be provided to the responsible care group.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.09.2023	31.10.2024	Medium	Partially complete	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme. March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024.			
Internal Audit/2023/117	28/07/2023	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	Performance Reporting Integrated Performance Report 2.1 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.	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	Performance Executive Director of Strategy & Transformation Director of Digital	01.01.2024	30/06/2024 (end of Qtr1 2024/25)	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Work continues and is in progress as per January 2024 update. On track for end of June 2024 due date. January 2024 Update - Performance Report continues to iterate - likely to continue into 2024/2025. December 2023 Update - Work Ongoing - Performance Framework being updated by end of December 2023 - proposing to take to January 2024 Board.			
Internal Audit/2023/117	28/07/2023	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	Performance Reporting Integrated Performance Report 1.1 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 MTP 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.	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Performance Executive Director of Strategy & Transformation Director of Digital	01.01.2023	31/12/2024 (end of Quarter 3 2024-2025)	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested. January 2024 Update - Performance Report continues to iterate - likely to continue into 2024/2025. Framework will be developed in parallel. December 2023 Update - Performance framework being produced / plan to complete by December 2023.			
Internal Audit/2023/124	31/05/2023	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	Concerns Follow Up Review 3.1 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.	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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	31.10.2024	Medium	Partially complete	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme. March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024.			
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 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.	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Planned Care Chief Operating Officer	01.09.2023	01.09.2023	High	Overdue	July 2024 Update - The CTMUHB evolved into the All Wales group with the policy being taken forward. CTMUHB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 1.2 A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	July 2024 Update - Once there is an all wales policy we will be able to locally implement with an SOP. CTMUHB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 2.0 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.	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.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 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 INNU as 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.	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.	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			

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Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHIB-2223-11)	Interventions not Normally Undertaken 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.	Application of the above actions	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHIB-2223-11)	Interventions Not Normally Undertaken 4.0 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.	Data work stream established to look at the recording of INNU's across CTMUHIB. An agreed coding and monitoring mechanism to be agreed and implemented.	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHIB-2223-11)	Interventions Not Normally Undertaken 5.2 Consideration should be given to the need to periodically report compliance / non-compliance at a relevant level within the Health Board.	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Medium	Overdue	July 2024 Update - CTMUHIB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHIB-2223-11)	Interventions not Normally Undertaken 3.0 The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing.	Review and update of waiting list 'holding names' to be undertaken	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Low	Overdue	July 2024 Update - CTMUHIB fully engaged in the national INNU review. A national policy is being developed for local implementation. Once we have a policy we will be able to include it in the daily performance reports and weekly meetings. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems, Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 6.0 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.	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 areas are significantly overspent. Further control measures need to be determined, implemented and monitored.	Facilities Chief Operating Officer	01.10.2023	29.02.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Purchasing and budgetary arrangements have been put in place for the revised Facilities Directorate and these align to the UHB Operational Structure. Systems are in place to track and monitor activity for Compliance to procurement process and for budgetary control.			
Internal Audit/2023/148	09/10/2023	IT Infrastructure, Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 2.1 Older, out of support devices should be removed from use.	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.	Digital & Data Director of Digital	30.06.2024	30.06.2024	Medium	Overdue	July 2024 Update - For legacy Servers, mitigation continues to be in place to ensure that the cyber risk is low. Work to eradicate/replace typically requires system replacements and a review of the servers in line with the replacement plans is currently being carried out. Programme to rollout endpoint devices requires additional staffing beyond BAU and progress has been minimal. May 2024 Update - Rollout has begun of the endpoint devices procured through the Cyber bid and end of year slippage funding. Progress is being made with our server estate, and we have removed a further 20 servers running Windows 2003/2008. We are actively working with Clinical Systems and suppliers to work through the remaining legacy servers. As a mitigation we are using Trend software to apply security patches to the legacy servers. Progress is also being made with our legacy network equipment. We have replaced 213 older Cisco 3750 switches. We have also recently purchased 900 new wireless access points through funding for the ePMA project to improve wireless resilience. This will enable us to replace the majority of our legacy access points. Additional funding is still required to be able to replace core network switches and edge switches. We have allocated some funding in the 24/25 Digital discretionary capital allocation to help redress the issue. However relying on discretionary capital and end of year slippage monies rather than a fully funded rolling replacement programme makes it challenging to manage our legacy estate.			
Internal Audit/2023/148	09/10/2023	IT Infrastructure, Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 3.1 Documentation should be produced that sets out the processes for: - Managing and configuring Solarwinds; and - Handling of alerts.	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."	Digital & Data Director of Digital	30.06.2024	30.06.2024	Medium	Overdue	July 2024 Update - Due to lack of resource/competing priorities minimal progress beyond day to day use and basic maintenance of the system has been made. May 2024 Update - Limited progress has been made here due to our ongoing operational workload and staff shortages in our networking team. We are about to start a recruitment campaign to add much need capacity to the team.			
Internal Audit/2023/148	09/10/2023	IT Infrastructure, Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 1.1a Work to complete the register / CMDB should be progressed. Asset information for the Bridgend area should be included and kept up to date.	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.	Digital & Data Director of Digital	31.03.2024	30/09/2024 (end of Qtr 2 2024/2025)	Low	In progress	July 2024 Update - PoC for Armitis (passive scanner for all networked devices including IOT and Media) is underway. This will conclude at the end of July and following that, a recommendation will be made around it's suitability as a register/CMDB will be made, with the case for funding to follow. May 2024 Update - We are trialing a passive discovery tool that will be used to monitor the network, identify devices and develop a CMDB. March 2024 Update - No further update this month.			
Internal Audit/2023/148	09/10/2023	IT Infrastructure, Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 6.1 The network topology and make up should be recorded outside of the monitoring tools.	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.	Digital & Data Director of Digital	31.03.2024	30/06/2024 (end of Qtr1 2024/2025)	Low	Fully complete (Awaiting approval)	July 2024 Update - Complete - Baseline LANWAN topology has now been created. Weekly meeting with infra leads to develop this further and ensure changes are captured. This will be an ongoing process. We are happy to close this action as complete. May 2024 Update - Good progress is being made, draft version of network topology has been created, which will be verified and continually developed.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHIB-2324-07)	Deprivation of Liberty Safeguards 1.1 A standard operating procedure (SOP) should be developed for reference by current and future DoLS staff to ensure a consistent approach is in place for all applications. The SOP could include the process for reviewing applications ahead of logging on the spreadsheet, completion of the spreadsheet, processes for chasing outstanding information, quality checks and the authorisation process.	The DoLS team will develop a Standard Operating Procedure (SOP) for the following processes: • Identification of a Deprivation of Liberty and how to make a referral (ward based) • Receiving, prioritising and recording applications. • Completion of Welsh Government datasheet and referral maintenance. The Role of the Best Interest Assessor, s12 Doctor, DoLS Administrator, DoLS Team Leader, Signatories, Relevant Persons Representative. • The ward responsibilities following authorisation. This SOP will complement the Health Board and Safeguarding Board DoLS policy.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.04.2024	01.04.2024	Medium	Partially complete (Overdue)	July 2024 Update - The Standard Operating Procedure and consultation process is complete. The document is on the Safeguarding Executive Group for approval on the 25th of July 2024. This action will then be complete. May 2024 Update - The consultation period exceeded expected time frame as it required relevant amendments, resulting in the SOP being unable to be approved at April's Safeguarding executive Group. The SOP is out for final consultation of two weeks and will be presented to the Safeguarding Executive Group in July for approval.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHIB-2324-07)	Deprivation of Liberty Safeguards 3.3 Consideration should be given to maintaining a log of returned applications, and the data used to identify if there are any training needs in certain wards or departments.	• Following the discussions prior to this report, a new returned applications log has been developed and trialled. This is completed on a daily basis and any returned applications are followed up the next day by the next BA monitoring the inbox. • Quarterly quality assurance meetings will be held by the Head or Deputy Head of Safeguarding to review a selection of returned applications and assessments for the purposes of identifying themes and barriers. These meetings will also facilitate oversight of audits and action plans.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.01.2024	30.04.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - This action is now complete. A Quality Assurance meeting has been held, terms of reference have been agreed and future meetings are planned for 24/25. Sequential numbers has been added to the database, along with changes to reflect each stage of the authorisation process. May 2024 Update - Quality assurance meeting has been held by Deputy Head of Safeguarding on the 10th of April 2024. Terms of reference have been agreed. Meetings are scheduled quarterly. Membership includes primary care, mental health, advocacy, DoLS team Leader and a member of the DoLS team. Quarterly reports will be presented to the Safeguarding Executive Group by Deputy Head of Safeguarding.			

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Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 4.3 Consideration should be given to capturing time in relation to casework stages to assist in identifying, quantifying and confirming areas where delays commonly occur.	The Health Board will undertake a retrospective review for the number of DoLS applications for the previous 4 years, when the MCA Amendment Act (2019) was passed. This data set will then be examined with a view to identifying possible trends in order to condition a respective trend for the forthcoming year. This will in turn decide on the ability to predict future flow and numbers for DoLS activity in CTMUHB.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.02.2024	30.04.2024	Medium	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - A report detailing analysis of four year data and future predicted DoLS activity was presented to the Safeguarding Executive Group in April 2024. Based on current resource and activity, the team would need to double to maintain a reduced backlog. This is currently being managed by outsourcing assessments to an external agency.			
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 4.2 Consideration should be given to capturing time in relation to casework stages to assist in identifying, quantifying and confirming areas where delays commonly occur.	- Current performance management spreadsheets will be reviewed and amended to reflect the complete DoLS process from referral to authorisation. - The development of a quality assurance and monitoring group headed by the Deputy Head of Safeguarding will identify and deliver a process for escalating operational deficits which impact on time.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.01.2024	29.02.2024	Low	Partially complete (Overdue)	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - As above, the quality assurance meeting has been held for April and quarterly meetings planned. Updates will be provided in a report at the safeguarding executive group. Sequential numbers are now utilised within the database. March 2024 Update - 6 of the 8 recommendations have been completed. Draft version of the SOP has been completed and is awaiting approval. First Quality improvement Group planned for April 24 where the TOR will be discussed, preparatory work remains ongoing.			
Internal Audit/2023/186	27.11.2023	Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUHB-2223-07)	2.1 Work by Care Groups and their finance support officers should continue in an attempt to close the gap between the savings targets and identified schemes.	Mental Health This happens on an ongoing basis. Unscheduled Care As referenced in the report, there is active engagement between the Care Group and CSGs with the Finance team to progress saving schemes. We do not propose changing this approach. The hope is that with the conclusion of the organisational change process and staff appointed to permanent roles and fewer management gaps, there will be capacity to focus on service transformation and release of savings. To M06 savings of £3.8m savings are forecast against the 2.6% improvement target and 1% stretch (£5.1m). Unfortunately, wider service pressures have driven increased spend elsewhere which has prevented the same level of progress towards the control total.	Care Group - Mental Health & Learning Disabilities / Unscheduled Care Chief Operating Officer	31.03.2024	31.03.2024	High	Fully complete (Awaiting approval)	June 2024 Update:- Mental Health The MHLd Care Group now have specific monthly meetings at Directorate and Care Group level as well as a monthly assurance meeting on Finance. Unscheduled Care Since the review the terminology has changed from CSG's to Directorate Management Teams. USC have refined and increased their monitoring of financial performance via the various methods: - Monthly Care Group Performance and Assurance Meetings for which Finance is a focus. - Monthly Care Group and Executive Financial Meetings - Care Group and Directorate Managers Finance meetings -- were monthly now increasing to weekly.			
Internal Audit/2023/186	27.11.2023	Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUHB-2223-07)	2.2a Guidance should be in place in relation project plans for identified savings schemes, including when consideration should be given to developing a detailed PID for a scheme. Guidance should also include details in relation to producing quality impact assessment and risk assessment for identified schemes. 2.2b Before a savings scheme starts and depending on size, a project plan should be put in place and a quality impact assessment and risk assessment should be undertaken, together with an assessment of the resources that may be required to deliver the anticipated savings.	Agreed. The guidance is already in place will be updated and will set out the documentation requirements and resource assessments etc for savings schemes, which will vary depending on the size of the schemes. This will be in place ready for 24/25 planning.	Programme Management Office (Change Hub) Chief Operating Officer	31.01.2024	31.01.2024	High	Fully complete (Awaiting approval)	June 2024 Update - These actions have been completed. Guidance was distributed as part of the 2024-2025 Financial Savings CHES process and was accompanied with a Spreadsheet checklist which included a section on scheme achievability.			
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 1.0 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.	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	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - A service agreement template has been approved for use for 2024-25 agreements. Due to changes to procurement requirements in 2024, staff will require further training to undertake agreements with providers. Training is being organised for Wales NHS teams and spaces for CTMUHB teams have been requested. The process for ceasing arrangements has been reviewed based on NHS service agreement changes and will be supplemented by a process for initiating new agreements. Meetings with each care group occur bi-monthly and provide a mechanism to support setting up, monitoring and ceasing agreements.			
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 5.0 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.	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.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - The regular care group commissioning meetings provide a structure to ensure appropriate review of agreements. A final adjustment to the register of agreements is inclusion of monitoring leads for both planning/ commissioning and care groups.			
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 3.0 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.	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Guidance will be finalised when the HB teams complete training on new procurement requirements, however the commissioning meetings with care groups provide a structure to ensure there is support for appropriate sign off and storage of agreements.			
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 4.0 SLAs should be reviewed in line with timeframes set out within them and the spreadsheet register kept up to date with renewal dates.	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.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	31.01.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - Monitoring and review of agreements is a constituent part of the regular commissioning meetings with care groups.			
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 1.1 As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.	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.	Planned Care Chief Operating Officer	30.04.2023	30.04.2024	Medium	Overdue	July 2024 Update - SOP updated in 2023. Update to document currently being reviewed as required as currently does not align with Regional working and current organisational structure following OCPs. As described training needs are being highlighted but review for implementation new post OCP phase 2 & 3 aligned with the updated SOP. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 2.3 Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Planned Care Chief Operating Officer	30.06.2023	30.04.2024	Medium	Overdue	July 2024 Update - Larger organisational changes are still currently taking place. But a paper has been produced for "consolidation of booking Teams" to move from POW over to CTM (M&R) under Medical Records. Discussions with SM and with MS confirmed that the ""re-structure"" of the booking teams is still ongoing but a review has been undertaken with a position paper submitted to the COO setting out the approach to the restructure. The paper outlines the proposal to transfer the line management of Princess of Wales Booking Team to come under the same management structure as the rest of the core outpatient booking and medical records in the Health Boards. This is now for Care Groups to agree the next steps of an OCP with the teams across POW site. Meetings have been arranged mid August. May 2024 Update - An update against this recommendation has not been provided on this occasion.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_ Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 3.1 The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	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.	Planned Care Chief Operating Officer	01.08.2023	30.04.2024	Medium	Overdue	July 2024 Update - SOP updated in 2023. Update to document currently being undertaken and required as currently does not align with Regional working and current organisational structure. As described training needs are being highlighted but review for implementation post OCP phase 2 & 3 aligned with the updated SOP. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report. December 2023 Update - Awaiting SOP update from Director of Operations Planned Care. October 2023 Update - additional work has been required and an update on the SOP is imminent.			
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_ Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 5.1 A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	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"	Planned Care Chief Operating Officer	01.08.2023	30.04.2024	High	Overdue	July 2024 Update - Reports on duplicates and pop ups are available and updated daily. A weekly report on Closed pathways but waiting is circulated to all teams weekly. Validation team in place for stage 1 waiting lists. Service validation continuous. Distribution and access requires update post Phase 2 & 3 of OCP. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2023/73	08/08/2023	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	Radiology Workforce Follow Up Review 4.1 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 POH and POW sites.	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.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	01.09.2023	29.02.2024	Medium	Overdue	July 2024 Update - Meeting with CB Learning and Devopment (18/06/24) to discuss appeals made for Consultant competencies. This is now with Learning and Development Team and SMEs. P/CJ also met with CB on 18/06/24 to review all other staff group core competencies. May 2024 Update - Meeting to review competencies on 18/04/24. Appeals process underway 16/05/24. March 2024 Update - work still underway. Learning and Development team have responded to state that they are short staffed but have signposted information on next steps to appeal against competencies which are felt unnecessary.			
Internal Audit/2023/73	08/08/2023	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	Radiology Workforce Follow Up Review 4.2 The CSE 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.	Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	01.12.2023	31.12.2023	Medium	Overdue	July 2024 Update - current core mandatory training compliance is 73.16%. Share point has not been updated for June 2024 compliance - email sent to AP to refresh. Ongoing in house Resus and Manual Handling training. Module of the month continues - Infection Control. Ongoing monitoring. May 2024 Update - Departmental Core Mandatory training compliance is 73.35%. All M&D staff have been contacted regarding compliance. Ongoing inhouse training. March 2024 Update - Current Overall Core Mandatory Training compliance 69.65%. Moving and Handling and Resus are lowest compliance due to lack of training available or staffs inability to attend due to clinical needs. The department has since trained the trainers to roll out both modules in house and are training 6 staff per month to improve compliance.			
Internal Audit/2023/73	08/08/2023	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	Radiology Workforce Follow Up Review 5.0 Work should continue to resolve the issues raised with the five Consultant job plans within POW.	Current compliance POW: • 7 signed off • 1 awaiting 1st sign off • 1 expired but booked – date arranged for 20/09	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	30.09.2023	31.12.2023	Low	Overdue	July 2024 Update - 23 Consultants with an up to date JP. 5 are booked or with a further change needed. 3 to be arranged (1 staff member on LTS). Compliance 79%. 58 emailed all consultants requesting them to 1st sign if they had not. May 2024 Update - 21 with an up to date JP, 6 booked or need further amendments, 3 not booked. 70% compliant. March 2024 Update - 17 with an up to date JP, 11 booked, 2 not booked. February 2024 Update - a programme of job plan bookings has been implemented to drive compliance. RGH 76% compliance, POW 75% compliance, PCH 100% compliance. December 2023 Update - job plan meetings have been set up for those who are either out of compliance or will be out of compliance scheduled throughout November and December. October 2023 Update - POW 6 signed off, 1 in first sign off, 1 in second sign off. 1 Awaiting a second JP meeting due to a flexible working application.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	1.1a A standardised approach to the application of the 4-hour performance clinical exception guidance should be established by the Health Board. 1.1Ba comprehensive SOP should be created for use across all sites setting out a standardised approach to the application of the WG guidance on calculating the 4-hour performance target and the use of breach exemptions. The SOP should include details on capturing and recording data in relation to the 4-hour performance target, especially definitions for recording of times, when breach exception codes can be used, the responsibility for inputting data and the validation process. Managers across all sites need to be involved in the process of creating SOP.	Develop standardised approach to application of 4 hour clinical exception to include a pan CTM SOP for application of WG guidance.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	1.2 A review of the breach reason codes should be carried out to establish a consistent set of codes to be used across all sites. This will allow the Health Board the ability to consistently monitor reasons for patients spending longer than 4 hours in ED and help inform decision making.	Develop a standardised set of codes to be used across all sites.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	2.1Staff should be reminded of the importance of consistently and fully completing CAS cards with all required information. Management should gain an understanding from staff why the summary table as seen on the front of PoW CAS cards is not being completed and determine if it's used could be beneficial for all sites.	Communicate through safety briefings the importance of fully completing CAS Cards and review implementation of summary table across all sites.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	2.2 The CAS cards at each site should be reviewed with a view to creating a standardised CAS card that explicitly sets out the key information that should be recorded.	Develop standardised CAS card for all sites in conjunction with Clinical Director and Lead Nurse.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	3.1 Acknowledging that two versions of WPAS are in use by the Health Board, were possible a consistent approach to WPAS training should be in place for staff across the sites to ensure data capture is consistent. Once a SOP has been agreed, standard training on the application of the breach exemption and breach reason codes should be provided to relevant staff, along with an overview of the rationale for capturing information.	Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	4.1The importance of clearly and consistently capturing key date and time information on the CAS cards should be reiterated to staff and additional training provided where necessary. The importance of accurately transferring data from the CAS cards to WPAS should be reiterated to staff and additional training provided where necessary.	Ensure standardised approach to training across all ED', monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	4.2The criteria for determining the treatment complete time should be reviewed with a view to having a consistent definition in place across all sites. Similarly, the approach to applying breach exemption codes, specifically relating the time in the patient's journey when they are applied, should be reviewed to ensure consistency. The agreed approaches should be captured in a SOP.	• Undertake review of treatment complete time and implement consistent definition on all sites. • Ensure breach exemption codes applied consistently, develop SOP and monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.1A record should be maintained of the adjustments made including who originally input the data and the error that was rectified. The data should be used to identify staff training requirements.	Implement a standardised approach to capturing any changes to records, monitor through Directorate Performance reviews	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.2Further work should be undertaken to ensure that those cases adjusted as part of the retrospective validation process are being correctly captured and reported. Consideration should be given to maintaining a record of the WPAS entries that have been adjusted in order to allow spot checks to be performed to confirm the adjustment was correctly captured on the system.	Undertake regular "snapshot" audits to ensure validation is correctly captured and monitor through Directorate Performance reviews.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.3A review of the validation approaches currently in place across the sites should be carried out. It should be clear what the objective of validation work is, and a standard approach applied across site to ensure consistency in reporting.	Review validation approaches across all ED's and implement a standardised approach to reporting.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.4A data cleansing exercise should be carried out on the POW outstanding cases spreadsheet. Given the age of some of the entries, it should be determined if validation is worthwhile.	Undertake review of outstanding cases at POW and determine if validation is required	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Low	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.1 Weekly senior management team meetings at POW should be reinstated as a forum for discussing ED performance matters including performance against the 4-hour target.	Re-instate weekly SM meetings at POW.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.2 Agendas and action logs of all key groups and committees should be retained to support the discussions and decisions made during the meeting and to ensure actions are captured and followed up at subsequent meetings.	Ensure agenda and action logs are retained.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.3 Consideration should be given to incorporating site specific data as part of the slide deck taken to the USC Care Group performance meetings to allow more enhanced monitoring and discussion of issues per site.	Site specific slide deck in place, ensure used to underpin discussions.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.4Consideration should be given to undertaking more detailed reporting that provides analysis of the data currently presented, such as the proportion of non-breaches that are as a result of clinical exemptions, and the proportion of 'did not wait'. Analysis of the breach reason codes, should be undertaken with the aim of better understanding the causes of patients exceeding the 4-hour target.	Develop a more detailed report to include analysis of breach codes.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	1.3Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated.	Ensure the Service Catalogue is updated to reflect all of the critical systems in place and complete the additional fields, including identifying if the system is locally managed or run by a supplier, and also identify where the system is hosted.	Digital & Data Director of Digital	01.07.2024	01.07.2024	Medium	Overdue	July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024. March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	1.1Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated.	Further refine and review the Service Catalogue and extend it to include dependencies of local, national and cloud infrastructure. E.g. The majority of systems are accessed via CTM Managed end user devices so the review should ensure that these common components (such as CIBn, Wireless, LAN and WAN) are reviewed for their resilience and recover ability.	Digital & Data Director of Digital	01.07.2024	01.07.2024	Medium	Overdue	July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024. March 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	2.1Management should ensure that knowledge management is progressed through the creation and development of ITIL aligned processes and procedures.	Creation of a Digital Service Management function. Create a Digital Service Management function as part of current structural review of Digital Delivery. Appoint into the vacant Head of IT Service Management role. Then assess current maturity of ITIL aligned processes and procedures and prioritise development.	Digital & Data Director of Digital	01.10.2024	01.10.2024	Medium	In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	3.1 Management should establish a defined relationship management framework to align expectations, improve communication and manage risk, and develop relationship metrics to assess their quality, value and impact.	Once a Digital Service Management function has been created (Action 2.1) develop a framework and approach to internal service relationship. This action is predicated on the development of our service catalogue (Action 1.1) as well as an approach to business relationship management (BRM) that will need to span the Digital Delivery, Digital Systems and Digital Intelligence, Compliance & Design.	Digital & Data Director of Digital	01.01.2025	01.01.2025	Medium	In progress	July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.1Management should implement and maintain a single, central register of suppliers and contracts to allow visibility and control over contract data, costs, documentation, action plans and supplier performance data.	Once a Digital Service Management function has been created (Action 2.1) develop a single, central register of suppliers and contracts. This will need co- ordination with our internal Business Admin team, Finance and Procurement.	Digital & Data Director of Digital	01.10.2024	01.10.2024	Medium	In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.2Management should ensure that an appropriate framework for effective supplier and contract management is developed which allows for clear, planned, and regular activity e.g., measuring and policing supplier performance and active management of contract key dates and milestones.	Creationof a tiered frameworkcategorising high, medium andlow value/importancesuppliers and contracts, and the appropriate level of governance and level of management given to each category.	Digital & Data Director of Digital	01.10.2024	01.10.2024	High	In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.3 Management should ensure that efficient contract control measures are developed and employed with appropriate oversight, to ensure that suppliers maintain performance and invoices are issued correctly.	This action is closely tied to action 4.2 and the appropriate controls will need to be placed with supplier and contract management framework.	Digital & Data Director of Digital	01.10.2024	01.10.2024	High	In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.1 Management should ensure that the pre-defined call functionality is expanded to all applicable services, to have a consistent approach to logging calls and more accurate metrics.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25.	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.2 Management should ensure that where available, the pre-defined call functionality is used to allow for the accurate recording of details, such as call type and priority.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25.	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.3Management should ensure that requests such as staff termination forms are accurately logged.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25.	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.4 Management should ensure that the classifications data held within ServicePoint is reviewed and cleansed of duplications and are configured for all applicable services.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25.	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	6.1Management should ensure that a defined problem management process and procedure is finalised, published, and adopted.	Once a Digital Service Management function has been created (Action 2.1) complete process and procedures for Problem Management.	Digital & Data Director of Digital	01.01.2025	01.01.2025	Medium	In progress	March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. July 2024 Update - There are further delays to recruitment, it is hoped that recruitment will now start in August. May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	1.1a Management should ensure there is a standardised approach to Controlled Drugs incident reporting. As such, the draft guidance should be reviewed and finalised as soon as possible, and made available to all relevant staff.	CD Incident Reporting Standard Operating Procedure to be approved by Operational Management Board.	Diagnostics, Therapies, Pharmacies and Specialities	01.04.2024	01.04.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	1.1b If the existing SOP at YCR is needed following the implementation of all Health Board guidance, it should be reviewed to ensure that it is consistent with the Health Board wide guidance.	Review of YCR SOP to see if still needed.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	1.2 Management should review the controlled drugs documents on the Health Board's intranet to ensure that only the correct procedures are available.	Review of searches for common controlled drugs search terms: CDs, Controlled Drug, Controlled Drugs, Gabapentin, opioid, equate to be reviewed and flagged to IT for removal.	Diagnostics, Therapies, Pharmacies and Specialities	01.08.2024	01.08.2024	Low	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1a A review of authorised signatory lists should take place to ensure they are up to date.	A review of authorised signatory lists will take place to ensure they are up to date.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.09.2024	01.09.2024	High	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1b Management should remind ward and theatre manager that it is their responsibility to inform pharmacy of any amendments that need to be made to authorised signatory lists.	Nursing management to remind ward and theatre manager that it is their responsibility to inform pharmacy of any amendments that need to be made to authorised signatory lists.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.05.2024	01.05.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1c A process should be established for reviewing authorised signatory lists on a periodic basis, for example forming part of the quarterly audit checks that pharmacy undertake at each ward or theatre.	A process will be established for reviewing authorised signatory lists on a periodic basis, for example forming part of the quarterly audit checks that pharmacy undertake at each ward or theatre.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.06.2024	01.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1d Pharmacy staff should be reminded of the importance of referring the authorised signatory lists to ensure order have been place by authorised staff.	Pharmacy staff will be reminded of the importance of referring the authorised signatory lists to ensure order have been place by authorised staff.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.05.2024	01.05.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.2 Management should remind ward and theatre staff of the SOP requirements around: - Retaining copies of order books and controlled drugs registers for the required period of 2 years. - The importance clearly signing controlled drugs orders and registers and printing names where required. - Completing all required fields within the order book and the controlled drugs register. Consideration could be given to requiring staff to sign to confirm they have read the SOPs and understood them, as was the practice at on theatre visited.	Nursing management should remind ward and theatre staff of the SOP requirements around: - Retaining copies of order books and controlled drugs registers for the required period of 2 years. - The importance clearly signing controlled drugs orders and registers and printing names where required. - Completing all required fields within the order book and the controlled drugs register. Consideration will be given to requiring staff to sign to confirm they have read the SOPs and understood them, as was the practice at on theatre visited.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024	01.05.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.3 Consideration should be given to amending the SOP to: - Require staff to print their name in addition to signing when taking receipt of controlled drugs from pharmacy and when entering the drugs in the controlled drugs register. - Being more explicit in the name used to describe the drug being ordered i.e. manufacturer name or drug name.	During the next review of the procedure, consideration will be given to amending wording to: - Require staff to print their name in addition to signing when taking receipt of controlled drugs from pharmacy and when entering the drugs in the controlled drugs register. - Being more explicit in the name used to describe the drug being ordered i.e. manufacturer name or drug name.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	31.10.2024	31.10.2024	Low	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	3.1 Management should ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.	Communication to ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.	Diagnostics, Therapies, Pharmacies and Specialities	01.05.2024	01.05.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	4.1a Discussions should be held with wards and theatres managers to understand why the weekly checklists are not being completed and if necessary amendments should be made to the current checklist.	Discussions will be held with wards and theatres managers to understand why the weekly checklists are not being completed.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	4.1a Discussions should be held with wards and theatres managers to understand why the weekly checklists are not being completed and if necessary amendments should be made to the current checklist.	If necessary amendments will be made to the checklist during the review of the CD procedure.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	31.10.2024	31.10.2024	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	4.1b Ward and theatre managers should be reminded that the weekly checklists cover a wider remit than just a count of controlled drugs held, and of the requirement to complete and retain them in line with the SOP.	Ward and theatre managers will be reminded that the weekly checklists cover a wider remit than just a count of controlled drugs held, and of the requirement to complete and retain them in line with the SOP.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.05.2024	01.05.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	5.1 Management should ensure Pharmacy audit checks are performed quarterly in line with the SOP.	Management will ensure Pharmacy audit checks are performed quarterly in line with the SOP.	Diagnostics, Therapies, Pharmacies and Specialities	01.06.2024	01.06.2024	Low	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.1 The importance of fully completing the quarterly CD/LN highlight / occurrence reports, including the details of the ward or theatre, should be emphasised.	When the request for the occurrence reports are sent out before the CD/LN, the importance of fully completing the reports, including the details of the ward or theatre, will be emphasised.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.04.2024	01.04.2024	Low	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.2 To aid the ability to proactively monitor CD related incidents for patterns and trends that could allow targeted training, the Medicines Management team should liaise with the Datix team to establish if there is a way for meaningful data that is quality checked to be extracted from the system. If this is deemed to not be feasible, then consideration should be given to collating the information captured in the quarterly CD/LN highlight reports to allow analysis to take place.	To aid the ability to proactively monitor CD related incidents for patterns and trend that could allow targeted training, the Medicines Management team will liaise with the Datix team to establish if there is a way for meaningful data that is quality checked to be extracted from the system. If this is deemed to not be feasible, then consideration will be given to collating the information captured in the quarterly CD/LN highlight reports to allow analysis to take place.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.06.2024	01.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.3 Consideration should be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.	Consideration will be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.	Diagnostics, Therapies, Pharmacies and Specialities	01.05.2024	01.05.2024	Low	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	7.1 A central electronic record should be retained of those staff that have undertaken Controlled Drugs training and refresher training. Consideration should be given to using ESR for this purpose.	A central electronic record is retained for staff trained since 2020, however consideration will be given to using ESR for this purpose.	Medical Director Diagnostics, Therapies, Pharmacies and Specialities	01.09.2024	01.09.2024	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	1.1a A policy that outlines the Health Board's approach and responsibilities for GI pathways including demand management should be put in place. 1.1b A review of the draft 'Single CTM Colonoal USC Pathway GP Referral Triage' SOP should be carried out, with a view to creating a single SOP that describes the step-by-step process that should be followed to ensure consistency in service delivery across all sites. It should be ensured that the SOP clearly sets out the excepted process to be followed for areas such as GP and internal referrals, the triage and triage process and timeframes for undertaking the various stages in the process. The draft SOP should be agreed at an appropriate level within the Health Board. Where there are variations in service delivery, such as the Nurse Led Rapid Access One Stop Colorectal Clinic based at PCN, then a separate SOP should be formalised for use.	A CTM Standardised LGI SOP to be developed, reviewed and agreed.	Planned Care Chief Operating Officer	30.06.2024	30.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHIB-2324-02)	1.2 Specific guidance should be developed and made available in relation to: • GPs outlining the processes relating to general or non-USC GI referrals; • Internal hospital departments in respect of processes to be undertaken for internal GI referrals.	Following completion of the LGI SOP - this will include flow/process charts and referral criteria to support internal and external referral process.	Planned Care Chief Operating Officer	30.06.2024	30.06.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHIB-2324-02)	2. Work should continue to explore the feasibility of integrating the WPRS and WCP/WPAS at PCH and RGH sites and negate the need for the current process of printing referrals from one system for scanning into another system. Management should remind staff that referral and triage documentation for cases should be complete, and records saved within WCP/WPAS.	1. Need confirmation for go live date for LGI/Surgery. 2. Set up meeting with Records and Digital Team	Planned Care Chief Operating Officer	30.04.2024	30.04.2024	Medium	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHIB-2324-02)	3.1 Processes should be implemented to ensure that referrals are efficiently and effectively triaged by clinicians within the shortest reasonable timescale after receipt, to minimise delay risks that could lead to patient harm. This should include the process to be followed where there is the known absence of a clinician. Where there appears to be service areas where triage is not being carried out as timely as others, then a review should be undertaken to understand the cause of this and identify ways of improving service delivery.	1. Complete and roll out new CTM LGI SOP. 2. Produce referral and setting process in line with SOP.	Planned Care Chief Operating Officer	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHIB-2324-02)	3.2 Management should review of the paper-based triage process used in a number of service areas to establish if the electronic processes used elsewhere can be rolled out. The use of fully electronic files will negate the need for printing and rescanning of records, meaning files can be traced and accessed, with an electronic record of decision making retained. Where paper triage forms continue to be used, forms should be revised to require the triage clinicians printed name in addition to their signature. Clinicians should be reminded of the importance of signing triage forms once complete to provide a complete record of the decision-making process.	1. Understand go live date for E-Ref for LGI/Surgery. 2. link in with Records/Digital team.	Planned Care Chief Operating Officer	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHIB-2324-02)	4. Periodic 'peer review' quality assurance exercises should be undertaken by clinicians to ensure consistency in approach to patient referral triage and triage. The review should consider patients that were added to pathways and patients where their case was considered to be an 'inappropriate referral'.	1. To become part of the GI Directorate agenda - date of first meeting to be confirmed. 2. Replicate endoscopy peer review in line with JAG guidelines.	Planned Care Chief Operating Officer	30.06.2024	30.06.2024	High	Overdue	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHIB-2324-02)	5. There should be a consistent approach to reviewing and monitoring referral and demand activity across the Gastroenterology and Colorectal GI services. This could be supported further by the use of the Medical Records reports that outline delayed and unsettled referrals. Regular reporting at a Care Group level should take place to enable management to effectively review and understand the efficiency of referral throughput and assist with the planning of services. Consideration should be given to other ways in which the data currently collected can be used to identify potential issues in processes and inform decision making to improve service delivery.	1. Initiated new CTM leadership structure. 2. Continue to work with our informatics teams to build purpose dashboards that support D&C and monitoring of productivity and efficiencies.	Planned Care Chief Operating Officer	31.12.2024	31.12.2024	Medium	In progress	July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion.			
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHIB-2324-13)	1.1 The terms of reference for the Environmental Sustainability Group should be reviewed in line with the frequency set out in them to ensure they remain current in relation to membership details and reporting arrangements. The review should ensure that there are named representatives for each of the Executive leads with decarbonisation responsibilities.	This recommendation is accepted and the terms of reference for the Environmental Sustainability Group will be updated to reflect this.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.07.2024	31.07.2024	Medium	In progress	July 2024 Update - The terms of reference were discussed at the July ESG meeting and the audit recommendations will be included in an updated terms of reference document which will go back to the October ESG for approval and then to Population Health and Partnerships Committee for ratification. May 2024 Update - The terms of reference have been re-drafted and will be discussed at the next ESG meeting in July.			
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHIB-2324-13)	1.2 The minutes of the ESG should capture the department / workstream that members are representing to ensure there is clear representation.	This recommendation is accepted and changes will be made to how the minutes record representation.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.07.2024	31.07.2024	Medium	In progress	July 2024 Update - This change has been enacted following the July ESG meeting. May 2024 Update - This recommendation will be enacted from the July ESG meeting.			
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHIB-2324-13)	4.1 To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed and approved in line with organisational governance. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not.	Action will be undertaken to cost appropriate elements of the plan as resources and available information allows. However budgetary constraints are such that it is unlikely that all elements will be affordable and as for 4.2 we will stay in close dialogue with Welsh Government regarding priorities.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	31.03.2025	High	In progress	July 2024 Update - This has been added to the workplan of the new sustainability manager. May 2024 Update - Following discussion at the Audit and Risk Committee, this recommendation and management response was revised and updated. This has been updated in columns D & E.			
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHIB-2324-13)	4.2 For those initiatives that can be quantified, a long-term model for the funding required to support the decarbonisation programme should be developed.	This recommendation needs to be undertaken in partnership with Welsh Government (through Directors of Planning/Directors of Finance channels) as the LHM works within its revenue and capital resource limits. For example, a key component of the LHM's capital planning is maximising access to funds available from Estates Funding Advisory Board for decarbonisation (which provided £0.9m in 23/24). There is a developing consensus that the decarbonisation goals for NHS Wales and those portions of it assigned to the individual health boards cannot be achieved simply by funding decarbonisation projects and initiatives; the carbon savings required are too great. What is needed is for decarbonisation to be considered for each action and activity undertaken by the health boards in their daily operations, as opposed to decarbonisation actions being thought of in isolation. Whilst the Health Board's IMTP references decarbonisation as a key priority in the 'Green 2030' section of the document, there is an opportunity to make greater emphasis on it throughout. For example, when discussing the major transformation schemes.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2026	31.03.2026	High	In progress	July 2024 Update - This has been added to the workplan of the new sustainability manager to do in conjunction with the DoP and DoF. May 2024 Update - Following discussion at the Audit and Risk Committee, this recommendation and management response was revised and updated. This has been updated in columns D & E.			
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHIB-2324-13)	5. Carbon impact assessments should form part of the decisions made and actions taken by the Health Board, especially in larger scale transformational projects.	This recommendation is accepted by the Health Board. Work on this recommendation will commence following the recruitment of the Sustainability Manager as this will create additional capacity needed to better understand how this can be enacted systematically across the health board. Environmental Sustainability Group meetings The terms of reference for the ESG state that they are responsible for monitoring progress in implementing the Health Board's DAP. We acknowledge that it would not be practical to review each initiative during these meetings. However, from our review of minutes for the group, it was not clear how the ESG is actively managing and overseeing the progress of implementation of the 30 initiatives it is responsible for that make up the DAP. The DAP is structured around the six Welsh Government workstreams. Highlight reports from three of the six workstreams should be presented at alternate ESG meetings. Whilst we could see regular updates from a number of departments, such as facilities, pharmacy and ICT, these did not clearly align to the workstreams. As such, we were unable to confirm if there was appropriate reporting on the workstreams. Board and Committee reporting Reporting progress against implementation of the DAP does not appear to be taking place bi-annually, as set out in the ESG terms of reference. Our fieldwork identified one instance of the DAP / monitoring return being submitted to the Population Health and Partnership Committee since returns began in quarter two of 2022/23. The report that we saw used the Welsh Government monitoring return format, so did not include narrative for the reader to gain an overarching view of the position of the Health Board against its targets. Whilst the cover report referred to 'varying degrees of success' and the risks to achievement of the target, there did not appear to be reporting against the Health Board's overall carbon reduction target of 16% by 2025.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	31.03.2025	Medium	In progress	July 2024 Update - This has been added to the workplan of the new sustainability manager. May 2024 Update - No update this month.			
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHIB-2324-13)	6.1 Reporting arrangements for the Environmental Sustainability Group should be reviewed to ensure that it receives the necessary information to have oversight of the DAP implementation, including clear reporting from each workstream, to allow meaningful updates on progress to be reported to the Board and its committees.	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.09.2024	30.09.2024	High	In progress	July 2024 Update - This change has been enacted following the July ESG meeting. May 2024 Update - This recommendation will be discussed at the July ESG meeting.			
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHIB-2324-13)	6.2 The reporting format should be supplemented to include a narrative report that allows readers to gain a clear understanding of the current position of the Health Board in achieving the initiatives in place for each workstream and the overall position against the Welsh Government targets. Reporting on progress in implementation of the DAP to the Population Health and Partnership Committee should take place at regular intervals, as set out in the ESG terms of reference.	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.09.2024	30.09.2024	High	In progress	July 2024 Update - This change has been enacted following the July ESG meeting. May 2024 Update - this recommendation will be discussed at the July ESG meeting.			
Internal Audit/2024/172	02.04.2024	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	1.1 Once the organisational governance structures are finalised a steering / ownership structure for digital should be defined.	Accept. The implementation of ePrescribing and the development of a Patient Contact Transformation Programme provides the Health Board with a new way and ownership of delivery for digital and data programmes. It is anticipated (ahead of final confirmation), that both programmes will report into the Improving Care Board and then into Executive Management Board. Discussions are also ongoing with the Chair regarding a greater emphasis at our public board on the Digital Agenda	Digital & Data Director of Digital	31.12.2024	31.12.2024	Medium	In progress	July 2024 Update - The review and recommendations for the new governance structures will be going to the Board in September and the implementation date will be agreed then. May 2024 Update - The plans for governance structures are still being discussed. Digital will look to report to an Operational Delivery Committee, as well as a Strategic Committee. We will also look to carry out an annual Board development session dedicated to Digital themes.			
Internal Audit/2024/172	02.04.2024	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	2.1 The requirement for digital literacy for all staff should be defined and for the Health Board, with the provision of training for staff if required.	Accept With the development of the Digital Transformation function within the digital and data function, roles are being created to support digital literacy, including an assessment of capability. This will be done in collaboration with Digital Communities Wales	Digital & Data Director of Digital	01.10.2024	01.10.2024	Medium	In progress	July 2024 Update - An outline case will be taken to the Board meeting on the 25th July 2024. May 2024 Update - Digital undertook a Board development session in March, which walked the Board through a range of Digital considerations such as Digital Literacy. The Board have asked for a follow up session in July to include an outline case for the next stage in the Digital Journey at CTM.			
Internal Audit/2024/173	03.04.2024	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06)	3. Management should ensure compliance with payment timescales e.g. communicate with NWSSP Accounts Payable to confirm contractual obligations and ensure compliance.	Agreed. Contracted timescales will be emphasised to all parties concerned and compliance thereto monitored.	Capital and Estates Executive Director of Finance	01.07.2024	01.07.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Correspondence exchanged with NWSSP stressing the need to comply with contracted payment timescales. To be monitored moving forward. May/June 2024 Update - Ongoing dialogue with NWSSP Accounts Payable to resolve repeated issues with late payments.			
Internal Audit/2024/173	03.04.2024	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06)	4. Management should engage with the Supply Chain Partner to ensure that subcontractors are promptly paid for certified work.	Agreed. Further dialogue will be had with the SCP to ensure compliance with PBA terms.	Capital and Estates Executive Director of Finance	01.07.2024	01.07.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Discussion had with SCP and with NWSSP SES. There is recognition of the differing contractual payment stipulations between existing sub-contractor contract terms prior to the PBA being introduced. May/June 2024 Update - Dialogue undertaken with the Contractor. The date in the month when payment is made into the PBA being variable makes it difficult, the Contractor states, to schedule payment to sub-contractors. Notwithstanding, the Contractor does schedule payments in line with the contract, which differ to PBA requirements. Discussion ongoing.			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHIB-2324-01)	1.1 Short, medium and long-term objectives should be developed that are specific to the leadership and management development programmes.	Short, medium and long-term objectives have been redeveloped and set out in a paper to go to the Executive Leadership Group. This has also been briefed to Care Group Leads at the Care Group Launch Event May 2nd 2024, as well as a series of socialisation meetings detailed in the paper. Actions: • Take leadership paper to Executive Leadership Group for approval of objectives and overall approach. • Re-share objectives with participants of Inspire Cohort 1, as part of launch communications.	People Executive Director for People	31.07.2024	31.07.2024	Medium	In progress	July 2024 Update - Leadership Approach paper final draft developed. Consulting Executive Lead to take to the Executive Group. Cohort 1 inspire participants currently being finalised. Once finalised, coms plan will be launched to share objectives and programme details.			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHIB-2324-01)	1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported.	These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a). Actions: • Develop new programme dashboards with HEIW, using functionality in Gwella.	People Executive Director for People	30.11.2024	30.11.2024	Medium	In progress	July 2024 Update - Reporting functionality built in to new Inspire Cohorts, with reporting available once programme launched. This will include evaluation data. Note regarding timeframes: These actions are dependent on two factors – Inspire being live and HEIW designing the dashboards. As such, timeframes are not reflective of audit guidelines, as we are unable to action immediately due to reliance on HEIW resources and programme timeframes.			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHIB-2324-01)	1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported.	These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a). Actions: • Report dashboards and programme performance indicators to People and Culture committee.	People Executive Director for People	31.12.2024	31.12.2024	Medium	In progress	July 2024 Update - Functionality built in to new Inspire Cohorts, with reporting available once programme launched. Reports will be shared with People & Culture Committee once available. Note regarding timeframes: These actions are dependent on two factors – Inspire being live and HEIW designing the dashboards. As such, timeframes are not reflective of audit guidelines, as we are unable to action immediately due to reliance on HEIW resources and programme timeframes.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-01)	2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure: • Data is accurate. • Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme. • Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme. 2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight.	2.1a • As per 1.2, develop new programme dashboards with HEIW, using functionality in Gwella. Ensure inclusion of evaluation data from 2.1b.	People Executive Director for People	30.11.2024	30.11.2024	High	In progress	July 2024 Update - Monthly Analysis Report updated with holding text to clarify that new dashboards are in development (as per R1.2 (rows 144 and 145)).			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-01)	2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure: • Data is accurate. • Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme. • Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme. 2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight.	2.1b • In-line with the relaunch of Inspire, apply HEIW's Kirkpatrick Bronze evaluation framework. This will supersede and replace any previous evaluation methods/ reporting, and will be reported to Inspiring People Board and People and Culture Committee.	People Executive Director for People	30.09.2024	30.09.2024	High	In progress	July 2024 Update - •Comprehensive Kirkpatrick Bronze Evaluation Framework designed and signed off by HEIW, which includes mechanisms to capture feedback and evaluate performance of the programme. •Framework will be embedded into programme delivery once live. •Full schedule of evaluation reports and feedback sessions contained in framework, the output of which will be shared with People Board/ People and Culture Committee.			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-01)	2.2a Given the apparent low completion rates, an exercise should be undertaken to contact learners that have registered for a programme but have not started the programme, and learners that have started a programme but have not completed to ascertain the reasons why they are not actively participating in the programme. Where appropriate, the feedback obtained should be used to make changes to the delivery or content of the programmes. 2.2b Consideration should be given to how to better capture feedback received from active learners and how that can be used to improve the current learning approaches.	2.2a • Design MS forms to capture data and send out to all participants who registered but did not complete the programmes.	People Executive Director for People	30.06.2024	30.06.2024	High	Fully complete (Awaiting approval)	July 2024 Update - •List of participants that meet criteria pulled from Gwella LMS database. •MS Forms designed to capture feedback. •MS Forms link sent to all participants 17/07/2024, with returns ongoing. •L&D team will now continue to monitor returns, pulling out key themes and adapting programme design as appropriate.			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-01)	2.2a Given the apparent low completion rates, an exercise should be undertaken to contact learners that have registered for a programme but have not started the programme, and learners that have started a programme but have not completed to ascertain the reasons why they are not actively participating in the programme. Where appropriate, the feedback obtained should be used to make changes to the delivery or content of the programmes. 2.2b Consideration should be given to how to better capture feedback received from active learners and how that can be used to improve the current learning approaches.	2.2b This will be actioned via the evaluation framework associated to 2.1b.	People Executive Director for People	30.09.2024	30.09.2024	High	Fully complete (Awaiting approval)	July 2024 Update - •Comprehensive Kirkpatrick Bronze Evaluation Framework designed and signed off by HEIW, which includes mechanisms to capture feedback and evaluate performance of the programme. •Framework will be embedded into programme delivery once live.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures). 1.1b Regular monitoring should be carried out to ensure compliance.	1.1a Staff have been reminded of the importance of completing Datix. The SOP will be updated to provide guidance to ensure accurate data is recorded. An audit is being developed with support from the BI team to easily identify and monitor accurate data recording.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - Meeting with BI team in respect of various audits. BI are now developing further audits and dashboards.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures). 1.1b Regular monitoring should be carried out to ensure compliance.	1.1b Regular monitoring is currently carried as part of the payment approval process. To support regular monitoring, a regular opened and closed cases audit is being developed with support from the BI team.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - Meeting with BI team in respect of various audits. BI are now developing further audits and dashboards. Staff have been reminded of the importance of data accuracy and the need for saving documents into Datix.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	2.1 Management should reiterate to staff the importance of ensuring all documentation relating to a case is saved to the Datix file.	Management have emphasised to staff at the Legal Services team meeting the importance of saving documentations to the Datix file. This will be emphasised on a regular monthly basis. Discussions will also be undertaken in 1.15 to emphasise this point further and raised on an ad hoc basis. The email following WRPC outcomes confirming reimbursement contains personal information on all cases, which does not allow saving this email to an individual file. A work-around to this will need to be implemented.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.07.2024	31.07.2024	Low	In progress	July 2024 Update - Staff reminded of the importance of saving documentation into the Datix system.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	3.1 Management should continue to remind staff of the importance of working towards the timeframes specified by WRP and should continue to monitor to ensure compliance with this requirement.	Management have implemented weekly Business meetings for the Quality & Safety and Legal Teams, where reporting in respect of LFERs is undertaken to ensure timeframes are met. LFERs are reviewed weekly in the Executive Director Led Patient Safety Meeting. A CMR due report is run monthly by management to ensure CMRs are submitted in a timely manner. A regular opened cases audit is being developed with support from the BI team to facilitate a more thorough check on when a CMR should be triggered.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - LFERs continue to be monitored via Care Group meetings, weekly business meeting and Executive Quality & Safety meeting. CMRs are audited on a weekly basis and is monitored in the Claims weekly meeting. This will be further strengthened with the Legal Services audit programme being developed by the BI team.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	4.1 Case Management Forms should be appropriately authorised.	The Standard Operating Procedure will be updated to clarify that the Case Management Review needs to be signed by two separate individuals and that it is not acceptable to be signed by the same person in a different capacity. This has also been reiterated at the Legal Services team meeting.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	31.08.2024	Low	In progress	July 2024 Update - SOP in process of being reviewed.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	5.1a The relevant section of the Standard Operating Procedure (SOP) will be reviewed to ensure that it clearly outlines what constitutes final payment and the process that should be followed if an invoice is disputed. Training will be provided once the SOP has been updated. This action will need to be aligned with the all-Wales approach and completion will be dependent on this.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - SOP in process of being reviewed.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	5.1b Management will attend or delegate staff to the WRP's Task and finish group to ensure the key stages are clearly defined. The SOP will be updated once the work has been finalised.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - Staff member identified to attend task and finish group.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	5.1c The SOP will be reviewed and updated to ensure authorisation details align to the information contained in the CMRs. Staff will be informed of the updates at the Legal Services team meeting.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - SOP in process of being reviewed.			
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	5.1d SOPs are available to staff in and accessible in the local drive. Finalisation is dependent of ongoing work and updates on from the all-Wales Task and Finish Group and updates to the OCQ system.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - Awaiting SOP updates and update form WRP Task and Finish Group.			
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	1. Consideration should be given to enabling SRM in order to better facilitate DR to alternate sites.	A review into the use of VSRM will be carried out. Although an automated DR would be optimal, there are a number of scenarios where it would be preferred to have manual intervention into this type of response. This is in part due to some of the other work that would be required to ensure systems were accessible at the DR site such as network addressing.	Digital & Data Director of Digital	30.09.2024	30.09.2024	Low	In progress	July 2024 Update - The UHB is working with CISCO to design and architect a modern network that supports DR more seamlessly.			
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	2.1 The Health Board should consider increasing alternate site capacity to enable full service delivery.	Prior to increasing capacity, CTM should complete the system criticality mapping, and therefore have a structure and precedence for systems to be brought back (while noting that certain key infrastructure components need to be present as a foundation – such as DHCP, File, Print and Clinic). Capacity relates to storage in this matter, and by not restoring legacy archive data, the storage requirements may reduce.	Digital & Data Director of Digital	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - An assessment has identified that POW has the capacity to enable full service delivery, as such replication of Virtual machines and services is being targeted to the PoW Datacentre.			
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	3.1 Once the DR site has been provisioned the resilience position should be tested to ensure it operates as anticipated. Going forward resilience should be subject to regular testing, failing over between rooms and across sites to ensure it still operates.	A schedule for end-to-end failover testing will be produced and implemented. This should include a full prioritised recovery of systems and validation by system managers/end users. An ongoing log will be maintained.	Digital & Data Director of Digital	31.12.2024	31.12.2024	Medium	In progress	July 2024 Update - Replication of Virtual machines from PCH to PoW is being setup to support this.			
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	4.1 The DR plan should be updated to reflect the new environment. The plan should consider the main types of failure such as IT, power, communications and cover the network infrastructure. • The DR plan should include processes to follow in order to restore services in the event of varying degrees of failure such as: • Failure of site provision of failover instructions, restore priorities; • Failure of rack provision of failover and restore instructions; • Failure of VM restore and restore from backup, and • Failure of system – VM restore / backup restore.	Develop the Recovery document for VXRail and the fault domains within the system.	Digital & Data Director of Digital	30.09.2024	30.09.2024	Medium	In progress	July 2024 Update - New responses have been drafted and are awaiting approval from internal audit.			
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	5.1 An assessment of the need for individual service DR plans should be undertaken. Following that detailed DR documentation should be in place, either within the Server DR document, or within individual DR documents for each service which sets out the architecture, and processes to follow in order to restore the service. The DR documentation should explicitly include information on the resilience tier and RTO/RPO and this should be communicated to service leads.	Develop plans for systems, based on most critical being completed first.	Digital & Data Director of Digital	30.12.2024	30.12.2024	Medium	In progress	July 2024 Update - New responses have been drafted and are awaiting approval from internal audit.			
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	6.1 The services to be restored to alternate sites should be formally defined and a prioritised order for recovery set out. This should be based on a formal assessment of service criticality and risk.	This links to the work being carried out for the NIS Regulations. This will be complete in line with MAx 2.5.	Digital & Data Director of Digital	30.12.2024	30.12.2024	High	In progress	July 2024 Update - New responses have been drafted and are awaiting approval from internal audit.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUNHB-2324-17)	1.1 In order to provide a comprehensive record of each risk over its lifetime, as risks are reviewed in Datix, risk owners should capture brief narrative in the notes section to explain any changes since the previous review and actions that have been taken. Where no changes are made, this should also be captured. Datix user guidance should be updated to incorporate information on the Health Boards expectation on what narrative should be recorded in the notes section in relation to demonstrating review of risks. Information should also be included in the guidance notes on the process to follow to check for duplicate risks.	Datix Risk Module User Guidance to be updated to outline the approach to managing the review of risks and where review updates should be captured in the Datix Risk module.	Corporate Governance Director of Corporate Governance & Board Secretary Patient Care & Safety Head of Concerns and Business Intelligence, Patient Care & Safety	31.07.2024	31.07.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - COMPLETE. Datix Risk Module User Guide updated and shared with Datix Colleagues for review. On track for finalising by the end of July for use with effect the 1st August 2024.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	1.2 User guides and training sessions should be used to remind risk owners that future risk review dates should align to the timescales set out in the Risk Management Strategy, based on risk score.	a) Risk Management Training Slides to include the guidance on review dates linked to scoring. b) Datix Risk Module User Guidance to signpost risk leads to the Risk Scoring Domain Matrix to assist them in identifying an appropriate review period.	Corporate Governance Director of Corporate Governance & Board Secretary Patient Care & Safety Head of Concerns and Business Intelligence, Patient Care & Safety	31.07.2024	31.07.2024	Low	Fully complete (Awaiting approval)	July 2024 Update COMPLETE. Risk Training slides updated to include review dates. Datix User Guide has had a significant review to ensure risk leads have guidance on all steps of the process including risk scoring information etc.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	2.1a Management should ensure that minutes of the service area and care group governance meetings accurately capture the escalation of risks between the tiers of the risk register.	Risk to be a routine agenda item at the appropriate Care Group/Corporate risk meetings that directs members to consider escalation and note the resolution as part of a decision log. A template will be shared with the leads of the groups to ensure consistency of approach.	Corporate Governance Director of Corporate Governance & Board Secretary Care Groups Chief Operating Officer	31.07.2024	31/08/2024	Medium	Partially Complete	July 2024 Update - Partially complete - meeting with Care Group risk leads held to agree the approach - further work is needed in this area to simplify the service to board escalation and provide some consistent templates. It is anticipated that this work will go beyond the agreed implementation date of 31.7.2024 and extension to the end of August is requested to allow for a more robust review.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	2.1b In absence of an 'escalation field' in the current Datix System, management should explore ways to improve the current system that will allow information to be recorded when risks are escalated or deescalated between the various tiers of risk registers. Information should also be captured when the Operational Management Board have determined that a risk should not be escalated to the QSR.	Assistant Director of Governance & Risk to explore with the Business Intelligence Team whether any additional prompts / fields could be added to Datix to record escalation of risks through the various stages of Service to Board.	Corporate Governance Director of Corporate Governance & Board Secretary Patient Care & Safety Head of Concerns and Business Intelligence, Patient Care & Safety	31.07.2024	31.07.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update COMPLETE. Exploration undertaken, meeting with Datix Team held on the 18th July. Agreed the development of a free text box to follow the escalation to the organisational risk register field to allow detail to be added in terms of escalation stages. On track to implement change with effect from 1st August 2024.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	3.1 Analysis of training attendance by Care Group and service area should be carried out and shared with the relevant managers to allow them to monitor uptake within their areas and promote attendance.	Analysis by Care Group / Central Function will be shared at the Operational Management Board via the "Risk" agenda item and Executive Leadership Group through the Corporate Governance Dashboard.	Corporate Governance Director of Corporate Governance & Board Secretary	31.07.2024	31.07.2024	Low	Fully complete (Awaiting approval)	July 2024 Update - COMPLETE. Training Analysis reports now developed. First analysis shared with Care Groups and Central Directorate risk leads on 12th July 2024. Will be incorporated into Organisational & Risk Register updates to Executive Leadership Group and Operational Management Board moving forward as appropriate.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	4.1 Clarity should be provided to Care Groups on the requirements of the risk management policy in relation to where risks of certain scores should be monitored. The information on the level of risk monitoring in the terms of reference for the care group QSR meetings should align to the risk management policy.	A proposed approach will be shared with Care Groups / Central Functions to ensure a consistent management of this activity is achieved at meetings on the monitoring of risk.	Corporate Governance Director of Corporate Governance & Board Secretary Care Groups Chief Operating Officer	31.07.2024	31.08.2024	Medium	In progress	July 2024 Update - meeting with Care Group risk leads held to agree the approach - further work is needed in this area to simplify the service to board escalation and provide some consistent templates. It is anticipated that this work will go beyond the agreed implementation date of 31.7.2024 and extension to the end of August is requested.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	4.2 DTFS The Pathology service area Clinical Governance meetings should be re-established and held on a regular basis to ensure an appropriate forum in place for reviewing their risk register. Therapies Integrated Governance meetings should ensure that it has oversight of the risks scoring 12 and above as we could not determine where these were being monitored.	a) Pathology Service Clinical Governance Meetings to be restarted. b) Therapies Integrated Governance meetings to ensure that it has oversight of the risks scoring 12.	Diagnostics, Therapies, Pharmacies & Specialities Executive Director of Therapies and Health Science	31.07.2024	31.07.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - COMPLETE. Pathology Service Governance Meeting recommenced and meeting held on the 27th June. The Therapies Integrated Governance Meeting Agenda has been revised to include an embedded report that documents risks scoring 12 which will enable oversight in relation to mitigating actions. The meeting already has oversight of high risks of 15 and above.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	4.3 Children & Families The terms of reference for the Maternity, Gynaecology and Integrated Sexual Health Service Wide Assurance Group should be finalised, meetings should commence, and departmental risk register should be routinely reviewed by the group. In line with their terms of reference, the Children & Families Care Group QSR meeting should regularly review the high and extreme risks on their risk register. The minutes from the meetings should record discussions and actions relating to the management of the Care Group risk register, as well as those risk issues that are reported to it by its constituent departments.	a) The terms of reference for the Maternity, Gynaecology and Integrated Sexual Health Service Wide Assurance Group to be finalised incorporating risk as a routine agenda item. b) The Children & Families Care Group QSR meeting to regularly review the high and extreme risks on their risk register and minutes and decision log reflect action taken.	Children & Families Executive Director of Nursing & Deputy CEO	31.07.2024	31.07.2024	High	Fully complete (Awaiting approval)	July 2024 Update - COMPLETE. Terms of Reference for the Sexual Health Service Working Group (SWAG) finalised and approved at Care Group Quality, Safety, Risk and Experience (QSRE) meeting in June 2024. Risk Management training arranged for service teams within the Care Group from the Assistant Director of Governance & Risk. QSRE has a standing agenda item to explore risk registers within the Care Group.			
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	4.4 Quality and Safety Corporate Directorate The terms of reference for the Quality and Safety Business Team Meeting should be finalised as soon as possible, so as to formalise the responsibility in relation to risk register monitoring and the process for escalation or risks. It should be ensured that department risk register is routinely discussed at the Quality and Safety Business Team Meeting with onward reporting and escalation to the Quality and Safety Improvement Meeting where necessary. Minutes or action logs from each meeting should be retained to allow clarity on what was discussed and actions that need acting upon.	The terms of reference for the Quality and Safety Business Team Meeting to be finalised incorporating the monitoring of risk as a routine item. Minutes and decision log reflect action taken.	Patient Care & Safety Executive Director for Nursing/Deputy CEO	31.07.2024	31.08.2024	Medium	In progress	July 2024 Update - The draft Terms of Reference for the weekly Quality & Safety Business meeting have been developed, formal review and approval scheduled for 13 August 2024. Revised due date of the 31.8.2024 proposed.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	1.1b Up to date terms of reference for each committee and group should be in place and include information such as purpose and remit of the group, frequency of meetings, attendees and quorum arrangements.	The Terms of Reference for the current established Care Group meetings have been drafted and will be reviewed and amended where required to reflect the audit findings, these will be taken to the relevant meetings for sign off. The Terms of Reference will be saved in the Care Group Teams channel and reviewed annually.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - The Terms of Reference have been reviewed and revised and will be taken to the next MH&LD People, Planning, Performance & Finance Meeting on 31.7.24 for final approval.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	2.1 Consideration should be given to the format of capturing meeting information. Whilst slide decks are a useful platform for presenting information, an appropriate mechanism to capture attendees, key points discussed, decisions made and actions to take forward should be in place.	The Integrated Performance Meetings Terms of Reference will be updated to ensure that key actions and decisions are documented and included for future meetings.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - The Terms of Reference have been reviewed and revised and will be taken to the next MH&LD People, Planning, Performance & Finance Meeting on 31.7.24 for final approval. These capture the need to document decisions and actions.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	4.1a When risks are reviewed within Datix, the narrative in the 'controls in place' or notes section should be updated for changes since the previous review.	Under the new care group structure, risks will be aligned to the new Directorate and relevant managers. The findings from this audit have been shared with Directorate Leads and risk managers have been reminded to use the narrative in the controls in place and note sections to update once a review has taken place.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - The Head of Nursing is continuing to work with each Directorate to ensure risks are updated and structured appropriately. This will be an ongoing action but the original action from the audit has been completed.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	4.1b The future review dates for risks should align to the timeframes set out in the Risk Management Policy.	Risks will be monitored through the QSRE structure of the Directorate and risk managers have been reminded of the frequency of reviews in line with the scoring of the risk.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - The Head of Nursing is continuing to work with each Directorate to ensure risks have the appropriate actions and timelines according to the Risk Management Policy. This will be an ongoing action but the original action from the audit has been completed.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	5.1 There should be greater clarity in the responsibilities of the Care Group PP&F Board and QSRE Group in relation to monitoring risks. It should be ensured that one of these forums has oversight of all higher scoring Care Group risks on a regular basis.	All risks are now monitored and managed through the Care Group QSRE structure. Any risks approved which score 15 or higher are then escalated to the Operational Management Board for consideration and adding to the Organisational Risk Register where approved.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - The Head of Nursing leads the risk review process within the Care Group and this is reported through QSRE.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	5.2 Where CSG IPMs have more than five risks with same high score, consideration should be given to reviewing all during the meetings or reviewing all across alternate meetings.	Terms of Reference for IPM will be updated to enable Directorates to raise more than five risks if they have the same high score to ensure these are reviewed and considered by the Care Group.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - The IPM Terms of Reference have been reviewed and assurance sought for all key risks. Within the last IPMs there were up to 28 risks identified by one Directorate. This is an ongoing action but the original action from the audit is completed.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.1 For absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed. All periods of absence should be fully covered by self-certification forms or medical certificates.	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Medium	In progress	July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.1 For absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed. All periods of absence should be fully covered by self-certification forms or medical certificates.	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate integrated Performance Meeting Quarterly.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - Work has commenced and this action is expected to be completed by the target date.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.2 Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Medium	In progress	July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.2 Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting Quarterly.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - Work has commenced and this action is expected to be completed by the target date.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.3 Long-term absence should be managed in line with the policy in order to prevent absences being longer than necessary.	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Low	In progress	July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.3 Long-term absence should be managed in line with the policy in order to prevent absences being longer than necessary.	A sample audit of 5 staff files for sickness absence documentation will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Low	In progress	July 2024 Update - Work has commenced and this action is expected to be completed by the target date.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	8 In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. The dates when PDRs are carried out should be recorded in ESR to allow accurate reporting of compliance rates and to ensure relevant information is available for those staff in pay increment years.	A base line audit of PDR compliance will be undertaken for all teams.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - As at the end of June, the PDR compliance rate for all Adult Services was 73.9%. All PDR information is recorded on ESR.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	8 In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. The dates when PDRs are carried out should be recorded in ESR to allow accurate reporting of compliance rates and to ensure relevant information is available for those staff in pay increment years.	PDR's compliance will be discussed as part of planned supervision with the Senior Nurse	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - PDR compliance forms part of the Supervision Pro Forma and is discussed in monthly supervision sessions.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	8 In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. The dates when PDRs are carried out should be recorded in ESR to allow accurate reporting of compliance rates and to ensure relevant information is available for those staff in pay increment years.	PDR compliance will be reported into the Directorate Integrated Performance meeting with clear counter measure plan in situ as required.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - PDR compliance is reported in all Directorate IPMs.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be 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.	A base line audit of compliance will be undertaken by Ward Managers and reported to the senior nurse with a trajectory plan in place to achieve and achieve 85% by 30.08.24.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Statutory mandatory training is reported in each IPM and the compliance rate for all Adult Services at the end of June was 82.22%.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be 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.	The Ward Manager will ensure that time is protected for staff to complete training modules.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - Work has commenced and this action is expected to be completed by the target date.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be 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.	A laptop will be made available which can be booked for the purpose of completing e-learning modules	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - Work has commenced and this action is expected to be completed by the target date.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be 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.	Mandatory training compliance will be reviewed and discussed as part of monthly Ward Manager supervision with the Senior Nurse.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Training compliance forms part of the Supervision Pro Forma and is discussed in monthly supervision sessions.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be 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.	Senior Nurses will review the ESR system and ensure that the correct core skills are allocated to each staff group.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Medium	In progress	July 2024 Update - Work has commenced and this action is expected to be completed by the target date.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	10.1 Care should be taken to ensure data is accurately transferred from the worked roster to the Health Roster system on a weekly basis.	Health Roster Management is discussed as part of monthly Ward Manager supervision.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Health roster sign off meetings take place between Ward Managers and the Senior Nurse. Health Roster management is being discussed as part of monthly supervision sessions.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	10.1 Care should be taken to ensure data is accurately transferred from the worked roster to the Health Roster system on a weekly basis.	A spot check audit of 2 separate weeks of Health Roster will be undertaken by the Senior Nurse which will compare paper roster and the Health Roster system for accuracy. This will be reported at the Directorate QSRE meeting.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	In progress	July 2024 Update - Work has commenced and this action is expected to be completed by the target date.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	11.1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.	All substantive inpatient consultant psychiatrists have had their job-planning meeting and all plans have been mutually agreed. The plans are in the process of being inputted to the Allocate system for formal sign off.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	High	Overdue	July 2024 Update - Job planning reviews have been scheduled and are in a process of being completed. This is an ongoing but priority action across the Adult Directorate and the Care Group.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	Risks	Barriers	Theming
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUJHB-2324-09)	13.1 As part of the budget monitoring process, on a periodic basis, Ward Managers should be provided with 'Staff in Post' lists for reviewing and confirming accuracy.	Staff in post for each area will be discussed and reviewed as part of monthly Ward Manager supervision with the Senior Nurse. Completion of relevant documentation i.e. termination forms will be included in these discussions.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Staff in Post lists and relevant changes form part of monthly supervision sessions.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUJHB-2324-09)	13.1 As part of the budget monitoring process, on a periodic basis, Ward Managers should be provided with 'Staff in Post' lists for reviewing and confirming accuracy.	Staff in post is reviewed at a monthly finance meeting by the Senior Nurse and finance officer. Staff changes will be reported and documented as part of this process.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Staff in post lists and changes form part of the monthly finance meetings held in each Directorate.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUJHB-2324-09)	13.1 As part of the budget monitoring process, on a periodic basis, Ward Managers should be provided with 'Staff in Post' lists for reviewing and confirming accuracy.	Ward Managers will be invited to attend the monthly finance meeting.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Ward managers have been invited quarterly to the monthly finance meeting. This ensure appropriate attendance but also managed demands on operational time.			
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUJHB-2324-09)	13.2 All managers should be reminded of the importance of actioning termination forms and change forms promptly to prevent overpayments to staff and impact on budgets.	The Senior Nurse will cross reference all termination forms at the 'staff in post' monthly meetings.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	Medium	Fully complete (Awaiting approval)	July 2024 Update - Termination forms are being confirmed in the Ward Manager monthly supervision and cross references during the finance meetings.			

Appendix 2 - Audit Tracker Development Work Programme

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
1. Requirement for additional fields within the AMaT System to capture "Revised Dates" and rationale. Revised dates currently captured in progress update narrative.	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	January 2025 July 2024 Update – COMPLETE (PART) (AMaT Release Note Q1 2024/25). Revised due dates captured within action history and data forms part of the Excel report export (original due date, current due date and number of changes). Further enhancement required in relation to rationale. May 2024 Update – DevLog 507 to be presented to AMaT Inspection Workshop July 2024 (email 26/04/2024).
2. Inspection actions to be defined as High Medium or Low in the system.	COMPLETE	CTMUHB Clinical Audit Team	June 2024 May 2024 Update – COMPLETE
3. Introduce theming across inspections.	Local and External Development Quality Assurance & Compliance Team to add theme criteria list and share with Clinical Audit for inclusion. AMaT to design a report that captures recommendations by theme.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team AMaT System/Report Developers	June 2024 July 2024 Update – CH ongoing discussions with colleagues at Audit Wales and in Internal Audit in relation to theming. May 2024 Update – Work has been completed in relation to theming wording in line with the Quality Standards within AMaT (email 30/04/2024). January 2025 July 2024 – Work ongoing with AMaT System/Report Developers. Further enhancements requested, awaiting approval and allocation to DevLog in relation to overall reporting functionality.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
4. Read only access for Audit & Risk Committee Members to view full reports as and when required.	Local Development If Audit & Risk Committee members will find this beneficial, individuals will be added as read only users.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	June 2024 Complete – All members advised of the process to gain read only access should they require it.
5. Requirement for additional fields / coding to capture "Paused" recommendations or individual actions	External Development To be added to AMaT's Development Log and if supported will be taken forward	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025 This request has been submitted and added to DevLog as at April 2024.
6. Requirement to capture in the system where recommendations have not been accepted generating a text box for rationale narrative to be added.	External Development To be added to AMaT's Development Log and if supported will be taken forward.	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025 This request has been submitted and added to DevLog as at April 2024.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
7. Notification Alerts – further refinement of sign off stages and at what delegated level	Local Development CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team to define what is required in terms of escalation and approval levels and set permissions accordingly.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	July 2024 July 2024 Update - Enhancement to notifications (AMaT Release Note Q1 2024/25). May 2024 Update – DevLog 262 & 371 to be presented to AMaT Inspection Workshop July 2024 (email 26/04/2024).
8. Fully Automated report in pdf design style addressing all the above requirements.	Local and External Development Quality Assurance & Compliance Team to confirm report criteria AMaT to design a report that captures recommendations by theme.	CTMUHB Quality Assurance & Compliance Team	March 2025 July 2024 Update – Ongoing. Further enhancements requested, awaiting approval and allocation to DevLog.
9. Internal Audit Reports – Tracker introductory Sheet to include assurance rating	COMPLETE	CTMUHB Quality Assurance & Compliance Team	May 2024 Update – COMPLETE. This detail is now included manually into reporting. Link to DevLog 388 for long term process.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
10.Overall outcome of Inspection	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPATED TIMESCALE/IMPLEMENTATION DATE July 2024 Update - Enhancement requested via DevLog 388.
11.New Open and Confidential check boxes	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPATED TIMESCALE/IMPLEMENTATION DATE July 2024 Update – Enhancement requested, awaiting approval and allocation to DevLog.
12.Full Inspection Action History	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPATED TIMESCALE/IMPLEMENTATION DATE July 2024 Update - Enhancement requested, awaiting approval and allocation to DevLog.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
13. Retaining previous comments/progress updates	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPATED TIMESCALE/IMPLEMENTATION DATE July 2024 Update - Enhancement requested, awaiting approval and allocation to DevLog.
14. Executive Lead as a separate Lead on Inspections.	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPATED TIMESCALE/IMPLEMENTATION DATE July 2024 Update - Enhancement requested, awaiting approval and allocation to DevLog.

Code	Title	Date of Inspection	Care Group & DoN Lead	Head of Quality & Patient Safety	Recommendations	Actions
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022	30.01.2017	Planned Care Sharon O'Brien, Nurse Director	Lydia Thomas, Head of Quality & Patient Safety Cally Holland-Brame, Senior Nurse	22	22
Healthcare Inspectorate Wales (HIW)/2020/136	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	10.12.2020	Unscheduled Care Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	3	3
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08.09.2020	Primary Care and Community Lucie Williams, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	2	2
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	20.04.2021	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	1	1
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30.06.2021	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	17	18
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	20.07.2021	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety Sian Lewis, Lead Nurse for CHC and NHS Funded Care	2	2
Healthcare Inspectorate Wales (HIW)/2022/129	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT]	01.11.2022	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	6	10
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22.03.2022	Children & Families Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology Sara Fox, Head of Midwifery & Gynaecology	7	7
Healthcare Inspectorate Wales (HIW)/2022/132	Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]	26.09.2022	Children & Families Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology Sara Fox, Head of Midwifery & Gynaecology	3	3
Healthcare Inspectorate Wales (HIW)/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	17.10.2022	Unscheduled Care Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	1	2
Healthcare Inspectorate Wales (HIW)/2022/36	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	14.11.2022	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	5	5
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07.03.2023	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	39	180
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital [Appendix A - Immediate Improvement Plan - PCH, E Dept & C D Unit - 31 July 01 & HMP Parc Prison]	31.07.2023	Unscheduled Care Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	2	2
Healthcare Inspectorate Wales (HIW)/2023/140		16.05.2023	Primary Care and Community Lucie Williams, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	7	7
Healthcare Inspectorate Wales (HIW)/2023/154	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	25.09.2023	Children & Families Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety	1	2
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07.09.2023	Unscheduled Care Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	50	50
Healthcare Inspectorate Wales (HIW)/2023/156	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	25.09.2023	Children & Families Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety	2	2
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13.11.2023	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	25	26
Healthcare Inspectorate Wales (HIW)/2023/158	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	20.11.2023	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	19	19
Healthcare Inspectorate Wales (HIW)/2023/159	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	19.10.2023	Children & Families Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology Sara Fox, Head of Midwifery & Gynaecology	5	22
Healthcare Inspectorate Wales (HIW)/2023/160	Appendix C - Improvement Plan: Ty Lliardd (Ref: 03362)	11.09.2023	Mental Health & Learning Disabilities Ana Llewelyn, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	20	32
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31.07.2023	Unscheduled Care Emma James, Nurse Director	Victoria Healey, Head of Quality & Patient Safety	31	36
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09.01.2024	Children & Families Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology	2	27
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09.01.2024	Children & Families Suzanne Hardacre, Director of Midwifery	Lydia Thomas, Head of Quality & Patient Safety Angharad Oyler, Head of Midwifery & Gynaecology	14	36
Healthcare Inspectorate Wales (HIW)/2024/184	Appendix A - Ysbyty Cwm Rhondda Ward B2 (Ref: 03467)	11.04.2024	Primary Care and Community Lucie Williams, Nurse Director	Claire Ellis, Head of Quality & Patient Safety	3	3
Healthcare Inspectorate Wales (HIW)/2024/185	Appendix C – Improvement Plan: POW IR[MEJR_14 April 2024 (Ref: 03497)]	14.04.2024	Diagnostics, Therapies, Pharmacies and Specialities Sharon O'Brien	Lydia Thomas, Head of Quality & Patient Safety	17	17

In progress	Inspection action is in the process of being completed and has not yet reached the deadline.
Partially complete	Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.
Partially complete (Overdue)	Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.
Overdue	Inspection action deadline has been reached and no recommendations have been completed.
Fully complete (Awaiting approval)	Inspection actions have been fully completed and are waiting to be approved to be closed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for further support of OE in hospital sites as no defined support/project management. Live trial of OpenEyes in 4 glaucoma community optometry practices ongoing. National DCHW-led rollout of e-referrals also delayed, but local work ongoing to establish single inbox for email referrals from primary care into Ophthalmology. Inbox monitoring rota being established, timeline for launch dependent on primary care NHS email roll out below but expected to be live by August 2024. CTM keen to promote roll out of M365 with community optometry practices following successful pilot - provided DCHW with priority list (focusing on practices involved in shared care/WG054) during their rollout of NHS email (rolling out April-Aug).	Planned Care	01.03.2023		Overdue	April 2024 Update - DCHW-led rollout of OpenEyes still delayed, possibility of reopening tender process. OE contract with CTM in place until at least Jan 2025 (currently only Glaucoma clinics live). CTM OpenEyes Business Project Manager no longer in post (contract not renewed past March 31st), significantly impeding further rollout of OE in hospital sites as no defined support/project management. Live trial of OpenEyes in 4 glaucoma community optometry practices ongoing. National DCHW-led rollout of e-referrals also delayed, but local work ongoing to establish single inbox for email referrals from primary care into Ophthalmology. Inbox monitoring rota being established, timeline for launch dependent on primary care NHS email roll out below but expected to be live by August 2024. CTM keen to promote roll out of M365 with community optometry practices following successful pilot - provided DCHW with priority list (focusing on practices involved in shared care/WG054) during their rollout of NHS email (rolling out April-Aug).
				Previous Updates - Stage 1 – to be completed by March 2023. Stages 2 & 3 – BC dependent – objective is to start implementation in first half of 2023/24.					
				December 2023 Update (Date of review: 12/12/23). Roll out of Open Eyes has been delayed nationally, with CTM & C&V the only 2 HBs live with EPR for glaucoma in hospitals. The programme plan was to implement glaucoma EPR in all hospital sites nationally as stage 1, e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3; the timeline has been delayed with host changeover from C&V to DHCW.					
				OpenEyes implemented in CTM hospital glaucoma clinics since March 2023. Further work on admin training and integration with hospital digital systems (WPAS & CTO) ongoing.					
				Primary Care have worked with the DMCW programme team to provide contact details for all optometrists requiring access/relevant training, currently focusing on national pilot of NHS email addresses for community optometrists (2 per HB to start) What next? By when? By whom?					
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	The CHC's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. (Patient Referrals - Referral Process) All parties (Welsh Government, NWS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Primary care has produced and shared patient information on CTM social media platforms to explain changes in patient referrals and enhanced services now being delivered in primary care/closer to home. Recent recruitment of additional Optometry Advisor [Jan'23] will support practices to improve communication and referral pathways for patients and will support practices where poor quality referrals are flagged. HES updates on waiting times are shared with practices via SEWROC to support conversations with patients and manage expectation.	Planned Care	01.04.2024		Fully complete (Awaiting approval)	April 2024 Update - EPR/E-referral - see MD1/1. Implementation plan for rollover of shared-care services to new WG054 pathways submitted to WG, with cross-sector discussion meeting planned 20/5/24. Once ratified, communications sessions & newsletter to update primary care options on changes will be delivered, as will updated patient service signposting. Dec 23 Completed - new optometry contract phased implementation began Oct'23 2- implementation of EPR across HB remains an ongoing process Dec 23 update The new national optometry contract will promote fuller conversations between patient and optometrist during WGOS service assessments, with optometrists [as part of the patient assessment]explaining how risk behaviours can effect their eye health and also enable practitioners to signpost patients to alternative services where required. EPR is already established within glaucoma clinics within HES. HB is working with national digitalisation programme to launch EPR system across primary and secondary care as a matter of urgency Actions 1. the national contract will be monitored monthly by primary care teams on an ongoing basis as part of the new contract arrangements. 2- the primary & secondary care staff will continue to engage with the national programme/DCHW to support implementation within the HB.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) A) Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate care pathway in a timely and efficient manner, avoiding unnecessary visits.	Primary Care /HES have already established a number of referral refinement schemes within practices in CTM: • Independent Prescribing • Wet AMD • Diabetic Retinopathy • Glaucoma (develop existing service in place	Planned Care	01.04.2024		Fully complete (Awaiting approval)	Completed: all schemes are now established within CTM April 2024 Update - Ongoing pathways continue to monitor under existing shared-care agreements during the WGOS transition phase. Improved data sharing between secondary and primary care re: patient outcomes within these pathways being scoped. Insufficient admin resources within HES team a significant challenge for this. Currently 1.5wte Band 3-5 admin support committed to these pathways (1.0wte Band 3 post vacancy imminent, but recruitment to replace agreed) further admin support necessary to scale up pathways. WG to identify regional Planned Care Board leads to signpost secondary care to potential funding to support WGOS delivery. New HB-wide glaucoma referral refinement pathway being designed, to be live by Oct '24. Dec 23 update Data for these schemes are reviewed monthly on an ongoing basis by the primary/secondary teams and pan HB team/practice meetings are held regularly to review schemes. All schemes will begin to fall under the new optometry contract through phasing in of new contract / WGOS and monitored by primary care.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) B) Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways.	Practices are notified when new local referral pathways are introduced and updates circulated to practices. Optometry newsletter to be produced in primary care and circulated 4 times a year. Accelerated Cluster Development will allow closer working for practices within clusters. CTM to hold first event Jan'23	Planned Care	01.04.2024		Fully complete (Awaiting approval)	April 2024 Update - ACD engagement successful across HB, HB protocol for managing failure to engage being ratified. Local discussion sessions with primary care optometry practices to be delivered once pathway changes finalised over next few months, with newsletter updates. Quarterly ECGG in progress following reinstatement in Dec '23 (next meeting May '24). Monthly cross-sector WGOS planning/implementation meetings between primary & secondary care teams for both Glaucoma and Medical Retina also taking place. Dec 23 update newsletters will continue to be sent to practices via primary care team regarding updates and new referral pathways. There will be ongoing engagement with practices due to the implementation of new contract/WGOS services and communication sent to relevant services i.e. GMS/pharmacy/secondary care on any relevant changes. Most practices are now engaged with ACD under the new contract obligations and work will continue to engage with those practices not yet engaged. HB ECGG will be the platform for primary care to share updates with secondary care on new contract/WGOS.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) C) Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.	> 90% of referrals come directly from optometrist with good communication between primary and secondary care. Optometry dept. working with OA developed letter templates to communicate insufficient referral detail to primary care for glaucoma referrals which has improved referral detail.	Planned Care	01.04.2024		Fully complete (Awaiting approval)	Dec 23 update the review of quality referrals sent by optometry practices will be an ongoing process
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) [Discharge patient – Quality of information) A) Health Boards should ensure feedback of diagnosis and a treatment plan is provided to referring optometrists following every referral made to the service, including whether a referral to a low vision service has been made.	Optometrists are copied into all clinic correspondence for new patients when the referral has come from the optometrist in POWH - this will be done across all sites within CTM.	Planned Care	01.04.2024		Fully complete (Awaiting approval)	April 2024 Update - Complete. Dec 23 update this is done by the admin staff across the HB in order to ensure that optometrists are kept up to date with patients status within HES. This will be an ongoing process by the service manager to ensure that when a patient is referred by the optometrist that a copy of the clinic correspondence is sent to them for information. All new starters to be informed of the process.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) [Discharge patient – Quality of information) B) Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible.	Primary care to work with HES to identify where this is an issue within practices and provide support via OA to ensure appropriate information is shared in the referral. New recruitment OA to undertake referral audits to support this. Optometrists contact details are not always clear on the referral form, internal arrangements being made to monitor the quality and individually feedback to the Optometrists via Local advisor.	Planned Care	01.04.2024		Fully complete (Awaiting approval)	Dec 23 update this will be an ongoing process. Optometry Advisors will continue to work with both practices and HES to ensure the submission of high quality referrals. Implementation of the ECR system will also support /improve referral process.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) [Discharge patient – Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	The implementation of Open Eyes will provide optometrists with access to patient information that will promote, simplify and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024		Overdue	April 2024 Update - EPR rollout delays. December 2023 Update (Date of review 12/12/23) See item 1What next? By when? By Whom?
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	CHC reports concerns around lack of information provided within secondary care prior to treatment (Patient Referrals – Communication Following referral) - Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent.	RCO leaflets provided about consent process in pre assessment Information leaflets provided for any eye emergency care Laser information Cataract information ECLO services Blepharitis leaflets FFA – Information Surgery information leaflets • CM08: Cosmetic Blepharoplasty • CM09: Cosmetic Ptosis Surgery • OP01: Cataract Surgery (phacemulsification) with Monofocal Intraocular Lens Implant • OP02: Blepharoplasty • OP03: Glaucoma Surgery (Trabeculectomy) • OP04: Retinal Detachment Surgery • OP05: Corneal Transplant Surgery • OP06: Correcting a Squint (child) • OP07: Entropion and Ectropion Repair • OP08: Ptosis Surgery (adult) • OP09: Correcting a Squint (adult) • OP10: Ptosis Surgery (child) • OP11: Intravitreal (Anti-VEGF) Injection • OP12: YAG Capsulotomy • OP13: Removing a Chalazion • OP14: LASIK Surgery • OP15: Removal of Pterygium • OP16: LASEK Surgery	Planned Care	01.04.2024	Fully complete (Awaiting approval)	April 2024 Update - Additional SLT (glaucoma laser procedure) leaflet being designed, along with procedure counselling guidelines from Glaucoma consultant team, to improve patient experience and laser clinic flow/efficiency. To be discussed in clinical audit meeting in June. Plan for reinstatement of local Glaucoma Patient Education Forums included in business case for potential Glaucoma Diagnostic Hubs at YCC/MCH. Dec 23 update Date of review: 03/08/2023 What next? The health board has a comprehensive selection of patient information leaflets available. In order to ensure that these meet the needs of our patients, these leaflets need to be well stocked and updated nationally through the EIDO programme to ensure that they reflect best practice. Objective to be discussed at directorate meeting to raise awareness to both clinicians and nursing staff about supplying patients with information during their clinical consultations. By when? Weekly review of leaflet stock within clinical area. Objective to be discussed at directorate meeting on 8th August 2023 By whom? Service Manager / Senior Nurse to cascade information to team. Information gathered from the clinical teams regarding what literature is available within the clinical departments. Objective to be discussed at directorate meeting to raise awareness of both clinicians and nursing staff supplying the patients with information during their clinical consultations.	
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Documents and resource related to FUNB patients are shared between the business Informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PIFU Patients with appointments cancelled	Planned Care	01.04.2024		Overdue	December 2023 Update (Date of review: 01/01/24) - What next? To continue to monitor the FUNB list across all sub specialities within ophthalmology By when on a weekly basis By whom service manager
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Patients on the FUNB and New list are all given a HRF and target date. When booking clinics the booking office will filter by target date and HRF ensuring that patients are booked into the most appropriate sub-speciality clinic by priority status. However, we continue to hold significant risk with the FUNB cohort and further resource in terms of validation and capacity is required.	Planned Care	01.04.2024		Overdue	December 2023 Update - this will need ongoing review by the service manager to ensure that the most clinically urgent patients are booked with priority. Ongoing review by the service manager, this practice is currently undertaken in Bridgend but will need to be put into practice in all parts of the HB to ensure a pan CTM approach.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A Significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024		Overdue	December 2023 Update - this work will be ongoing to ensure lists re kept up to date and 'clean' at all times. Ongoing review by the service manager to validated and ensure correct ratio of new and follow patients in all clinic templates.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024		Overdue	December 2023 Update (Date of review: 12/12/2023) - What next? Band 5 1.0 Vacancy not appointed in to - position being re-advertised on Trac. Position escalated to HON and CSGM to look for support in the short term. CSGM to determine if harm review team funding can be extended past March 2024 as the project is still ongoing. Macular cluster report due by 15/12/2023, good progressing being made towards this but absence of the Band 5 FLO support is stalling the work. By when? Closing date TBC for band 5 position. Awaiting feedback about alternate staffing to support in the short term. CSGM to feedback if funding can be extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSGM September 2023 Update (Date of review: 03/08 /2023) - What next? Vacancies for harm review workforce are currently out to advert. An cluster RCA commissioning meeting is to be arranged within the next 2/52 regarding the macular service and the patients who have experienced moderate and above harm as a result of a follow up not being booked By when? to be reviewed in 2/52 with update. By whom? Senior Nurse. An SBAR for additional harm review workforce was submitted to Planned care recovery and funding was approved in July 2023 for 2 fixed term positions until the end of March 2024. These positions include 1 WTE Band 7 clinical investigator, 1 WTE band 5 governance support officer / family liaison officer. The workforce will be dedicated to support the legacy open NI's from 2016-Feb 2022 from RTE, as well as the review all legacy and current open incidents under the Ophthalmology service. The workforce will be supporting any commissioned RCA's and will work closely with the clinical and administration teams in the review of action plans and learning from events. Date of review: 08/11/2023 What next? Band 7 1.0 Vacancy filled with 2 individuals job sharing and fixed term until the end of March 2024. Band 5 Investigation support officer currently in shortlisting phase - this role to act as the FLO for all 2 candidates for interview, date TBC. CSGM to determine if funding can be extended further. By when? Interview for band 5 post to take place in the next 2/52. CSGM to feedback if funding can be extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSGM.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	a) CTM has a well established optometry department which has a number of experienced, highly skilled and qualified optometrists working across glaucoma, medical retina, DRSS, unscheduled care, paediatric clinics and specialist contact lenses. Recent expansion of the service to include community optometrists on a sessional basis which has increased our capacity across these services whilst additionally improving training to community optometrists to in turn reduce referrals and improve referral quality. Hospital based optometry due to start implementing an optometry laser led pathway to improve SLT and laser capacity in the coming months.	Planned Care	01.04.2024		Overdue	April 2024 Update - eye drop instillation by unregistered staff in early implementation phase - nursing team signoff complete, in use. Further short term extension of 2x Band 7 1.0wte Specialist Optometrists providing significant clinic activity in Medical Retina - extended to 30/9/24 but urgent longer term/permanent extension required to maximise clinic output/booking. MDT GIRFT working group on pause following management changeover. Longstanding vacancies in Heads of Optometry and Orthoptic services - recruitment strategy in evaluation, as risk to service development without these posts. Further review is required / Action to be removed and replaced with a subsequent agreed action December 2023 Update (Date of review: 12/ 12 /23) - New clinical policy approved to allow for unregistered staff to instil eye drops, freeing up registered staff for more skilled tasks/faster clinic flow - implementation imminent. Optometry Department SBAR demonstrating value of workforce & need for expansion completed. Secured fixed term contract extension for 2 sessional optometrists supporting Medical Retina clinics for next Q (via VBMC), further extension required to maximise clinic planning. MDT workforce working group for GIRFT process due to start in Dec '23, tasked with evaluating non-medic workforce/skill mix and maximising use of MDT (to top of license). Optometrist role expansion into glaucoma laser delivery successful (training, signoff & SOP complete) - SLT WL reduced to 12/52. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CARRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024		Overdue	April 2024 Update - HES training/consultant mentoring for higher qualifications for community optometrists (to allow them to deliver enhanced services) in progress, with joint co-hosting with Cardiff University. 5 CTM consultants currently agreed to provide mentoring services over 2024/25. HEIW funding for administrative placement co-ordinator secured, to be advertised asap. December 2023 Update (Date of review: 12/12/23) - Community optometry completed funded academic course successfully, placement pending 2024 [delayed due to consultant workload]. Community optometry post-grad placements widely delayed due to HES workload/lack of funding - Joint collaboration with Cardiff University to co-host placements in 2024, reducing time intensive burden on hospital site. Funding request for admin placement co-ordinator role submitted to HEIW. AMD community scheme live (June 2023), running well with consultant feedback. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health boards should learn from the experiences following progress made in other areas (Treatment – initiatives to improve Capacity) A) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from/with staff in other areas.	Weekly performance meeting have been arranged between the Clinical Service Group Manager (CSGM) and Interim Director of Planned Care to discuss key performance measures and any ad hoc issues which arise. CSGM from other sites are in attendance for shared learning purposes. Any risks we have assessed in the service is held on the corporate risk register which we update regularly with mitigations to reduce the risks. We also provide regular updates on the above to the Quality, Safety and Risk Group, as well as to the Planned Care Recovery Finance Group and the Joint Executive Team Meetings.	Planned Care	01.04.2024		Overdue	April 2024 Update - CD attending national CIN meetings, to develop regional strategies/shared learning. December 2023 Update - No update received.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	WG to answer	Planned Care	01.04.2024		Overdue	December 2023 Update - No update received.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	ECLO – Limited capacity/cover (Service Support Staff – Eye Care Liaison Officer) Health Boards should ensure that there is ECLO for their eye care clinics at all times and consideration should be given as to whether one ECLO is sufficient for the eye care service.	POW – RNIB ECLO coverage 4 days RGH / PCH / YCR – NHS ECLO for RGH, PCH, YCR – coverage 3 days ? Commissioning issue - ask Elizabeth Beadle	Planned Care	01.04.2024		Overdue	December 2023 Update - No update received.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns raised by staff in relation to a lack of processes in place to submit comments/suggestions to health board management. (Service Support Staff – Eye Care Liaison Officer) Health Boards must ensure that there are methods in place to allow all staff to raise any concerns/suggestions about improvements to service provision they may have. This process should to ensure that feedback is routinely provided to individuals.	Eye care collaboration and directorate meeting.	Planned Care	01.04.2024		Fully complete (Awaiting approval)	Complete 01/12/2023 Dec 23 update Date of review: 12 / 12 /23 ECCG re-established as of 1/12/23, regular directorate meetings ongoing What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024		Overdue	April 2024 Update - CTM Optometry co-authored WG white paper on role of Hospital Optometry in NHS Wales, with specific recommendations on expanding the Welsh hospital optometry workforce and establishing a Hospital Optometry Forum in Wales. To be presented at CIN in May to identify potential resources to implement recommendations nationally, to be followed by local presentation by CTM Optometry at each HB's ECCG over next quarter, to highlight need to develop this workforce across Wales. CTM Optometry collaborated with WIRG, HEIW and ABUHB Optometry on development of UK-wide ESR updates for Optometry. New roles allowing for a defined career progression pathway for optometrists, and more accurate Areas of Work, Occupation Codes and Staff Group approved nationally by NHS Digital in March 2023, to be implemented UK-wide in the National Workforce Data Set June 2024. This will allow the optometry workforce to be more accurately captured by ESR across the NHS, aid in recruitment and offset workforce attrition for Hospital Optometry on a national scale. December 2023 Update (Date of review: 12/12/23) - Optometry SBAR detailing need for hospital optometry workforce expansion in size and clinical role completed. Funding secured from HEIW for 3 hospital optometrists to complete Higher Certificate in Medical Retina qualification (commencing March '24). Optometry-led laser service in situ in RGH, successfully brought laser WL down. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around indemnity, resource & finance arrangements, training and communication, for optometrists.	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPQS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024		Overdue	April 2024 Update - GIRFT MDT working group on pause following management changeover. December 2023 Update (Date of Review: 12/12/23) - As above, await outcomes from GIRFT MDT workforce working group that will be reviewing the workforce. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues in relation to poor relationships between primary and secondary care staff impacting on progress to service developments Health boards must ensure that relevant staff engage with the local Eye Care Group. The group should meet regularly and be chaired by a member of the executive team. A key objective is to improve the working relationships between primary and secondary care staff to foster joint working initiatives.	Primary/Secondary care have worked collaboratively to implement shared care pathways in Independent Prescribing/Glaucoma/Wet AMD/Diabetic Retinopathy, work continues to improve and develop these services. Health Board to ensure appropriate representation at local ECCG from a primary care management and clinical perspective/HES management and clinical team to enable appropriate scrutiny/oversight on actions taken to support reduction of waiting times/workforce/new pathways/implementation of open eyes/contract reform developments	Planned Care	01.04.2024		Fully complete (Awaiting approval)	April 2024 Update - Good cross-sector representation at ongoing ECCG and local OLG meetings. Dec 23 update - Date of review: 12 / 12 / 23 4 shared-care schemes established with frequent cross-sector contact/consultant input/feedback sessions etc. Consultant Connect implemented for Glaucoma scheme (Nov '23) to allow community optoms direct access to Glaucoma team for advice & guidance. ECCG re-established 1/12/23 with good cross-sector collaboration and attendance. HB Optometry Liaison Group long established - continues bimonthly, with both primary & secondary care rep. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2020/136	10.12.2020	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	The health board must provide HIW with assurance that staffing levels are not currently impacting on the effectiveness of care being delivered to patients and that any changes resulting from the review into staffing establishments at the unit will help reduce the pressures faced on existing members of staff.	During the pandemic additional staff above the established levels for the unit have been agreed to support the pressures within the unit. However filling the shifts was problematic despite agency and bank requests being made to staff bank 6 weeks in advance. The fill rates; October 2020; 64% equivalent to 155 shifts filled and 86 shifts remain unfilled. November 2020; 62% equivalent to 131 shifts filled and 79 shifts remained unfilled. Every effort is made to fill the shifts by offering staff overtime at enhanced rates as agreed by the Health Board. The sickness levels for the unit are robustly monitored; December 2020 9.1% January 2021 10.2% February 2021 6.37% The team are hopeful with the reduced pressures from the pandemic that the sickness trajectory will continue to improve. CDU staffing establishments have been agreed for the 24 bed ward with the GP assessment area being managed separately. Posts have been filled with staff members commencing March 2021 the remaining vacancy rate will be 0.34WTE. In response to the pandemic and high acuity levels within the hospital the surge capacity within CDU has been utilised in line with the escalation policy, the use of these additional 4 beds is being monitored. Continuous quality monitoring continues through the use of a number of systems inclusive of ward based assurance audits, Datix incident reporting, Serious Incidents and patient feedback (complaints/complements). The data is triangulated and continues to indicate that there is no increase in harm or compromised care for patients.	Unscheduled Care	01.03.2021		Fully complete (Awaiting approval)	February 2024 Update - Complete - 14 February 2024 post Covid -19 and remodelling of services in PCH. The unit remains a 24 bedded unit with the same establishments, current vacancies 2.37 wte RN and 2.22 HCW, the Band 7 is 100% supernumerary. There has been positive recruitment to the unit over the past 2 years including new graduates and IEN nurses. CDU establishment including bank and agency use is monitored via 6 weekly Health Board Workforce and Business meetings. Safe to Start commenced in November 2022, 08:00 and 14:30 hours, a whole system approach to review patient flow including safety indicators and nurse staffing-this is essential to ensure staffing is reviewed and measures are put in place to support any short term absences with an audit trail of decision making and actions taken. The fill rate for the past 5 months August, September, October, November, December 2023 and January 2024 - 90%, 93%, 90%, 80, 94% and 95% respectively.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2020/136	10.12.2020	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	The service must ensure that any issues identified in Point of Care Audits are actioned in a timely manner and HIW would expect to see an improvement in compliance in future audits undertaken at the CDU. The health board must provide assurance of further actions undertaken in response to the Infection Prevention and Control (IPC) audit undertaken in July 2020. Additionally, the health board must provide assurance that the systems currently in place to monitor and improve IPC standards at the unit are appropriate to ensure the required IPC standards are met.	The key issues for the unit are related to the environment, which are addressed in point 1. Following receipt of the audit report, the Head of Nursing requested an urgent IPC audit, the results have increased to 88%. Key actions remain with the estates department and are being progressed. Daily Spot Checks are undertaken by the ward manager and overseen by the senior & lead nurse. Point of Care monthly audits continue and each area has an improvement plan which will be monitored by the Lead Nurse.	Unscheduled Care	01.03.2021		Fully complete (Awaiting approval)	February 2024 Update - Complete 14 February 2024 post Covid-19 and remodelling of services and nursing structure-Point of Care audits have been replaced with monthly AMAT (Audit, Management and Tracker) as well as unannounced formal audits undertaken by the ICT. To date the Environmental audit is between 94.6% and 100%. The Head of Nursing chairs the monthly acute services IPC meeting, whereby exception reports are completed by the Senior Nurse and KPI's are monitored closely. Where any deterioration in trends may be identified, targeted work is undertaken with the MDT to maintain and sustain the standards expected. IPC training of the MDT is integral to the improvement work and is monitored via the 6 weekly Workforce and Business meetings. Currently IPC Level 2 for RN=84.65% and 72% HCSW xxxx%, ANTT RN= xxxx%. Compliance of IPC audits and training is also monitored via the quarterly IPC Committee meetings chaired by the Director of Nursing, again any required actions are scrutinised and monitored closely.
Healthcare Inspectorate Wales (HIW)/2020/136	10.12.2020	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	The service must improve their ongoing compliance with staff Performance Appraisal and Development Reviews (PADRs) and provide evidence to HIW within three months that all overdue PADRs have been completed.	The compliance at the time of the audit was 53.1%, this has now increased to 79.24%. The outstanding PDR's are due to staff absence and errors within the hierarchy of ESR, these are currently being cleansed to reflect the correct staff in post.	Unscheduled Care	01.03.2021		Fully complete (Awaiting approval)	February 2024 Update - Complete - 14 February 2024, PDR compliance is 91% for the nursing team and this is monitored via the 6 weekly Workforce and Business meeting and clearly aligned to the nursing staff training plans.
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the policy for infection, prevention and control is reviewed.	To present the new IPC strategy to the next IPC Committee meeting in October 2020 for approval, then for sign off.	Primary Care & Community	01.12.2020		Overdue	IPC strategy to be presented at the July 2023 IPC Committee meeting for approval.
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the escalation procedure is reviewed.	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM Intranet site.	Primary Care & Community	01.10.2020		Overdue	Escalation plan developed and out for consultation.
Healthcare Inspectorate Wales (HIW)/2021/135	20.04.2021	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure future compliance with mandatory training.	85% of applicable staff groups will be fully compliant with mandatory training in PMVA, ILS/BLS and Fire training. Progress towards this target and future training compliance rates will be managed using ESR and monitored through line management arrangements. Deviation from the proposed improvement trajectory and failure to maintain the target levels of compliance will be escalated at Clinical Service Group Performance Review meetings. Mandatory training compliance to be included as a standing agenda item during line management sessions. Compliance to be reported on and monitored in the Clinical Service Group (CSG) Workforce and Organisational Development meeting and ILG Performance Review meeting.	Mental Health & Learning Disabilities	10.07.2021		Fully complete (Awaiting approval)	Partially Complete. • Training plan was instigated with trajectory for 85 % compliance by 10 July 2021. At time of reporting (10/7/21) compliance is April 21 July 21 ILS 6% ↑64% BLS 0% ↑38% PMVA – Mod D 20% ↑73% PMVA Mod A/B – 41% ↑87% PMVA Mod C 8% ↑67% Fire 50% ↑87% Covid risk assessment 46% ↑80% • PMVA mod A/B&C is time intensive training (6 hours per person) and clinical pressures have delayed completion. Additional pay has been used to release capacity to ensure 85 % compliance by 10th August 2021. • BLS attendance has been impacted by availability of training sessions with ward based model now established to address
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The Cwm Taf Morgannwg (CTM) Crisis Review Forum will develop guidelines around crisis plans for those not under Care and Treatment Planning (CTP) who have had contact with Mental Health Services. CTM continue to audit crisis contingency plans developed under Part 2 to ensure they are co-produced and support the individual to recognise and respond to crisis. This is fed through the CTP Monitoring group.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action updated as at May 2024 - CTP training programme has been amended to include a stronger emphasis on relapse indicators, contingency plans and crisis plans when required. Example formats are provided and discussed and again making such plans individual and person centred is reinforced. CTP lead has been targeting teams PAN CTM to improve attendance at the training sessions. This has proved to be effective with generic sessions circulated yielding poorer attendance. CTP audit in place and monitoring in place. April 2024 Update - Evidence being collated. Due for closure and ratification by MH&LD QSRSE June 24.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	Results of audits from crisis contingency planning to be fed back through the Together for Mental Health partnership forum on a 6 monthly basis for assurance and evidence of improvement.	Mental Health & Learning Disabilities	01.06.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action updated as at May 2024 - CTP training programme has been amended to include a stronger emphasis on relapse indicators, contingency plans and crisis plans when required. Example formats are provided and discussed and again making such plans individual and person centred is reinforced. CTP lead has been targeting teams PAN CTM to improve attendance at the training sessions. This has proved to be effective with generic sessions circulated yielding poorer attendance. CTP audit in place and monitoring in place. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Please note this work was superseded by the rollout of 111(2) completed in April 2023 Action updated as at May 2024 - This work has been superseded by the roll out of 111&2 since April 23 in CTMUHB, providing a single point of access for citizens across the health board. Following triage of need, an agreed set of pathways are in place to ensure assessment is provided within given timeframes based on clinical need. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	Revised Due Date November 2024	Partially complete	June 2024 Update - Partially complete, but with outstanding work. Complete by August 2024. Action updated as at May 2024 - An initial meeting was set up between MH and PC AMD to discuss this but meeting did not take place. Ongoing communication between MH&LD MD and PC MD is in place to establish which existing forum this work can best sit to ensure action. Mitigating Actions Dedicated lithium and clozapine clinics are in place across adult and older adult CMHTs that have a consistent standard and ensure follow-up for patients who do not attend. There is an offer of physical health monitoring in all adult and older adult CMHTs. Improving the physical health of people with severe and enduring mental health problems is a priority of the MH&LD Care group, and a Physical Health Monitoring Group reporting through QSRSE governance structures is in place. April 2024 Update - Partially complete, but with outstanding work. Complete by August 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action update as at May 2024 - In Bridgend an ICF scheme implemented 3 RMNs managed by the GP cluster networks. Funding secured funding 2 of the posts substantially. Advertising shortly. Professional supervision provided by MH&LD Mental Health Practitioners are in Community Health and Wellbeing Teams in MC and RTE, additionally the TE cluster have funded x2 band 6 MHP posts within the TE area – this is due to end in March 24: awaiting feedback from the cluster development manager about future funding. Primary care professions are able to access timely advice and referral options via 111&2 professional line. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action updated as at May 2024 - In addition to the development of RMHN in GP surgeries to aid timely specialist advice, Consultant Connect is available. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards need to consider how they can strengthen linkages between services to improve access and provision for individuals needing support for their mental health and well-being.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action updated as at May 2024 - The roll out of 111&2 since April 23 in CTMUHB has provided a single point of access for citizens across the CTMUHB region. The professionals' line is available to colleagues in arrange of services, including PC, third sector, SWP and WAST. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.	Service Mangers in Mental Health are working with 3rd sector to develop managed posts utilising C-19 response grants to support people who have been in crisis but not requiring secondary care to ensure their follow up has been helpful or to advise alternatives.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	Excluded April 2023 June 2024 Update - Approved QSRSE June 2024. Action updated as at May 2024 - Analysis completed with recommendations of extension to 3rd sector coordinator roles, but challenging to make firm conclusions around need at that time. Improved data sharing processes to GPs following crises assessment: -Bridgend Crisis Assessments and/or discharges trigger an emailed notification to GP within 24 hours/ next working day. -111(2) assessments are documented on Adastra, which is shared with relevant GP practices at the end of every working day -RTE and MC CRHTT and MHLTs have an information sharing process in place to ensure clinical and risk assessments are shared with GPs. -Ongoing pilot in RTE to ensure follow up with GP practice RMHN following crisis assessment (where no ongoing input). April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards need to consider how they can strengthen the role and involvement of the third sector to improve the range of provision for individuals needing support for their mental health and well-being.	Programme of review of Service Level Agreements to be in place as well as develop future services.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action update as at May 2024 - Funding of the development of three MH development officers was established and employed via CVCs. There are quarterly provider & commissioner meetings take place between CTMYHB and third sector. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health & Learning Disabilities	31.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action update as at May 2024 - A single point of access is available into CTMUHB mental health services for citizens across the CTMUHB region via the 111&2 service. Following triage of need, an agreed set of pathways are in place to ensure assessment is provided within given timeframes based on clinical need. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRSE June 24 Complete April 2023
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards should review the community mental health services available in their localities, to ensure that services focus on individualised needs of people to prevent a deterioration in mental health, and to provide timely care and support in all community services when required.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRSE June 2024. Action update as at May 2024 - As outlined above, MH practitioners are embedded in RTE and MC GP clusters. RTE cluster has also invested directly in two posts. Bridgend cluster has developed two posts that will be professionally managed within the MH&LD care group. Regular reports of activity are collated. April 2024 Update - Complete. Collating evidence and due for ratification in MH&LD QSRSE June 24

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards, emergency services and primary care services should consider how mental health staff can be incorporated within emergency call handling teams across Wales, to enable early advice and support to people who need urgent care or support for their mental health.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSR6 June 2024. Action updated as at May 2024 - This work has been superseded by the roll out of 11182 since April 23 in CTMUHB, providing a single point of access for citizens across the health board. Following triage of need, an agreed set of pathways are in place to ensure assessment is provided within given timeframes based on clinical need. The professionals line is well used by SWP and WAST. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSR6 June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards should ensure clear advice and information is available and promoted to people with mental health needs, to help maximise their knowledge about additional support services available within the community including the third sector.	Ongoing work regarding the development of specific mental health information advice and support through the development of Cwm Taf Morgannwg website.	Mental Health & Learning Disabilities	31.10.2022		Fully complete (Awaiting approval)	Completed April 2023 June 2024 Update - Approved QSR6 June 2024. Action updated as at May 2024 - The MH&LD Care Group has worked with third sector partners to develop a website to promote local third sector services. The Website went live Q2 2022.Regular analytic reports are received to monitor most and least visited pages. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSR6 June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	Completed January 2023 June 2024 Update - Approved QSR6 June 2024. Action updated as at May 2024 - The roll out of 11182 since April 23 in CTMUHB has provided a single point of access for citizens across the CTMUHB region. The professionals' line is available to colleagues in the third sector. Colleagues in the third sector are also able to support people to contact 11182 directly. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSR6 June 24 Completed April 2023
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	June 2024 Update - Approved QSR6 June 2024. Action updated as at May 2024 - The roll out of CTMUHB 11182 in April 2023 has provided a single point of access for citizens across the CTMUHB region The professionals line is available to colleagues in arrange of services, including PC, third sector; SWP and WAST. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSR6 June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health & Learning Disabilities	01.10.2022		Fully complete (Awaiting approval)	Completed April 2023 June 2024 Update - Approved QSR6 June 2024. Action updated as at May 2024 - As outlined above, MH practitioners are embedded in RTE and MC GP clusters. RTE cluster has also invested directly in two posts. Bridgend cluster has developed two posts that will be professionally managed within the MH&LD care group. Regular reports of activity are collated. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSR6 June 24
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards should consider how adults with urgent mental health needs, and who are experiencing mental distress, can easily access safe places in the community, which can provide a calm and safe space in a less clinical setting as an alternative to hospital admission or contacting emergency services.	Sanctuary services have been developed with third sector in Bridgend locality. This is being rolled out across Merthyr Cynon in the next 12 months with a view to further roll out across CTM.	Mental Health & Learning Disabilities	01.03.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved QSR6 June 2024. Action updated as at May 2024 - A Sanctuary was established in Bridgend in 2020, in partnership with Mental Health Matters. The MH&LD care group is working on the development of further sanctuary services within its transformation portfolio of work.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards, and Public Health Wales, should consider what additional steps can be taken to raise mental health support awareness in men, to support their mental well-being and signposting to support services.	A Grant of 75k is being made available for community groups to bid against to support men who do not typically access primary care or mental health services about their mental wellbeing. Successful bidder's programmes will be evaluated after 12 months for impact.	Mental Health & Learning Disabilities	01.12.2022		Fully complete (Awaiting approval)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSR6 June 24 June 2024 Update - Approved QSR6 June 2024. Action updated as at May 2024 - The identified money was not allocated as planned as it was not felt that there was enough stability across the local CVC to collaborate well at that time. There has instead been a focus through existing contracts / organisations and the regional suicide group on men's mental health. April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSR6 June 24
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	The health board must provide assurance on how it will meet principle nine outlined by the Chief Nursing Officer for Wales for at least two registered nurses to be rostered every shift, or if determined as not necessary, that there must be the ability to deploy a second registered nurse without delay.	Undertake a review of the right time staffing resource across the rehabilitation service in CTM and develop an options appraisal to address the risk of one registrant by night.	Mental Health & Learning Disabilities	30.11.2021		Overdue	October 2023 Update (Date of Review: 20/10/2021) - Further to discussions with the Head of Mental Health Nursing it has been advised that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however, continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times.
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	The health board must provide assurance of its plans to ensure all staff are fully compliant with their mandatory training as soon as possible.	Review all core competencies across the rehab service with an improvement plan for 85%+ compliance.	Mental Health & Learning Disabilities	30.11.2021		Overdue	October 2023 Update (Date of Review: 14/10/2021) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&D department: 1) Review hierarchy lists; 2) Ensure Group alignment numbers are correct; 3) Look at appropriate required compliance and accurate records and L&D department will take forward to the subject experts on teams' behalf. Regular meetings with new L&D representatives to address and correct the issues associated with core mandatory training compliance.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board must implement a signing in and out book to ensure an appropriate audit trail of medication stock.	Spot checks to be completed by the Senior Nurse to monitor compliance	Mental Health & Learning Disabilities	28.04.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board must implement a signing in and out book to ensure an appropriate audit trail of medication stock.	Audit of medication to take place. CTMUHB Homecare visited the team on 20th January 2023 and they have agreed to attend the CMHT monthly for three months and then three monthly to audit and help with stock management checks. The home care team only audit Polar Speed medication (Ablify and Paliperidone). For all other depot medication staff who order these medication will audit at the same time.	Mental Health & Learning Disabilities	28.04.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board must ensure that substantive medical staff are appointed as far as possible to ensure continuity of care.	The health board will continue in its attempts to recruit substantively into the consultant post. This is against a background of higher demand for posts than the supply of senior medical staff to fill them.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board and local authority should reflect on comments from staff relating to access to care documents and systems	This is reviewed in monthly performance review meetings with the Senior Team which includes a table on the status on all medical positions in the locality. Progress on recruitment is discussed and there is a focus on having Royal College of Psychiatry Approved Job Descriptions ready for advertisement should a vacancy appear.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board and local authority should reflect on comments from staff relating to access to care documents and systems	A business case for WICCIS implementation has been written and requires Executive sign off for funding. The Mental Health Care Group have allocated a Project Manager.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board must ensure that medical staff complete all safeguarding related refresher training in a timely manner	All medical staff to attend 'Safeguarding People' Day	Mental Health & Learning Disabilities	28.04.2023		Overdue	Medical staff booked in to attend 'Safeguarding People'
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board must ensure that Community Treatment Order (CTO) documentation contains all of the required detail	The MHA team propose to develop an audit tool for CTO MHA statutory documentation and to conduct a CTM wide audit of detention papers for those patients subject to a Community Treatment Order. Compliance will be monitored through our QSR6 meetings	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board must ensure that Community Treatment Order (CTO) documentation contains all of the required detail	We have asked our IMHA provider and South Wales Advocacy to obtain feedback on our service from patients on a community treatment order (CTO). The MHA team and South Wales Advocacy are working collaboratively to develop a questionnaire. The health boards MHA operational group and Mental health act monitoring committee will be kept up to date on progress.	Mental Health & Learning Disabilities	28.04.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board and local authority should reflect on the staff feedback comments provided in this report	A debrief session has been arranged to reflect on the HIW inspection and feedback comments provided in the report.	Mental Health & Learning Disabilities	21.02.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CWM Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hosptal). (Ref: 3189)]	The health board and local authority should reflect on the staff feedback comments provided in this report	The inspection findings will also form part of our local QSR6 meetings standard agenda to maintain monitoring of the review	Mental Health & Learning Disabilities	28.04.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	Revised Completion Date 01/09/2023	Overdue	September 2023 Update - new consultant appointments enable 2 sessions of elective work to be staffed by consultant obstetricians. Awaiting 1st consultant to agree job plan 18.09.23 to commence one session a week, moving to 2 session in January 2023.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Patient records are secure and kept out of view at all times to maintain patient confidentiality	All patient records are kept in secure locked trolleys. Monitoring of the security of patient records is completed twice daily by a member of the senior midwifery team	Children & Families	31.01.2024		Overdue	September 2023 Update - recent concern from PCH identifies that learning and improvement is still required in this area.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: All staff signatures are identifiable with no gaps in signature sections	The use of the stamps will be audited through the rolling annual record keeping audit. Findings are fed back annually and improvement plans developed quarterly.	Children & Families	01.08.2022		Overdue	September 2023 Update - The stamps are available to all clinicians, the review of the annual record keeping audit will be completed and presented by CSfM team in November 2023 meeting.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	Risk assessments are undertaken and recorded in patient records. Medical discussion and decisions are accurately recorded in patient records.	The specific areas of risk assessment, medical discussions and decisions will be added to the record keeping audit and all service medical staff to participate in this annual audit to drive multi professional improvement in this area.	Children & Families	01.08.2022		Overdue	September Update (Date of Review: 08/09/23) - email sent to Medical Director of care group for advice on how to progress this recommendation.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Occupational health referrals are dealt with in a timely manner.	Lead for Occupational Health Services asked for target time for referrals to be addressed to support realistic and accurate information giving to staff members	Children & Families	31.01.2024		Fully complete (Awaiting approval)	Sept Update - 8.9.23 email sent to OH lead to advice on progress with this recommendation. Email response from Nicola Bevan - OH Lead giving assurance. The Occupational Health service has successfully recruited into the long-standing vacancies within the service and are due to be fully established by end of September 2023. The previous substantive OH Consultant retired in April 2023 and a new provider has been procured providing two clinics per week plus 5 day clinical support if required. A new OH Physiotherapy template has also been developed to ensure there is sufficient capacity within the service to deliver the full range of Occupational Health Physiotherapy activities. As a result, the waiting times within the department have significantly reduced. In October 2023 CTM Occupational Health Service will be transitioning to a new OH software system as part of an All Wales Occupational Health initiative. One aspect of the new system will introduce an online management referral system which will improve the quality of the referrals and the communication mechanisms between managers and Occupational Health, which will increase transparency and allow the manager to monitor the progress of the referral-Action reviewed by Head of Midwifery (SP) and update to a closed and complete action.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Additional welfare support is available for KIT staff.	Workforce team asked for specific resources for KIT staff going forward.	Children & Families	01.06.2022	Revised Completion Date 01/10/2023	Overdue	September Update (Date of Review: 08/09/23) - email sent to care group's People's Services Lead to advice on progress with this recommendation.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: The backlog of incidents are cleared and consideration of further funding should continue.	Incident backlog due to be closed by 31.5.22. Service agreed target: All incidents managed and closed within 3 months – using Datix action tracker for ongoing work.	Children & Families	01.06.2022	Revised Completion Date 01/10/2023	Overdue	September 2023 Update - Incident report monitored by executive team. Timely review and closure for moderate harm and above incidents but low and no harm process requires further reviewing and dedicated allocation of time.
Healthcare Inspectorate Wales (HIW)/2022/132	26.09.2022	Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]	The health board must ensure that they obtain UNICEF reaccreditation.	Social media, weekly feeding post (appendix 1) BFI standards audit (appendix 2) BFI gap analysis (appendix 3) Recruitment of 0.4wte infant feeding midwife to support community midwifery Dashboard breast feeding data and QI projects (appendix 4/6) Senior team BFI training (appendix 5) Executive Director of Nursing appointed as Baby Friendly Guardian(appendix 6)	Children & Families	30.04.2024		Overdue	Assessment for accreditation for UNICEF Baby Friendly to be completed by October 2023. Update 28.03.23 Assessment confirmed for December 2023. All staff will have attended 1 day update by September 2023, overseen by Infant Feeding Coordinator (Maternity) - Sept 2023 Pre assessment audit completed and advised by UNICEF BFI to postpone for 3 months to drive further improvement in practice. New specialist midwife commences role 18.09.23 (vacant role for 3 months)
Healthcare Inspectorate Wales (HIW)/2022/132	26.09.2022	Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]	The health board must ensure that oxygen is being recorded on the prescription charts.	Oxygen prescription to be added to 2023 annual record keeping audit. Good practice guidance provided in monthly governance newsletter.	Children & Families	01.02.2023	Revised Completion Date Autumn 2023	Fully complete (Awaiting approval)	New record keeping audit due to be commenced Autumn 2023 - Sept Update - added to annual record keeping audit sept 23-24. Email advice from service pharmacist 7.8.23 to advice of correct prescribed method for obstetricians as requested

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2022/132	26.09.2022	Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 31101)]	Review Birth Rate Plus and ensure that staffing requirements are appropriate for the unit.	Current establishment is compliant with 2019 Birth Rate Plus report.	Children & Families	01.02.2023		Fully complete (Awaiting approval)	Draft report received April 2023 Sept Update-CTMUHB Birth-rate plus report 2023 has been agreed by DOM and recommendations around actions will be presented to executive team in October 23
Healthcare Inspectorate Wales (HIW)/2022/133	17.10.2022	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 33261)]	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Plan to work with corporate nursing team to review options of creating a digital solution for audit surveillance and daily checks to further improve oversight of status.	Unscheduled Care	01.02.2023		Overdue	June 2024 Update - We have progressed towards standardised audits on AMAat across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved.
Healthcare Inspectorate Wales (HIW)/2022/133	17.10.2022	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 33261)]	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Work with Care Group Directors of Nursing and Midwifery and Heads of Nursing across the three acute sites and community hospital sites in establishing a consistent model of surveillance and checking practice.	Unscheduled Care	01.12.2023		Overdue	July 2023 Update - Working across CTM to ensure standardised audits are implemented. June 2024 Update - We have progressed towards standardised audits on AMAat across the three sites, the ED audit report remains outstanding however we anticipate this will be in place within the next 8 weeks and will provide an update when achieved.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton Clinic – Glanrhyd Hospital (Ref: 31711)]	The health board must ensure that the following environmental issues are resolved:- Ceiling tiles in staff office on Ward 2 need replacing.	Ceiling tiles in staff office on Ward 2 need replacing. Re-booked with estates on 26/01/2023, job reference 63119. Environmental audits to take place monthly. Environmental issues to form part of monthly Ward Managers meetings and if issues remain unresolved, escalation process to be followed which includes informing IPC leads in weekly meeting and informing Senior Management Team.	Mental Health & Learning Disabilities	28.04.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved QSRE June 2024. See Appendix 9 for all estates issues and progress
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton Clinic – Glanrhyd Hospital (Ref: 31711)]	The health board must ensure that restraints are recorded in patient records and that patient's notes are updated.	Datix to be submitted and written account of restraint to be documented in patient notes. Restraint forms to be completed and uploaded to Datix. Compliance to be monitored through monthly nursing note audits, ward manager meetings and Quality, Safety, Risk and Experience Group meeting.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton Clinic – Glanrhyd Hospital (Ref: 31711)]	The health board must ensure that all staff are confident in how to deal with a safeguarding referral.	80% compliance to be achieved for Level 2 and Level 3 Safeguarding Training. Safeguarding to be a standard agenda item in staff meetings to reiterate the process. Safeguarding referral process to be clearly visible in nursing office on both wards.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton Clinic – Glanrhyd Hospital (Ref: 31711)]	The health board must ensure that patients' risks are regularly updated and recorded in patient records.	This will be monitored in the Quality, Safety, Risk and Experience Group meeting and closed after 6 months if compliance is maintained and standards upheld.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angleton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angleton Clinic – Glanrhyd Hospital (Ref: 31711)]	The health board must ensure that outcome measures are clearly recorded in patient records.	Older Peoples Inpatient Mental Health Service Outcome Measures implementation group to be progressed to identify appropriate outcome measure tool which can then be implemented and embedded into the service, in line with the national work led by Improvement Cymru.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Sept Update-Action complete July 2023 Update-Outcome Measures working group established. Additional outcome measures training day arranged for 01/08/2023 with PHW. Appropriate OMs identified.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	The oversight of this recommendation will be via the High Quality Records Work stream.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QSRE. September 2023 Update - Lead Nurses to meet on 18/09/2023 to review work streams and action progress. Further updates will be provided following this meeting for all actions relating to the Discharge Review.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Admission pathway for inpatient units will be reviewed to ensure that that comprehensive mental health assessments and physical health assessments will be completed within 6 hours of admission as standard.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	On completion agreed pathway will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" as detailed in Recommendation 40	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Completion of mental health and physical health checks will be added to the Admission Pathway for all inpatient wards.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Evidence of routine compliance will be shown by adding audit of this standard to the weekly Ward Manager Audit: initial review will be of all admissions for no less than one month or until compliance; and each ward will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	The oversight of this recommendation will be via the Skilled and Motivated Workforce Work stream.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	All staff who are expected to complete clinical risk assessment will receive training in WARRN (nationally recognised) risk assessment and formulation.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	This training will be delivered to all new staff within 8 weeks of commencement of an inpatient role or at induction period for junior staff, with a target of 85% for all staff who require the training. The HB standard for all mandatory training is 85% minimum, and is considered to be a prudent and appropriate target, with consideration of predictable staff turnover and anticipated unavoidable challenges to training.	Mental Health & Learning Disabilities	31.07.2023	Revised Due Date 31/01/2024	Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QSRE. February 2024 Update - WARRN compliance 69% There is an expectation that 85% training compliance is achieved by next improvement Board 27/02/2024. December 2023 Update - Compliance for WARRN Risk Assessment training is at 68% as at 24/11/23
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	Compliance will be reported monthly by the CTP Lead and monitored through the Risk Steering Group. An initial demand and capacity exercise has been completed, with external training provision through Spring 2023. Present compliance is at 69.5 % (from 35 % in Feb 2023) with a trajectory of 80% by end of June 23. There is a programme of ongoing WARRN training delivered by a cohort of clinical trainers. This programme has been developed to ensure that there is capacity to deliver against 100% of anticipated demand annually.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	Inpatient units will review paper and electronic archives and systems and remove all risk documentation other than the HB approved Clinical Risk Formulation and Management Plan.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of risk assessment documentation of a sample of patient records. Mental Health Ward Assurance audits will be added to the Health Board electronic audit system.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	The oversight of this recommendation will be via the Safe Discharge Work stream.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	The Inpatient multi-disciplinary team have developed a formal template for documentation of patient reviews and multidisciplinary discussions. This formalises the necessity to routinely record the MDT opinion of the person's capacity and any need for full Mental Capacity Assessment using the approved Health Board Framework. This will be implemented across the Care Group.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of MDT documentation of a sample of patient records.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Ward manager Audit tool has been digitised to enable rapid real time reporting of results through the "Audit management and Tracking (AMAat) process. Non-compliance will be reported weekly by ward managers to Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Compliance/non-compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	Each clinical area (inpatient and community) will have designated training board/information space for the sharing of learning / local audit/ educational resource; with specific information (leaflets/posters) relating to the right of the carer under the Social Services and Wellbeing Act.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Admission pathways for inpatient units will be reviewed to ensure that carers assessments are routinely offered where required.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Carers assessments are offered at the point of admission and recorded on admission paperwork. The process will be shared with all staff through Communication and Learning Framework (Recommendation 40). Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	The inpatient multi-disciplinary team have developed a formal template for documentation of patient reviews and multidisciplinary discussions. This formalises the necessity to routinely record consultations with the patient's family and care network.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Evidence of discussions with carers will be recorded within the clinical notes, following the template format. Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of MDT documentation of a sample of patient records.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Ward Manager Audit tool has been digitised to enable rapid real time reporting of results through the "Audit management and Tracking (AMAat) process. Non-compliance will be reported weekly by ward managers to Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete - Manual Audits to be undertaken until audit can be digitalised.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Audit information will also be communicated to all staff through Ward training boards, daily safety briefing etc.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 - Completed
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.	Inpatient units have reviewed paper and electronic archives and systems and removed all care planning documentation other than the HB Inpatient Management Plan and Care and Treatment Plan (CTP)	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.	The standards around signing reviewed and completed Care and Treatment Plans which are outlined in the HB Care and Treatment Plan (CTP) Policy will be communicated to all appropriate staff through ward training boards and daily safety briefings.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.	The CTP audit tool has been reviewed, digitised and added to "Audit management and Tracking (AMaT) process. A bi monthly audit programme is underway as a pilot with roll out from July 2023.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.	Evidence of routine compliance will be shown by adding audit of this standard to the weekly Ward Manager Audit: initial review will be of all admissions for no less than one month or until compliance; and weekly sample of admissions going forward.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.	Effectiveness of implementation will be evident in audit outcomes and compliance with national reportable KPI. These are monitored through the monthly Integrated Performance meeting chaired by the Care group Service Director and informed by the "Performance Scorecard" that is produced monthly by the MH Performance team.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	A review of ward round arrangements across the Health Board will be undertaken. This will include include: Consultation with patients and carers Consultation with the multi-disciplinary team Benchmarking with other mental health services	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	Standards for ward round arrangements will be developed, communicated and implemented across the Care Group. These arrangements will be shared with all staff through Communication and Learning Framework (Recommendation 40). Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	An audit tool for the monitoring of these standards will be developed and included as part of the Health Board Electronic System.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	Audit of ward round arrangements will be undertaken weekly. Compliance/non compliance will be formally reported at CSG QSR (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	The Safe Discharge Work stream will develop standardised discharge communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct work streams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSR.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Reorganisation of MHLD Care Groups has commenced with shadow directorates from 01/02/2024.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Compliance/non compliance will be formally reported at CSG QSR (with any variation over time noted) and reported/escalated through Care Group Governance Framework).	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Reorganisation of the MHLD Care Group in progress.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion date 21/11/2023	Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion date 21/11/2023	Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	A review of ESR function and recording of mandatory and MH specific training within the MH care group and has developed a universal spreadsheet to enable accurate and consistent reporting of compliance. This was completed in March 2023.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Subsequently the care group has rolled out a local training record that will enable accurate reporting of the range of mandatory and MH specific training.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	WARNR risk management training: An initial demand and capacity exercise has been completed, with external training provision through Spring 2023. Present compliance is at 63.3 % (from 49 % in April 2023) with a trajectory of 87% by end of October 23.	Mental Health & Learning Disabilities	31.07.2023	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	February 2024 Update - Revised completion date 27/02/2024, 69% Currently.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	PMVA, An initial demand and capacity exercise has been completed, with external training provision through Spring 2023. Present compliance is at 69.5 % (from 35 % in Feb 2023) with a trajectory of 80% by end of June 23.	Mental Health & Learning Disabilities	31.07.2023	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	December 2023 Update - WARNR Risk Assessment Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Care and Treatment Planning	Mental Health & Learning Disabilities	31.07.2023	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	December 2023 Update - PMVA Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Information Governance Compliance for WARNR and CTP will be reported monthly and monitored through the Risk Steering Group. This will be monitored via Clinical Service Group performance meetings. This will also enable reporting of training compliance through monthly Integrated Performance meeting chaired by the Care group Service Director.	Mental Health & Learning Disabilities	31.07.2023	Revised Completion Date 27/02/2024	Fully complete (Awaiting approval)	February 2024 Update - Current compliance 70% Revised completion date 27/02/2024.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	Additional bespoke training will be developed in response to the TNA the completion of the work of the Safe Discharge Work stream.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Information Governance Training compliance as at 24/11/23 is 81% Revised completion date to 31/01/24.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	The care group is developing a Service Improvement Team (SIT) the service lead of which will gather intelligence from the wider Audit programme, unmet need process, wider learning and staff feedback through PADR to develop a training needs analysis (TNA).	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Current compliance 81% Revised completion date 27.02.2024
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	4.4 Ensure that arrangements are in place to maintain comprehensive records following formal MDT meetings, discharge planning meetings or others relating to patient care, and ensure these are shared and reviewed by relevant staff.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	As part of the ward round and multi-disciplinary review (recommendation number 6) the Safe Discharge Work stream will develop standardised approaches for recording multi-disciplinary meetings across the Care Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct work streams within the "High Quality Inpatient Care" sub-programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	The Safe Discharge Work stream have agreed standards for format of content of ward round and MDT meeting to record attendance, key discussion points and agreed actions; an agreed template for recording this in the patient notes; and storage and access arrangements for all involved professional across CTM.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Reorganisation of the MHLD Care Group in progress.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Work stream has developed a matrix for clinical team /staff access. ("Who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	An audit tool for the monitoring of these standards will be developed and included as part of the Health Board electronic audit system.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Audit tool developed but not yet digitised. Manual audit to be undertaken until audit can be digitised. Completed during this period.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	Compliance/non compliance will be formally reported at CSG QSR (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	As part of the ward round and multi-disciplinary review (recommendation number 6) the Safe Discharge Work stream will develop standardised approaches for ensuring that family, carer and/or advocate views are documented across the Care Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct work streams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Audit tool for the monitoring of these standards will be developed and included as part of the Health Board electronic audit system.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Compliance/non compliance will be formally reported at CSG QSR (with any variation over time noted) and reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	The views of people with lived experience are critical to the safe and effective delivery of mental health services. The Lived Experience Group will develop a lived experience framework so that people can contribute meaningfully to both care and service design/delivery.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 12 The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct work streams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 12 The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 12 The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	The process will be shared with all staff through the Communication and Learning framework (Recommendation 40). Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 12 The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	As part of recommendation 7 the Safe Discharge Work stream will develop standardised discharge recording and communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct work streams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	Ward manager Audit tool will be digitised to enable rapid real time reporting of results through the "Audit management and Tracking (AMaT) process. Non-compliance will be reported weekly by ward managers with Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	Compliance/non-compliance will be formally reported at CSG QGRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	The oversight of this recommendation will be via the Safe Discharge Work stream. The work stream will define an expedited discharge and develop a procedure for management of expedited discharges to ensure: An Offer of Home Treatment following discharge Formal communication with the Community Mental Health Team by ward manager Those identified as expedited will be escalated to the Clinical Service Group Senior Management Team for scrutiny and learning Review of process and decision making for each case	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	The care group will audit all cases who are considered to have been subject to "expedited discharge" using standards agreed within the procedure.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Compliance/noncompliance will be formally reported at CSG QGRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Audit results will be shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	30.06.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	The expedited discharge procedure will not include measure to support inpatients who have been given leave earlier than planned as this process is defined in Health Board Policy for Management of Section 17 leave (MH 12), and Policy for planning leave for informal patients (MH44).	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 15 The health board must provide an update to HIW on the actions taken or are outstanding, to mitigate the risks associated with the availability of inpatient beds.	The oversight of this recommendation will be via the Access and Alternatives to Admission Work stream. It is uncommon for CTM occupancy to be at 100% even at ward level. However, current arrangements for escalation of bed availability differ across the acute hospital sites in the Health Board. A standardised approach will be developed to include: •Daily care group huddles •Shared process for the management of bed availability •Action card guidelines for the management of acuity •Out of hours contingency arrangements •Daily reporting of bed availability	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 15 The health board must provide an update to HIW on the actions taken or are outstanding, to mitigate the risks associated with the availability of inpatient beds.	The Mental Health Act operational group will lead on the development of the Section 140 Policy so that there is clarity about the arrangements when CTM occupancy is at 100%.	Mental Health & Learning Disabilities	31.07.2023	Revised Completion Date 15/03/2024	Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QGRE. February 2024 Update - Revised completion date 15/03/2024. December 2023 Update - Revised completion date. Revised timescale refers to the ratification of the new S140 policy.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 16 The health board should consider the benefits of reinstating the huddle meetings to help manage the issues with patient flow in and out of the inpatient units.	The oversight of this recommendation will be via the Access and Alternatives to Admission Work stream. See response to recommendation 15	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 17 The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.	The oversight of this recommendation will be via the Safe Discharge Work stream. The Care group will undertake a review of inpatient demand and capacity to: •Define the conditions described by staff in the review •Understand potential causes of delayed discharges. •Identify nursing/MDT •Interventions that will address inpatient blockages to flow The outcome of the demand and capacity review will inform the work of the Access and Alternatives to Admission work stream and the Rehabilitation Programme.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 18 The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed: a) to ensure a standardised approach to allow for more efficient access to patient information; b) to maintain the security of patient data and clinical information	The oversight of this recommendation will be via the High Quality Records Work stream. A programme of work is underway to: •Standardise approaches to the management of paper records if these are required •Maximise risk mitigations for existing processes •Undertake a scoping exercise to phase out paper notes ensuring that the Care Group maximises the use of existing digital systems prior to the implementation of the Single Electronic Record. •Learn from the clinical record improvement at Ty Llidard whilst recognising that the wider care group has additional challenge in terms of scale and complexity.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 18 The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed: a) to ensure a standardised approach to allow for more efficient access to patient information; b) to maintain the security of patient data and clinical information	The Safe Discharge Work stream have introduced governance measures to limit access to any patient held on the W and T electronic drives , with senior level authorisation required in order to gain access	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 18 The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed: a) to ensure a standardised approach to allow for more efficient access to patient information; b) to maintain the security of patient data and clinical information	Medical records teams on PoW and RGH sites are responsible for maintaining confidentiality and access to patient paper based records, tracking notes when in use. Out of hour there is access to paper records through the Crisis resolution services on both sites.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 18 The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed: a) to ensure a standardised approach to allow for more efficient access to patient information; b) to maintain the security of patient data and clinical information	The Safe Discharge Work stream are rolling out best practices across Bridgend (in line with RTE learning) , to rationalise the volume of appear records held, undertaking a scoping exercise into the efficacy of a paper record phase out pre WCCIS implementation. (Completion date 15 July 2023)	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 18 The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed: a) to ensure a standardised approach to allow for more efficient access to patient information; b) to maintain the security of patient data and clinical information	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Work stream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023		Overdue	June 2024 Update - Progress to date: In-Patient Matrix devised for all in-patient and rehab units to mitigate risk of inability to access/share current patient information Matrix supports ward staff in and out of hours and gives staff contact numbers of who to contact should the patient come from another locality where a different clinical system is being used. This allows current information to be accessed/shared timely. February 2024 Update - It has been decided that WCCS would no longer be the system implemented and that the Health Board are exploring two system options whilst awaiting a National Solution. December 2023 Update - Status relates to the implementation of WCCS Update to be provided to HW 31/01/2024 The Health Board is working closely with Digital Health and Care Wales and other Health Boards in relation to implementation. However, in light of implementation challenges faced by another Health Board, discussions at a national level are ongoing in relation to the preferred digital solution to a unified patient clinical record system.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	A business case has been developed and endorsed by the Executive. There are however challenges with the preferred national system. The Health Board is working closely with Digital Health and Care Wales and other Health Boards as part of the review of the national strategic programme for the Welsh Community Care Information System. The outcome of this review will influence timescales for WCCS implementation for the Health Board. A CTMUHB WCCS Workshop is scheduled for 15th June 23 led by MHL D Service Director. CTMUHB WCCS Programme Board to start from 25th July 23 chaired by the Deputy Chief Operations Officer and Executive Director for Digital. A WCCS Operational Group will start in July/ August 23 chaired by MHL D Service Director and IT/ Digital Senior manager. WCCS Implementation Plan timescales for MHL D to be refreshed and presented to WCCS workshop on 15th June 23.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Work stream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	WCCS implementation aim end 2024
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 20 The health board must implement actions to mitigate against risks associated with staff access to clinical records in different teams to patient information in a timely manner.	The oversight of this recommendation will be via the High Quality Records Work stream. As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Work stream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 20 The health board must implement actions to mitigate against risks associated with staff access to clinical records in different teams to patient information in a timely manner.	In alignment with the Access and Admission work stream and Safe Discharge work stream drivers, process mapping has been undertaken and flow diagrams regarding passing patient information between CMHT and Inpatient for admission and discharge have been completed and shared across the MHL D care Group.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	"This element of recommendation 21 has been addressed as part of the immediate assurance action plan: 4.1.1. Review discharge letter templates, to ensure they provide sufficient information to patients and other key staff to support a patient following discharge and help maintain their safety and wellbeing"	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Aligned with recommendation 6 and recommendation 11 the Safe Discharge Work stream will ensure that there is a standardised approach to communication with patients and where appropriate their family or carers.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct work streams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	Reorganisation of the MHL D Care Group in progress
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	In alignment with the work undertaken by the High quality records work stream , the inpatient units are now using a uniform template for electronic discharge letters and recording, storage and circulation if also uniform. This has also been adapted for OA Services to ensure parity across inpatients and CMHTs.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Work stream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all discharges to the Adult inpatient units using the "ward managers Audit tool.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Ward manager Audit tool has been digitised to enable rapid real time reporting of results through the "Audit management and Tracking (AMaT) process. Non-compliance will be reported weekly by ward managers to Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Compliance/non-compliance will be formally reported at CSG QSR6 (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Staff will learn from audit results when shared with staff teams through the Quality/Audit/Learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	The oversight of this recommendation will be via the Care Group Policies Group.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	The inpatient team will revise the Hospital Discharge Procedure (MH40) in line with Nice Guideline [NG53] Transition between inpatient mental health settings and community or care home settings.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	This will make explicit a standard that within 24 hours, a letter which includes the details of a person's current prescription, the reasons for any changes in medicines and their immediate medication treatment plan, is emailed to the person's GP, with a copy given to the person and, if appropriate, the community team and other specialist services.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	The procedures will be shared with all staff through Communication and Learning Framework (Recommendation 40)	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	Evidence of routine compliance will be shown through a process audit of all discharges within 24 hours (ward manager) and BI weekly document review (Senior Nurse) , and BI monthly CTP audit (CTP Lead).	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 23 The health board must ensure that discharge summaries are completed and sent out to the patients' GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.	The oversight of this recommendation will be via the Ward Assurance Group. This standard is explicit within the Health Board Procedure (MH40) standard and is monitored through a process audit of all discharges within 24 hours (ward manager) and BI weekly document review (Senior Nurse). This audit will be included in the Health Board electronic audit tool.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	The oversight of this recommendation will be via the Ward Assurance Group.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	This standard is explicit within the Health Board Discharge Procedure (MH40) standards.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	This standard is monitored through a process audit of all discharges within 24 hours (ward manager) and BI weekly document review (Senior Nurse) , and bi monthly CTP audit (Community Senior Nurse). This audit will be included in the Health Board electronic audit tool	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	The High Quality Clinical Records Work stream will provide solutions for the monitoring of discharge follow up by community teams using different record systems.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	The oversight of this recommendation will be via the Skilled and Motivated Work stream.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by CSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	The inpatient units have developed staffing escalation processes to ensure effective support to those staff who have responsibility for safe staff decision making on a shift by shift basis. These will be reviewed to ensure a consistency of approach across all inpatient units.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	A review of nursing establishments across the inpatient units is underway. This will be informed by present best practice guidance and the principles that have been developed by the ongoing All Wales Mental Health Nurse staffing programme.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Alternative approaches to recruitment and retention will be explored including: •Recruitment events •Roll mix review •Exploration of Band 4 roles •Overseas recruitment •HCWSW to registered nurse training pathways	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	The care group will monitor staffing, recruitment and retention issues and the effectiveness of the approaches detailed through a monthly Nursing Staffing and Workforce meeting.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 26 The health board should undertake a community workforce capacity and demand review, to ensure relevant community teams are sufficiently resourced to manage their patient caseloads.	The oversight of this recommendation will be via the Care Group Strategic Transformation Board. The Health Board will undertake a demand and capacity review of the community teams and will consider •Referral pathways •Utilisation of local resources •Thresholds for access to community teams •Caseload numbers and acuity •Skill mix •Workforce wellbeing	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 26 The health board should undertake a community workforce capacity and demand review, to ensure relevant community teams are sufficiently resourced to manage their patient caseloads.	The demand and capacity review will include engagement with staff working within community teams within the health board, as staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service review.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	The oversight for this recommendation will be via the Access and Alternatives to Admission Work stream. The PCH Crisis Assessment Space is now operational within PCH Emergency Department.	Mental Health & Learning Disabilities	30.09.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSR. February 2024 Update - Discussed in Improvement Board Meeting 23/01/2024. Lead Nurse tasked to provide an update at next meeting 27/02/2024. December 2023 Update - Capital works in PCH are ongoing. The Care Group is working closely with colleagues at Prince Charles Hospital as part of the estates planning processes and to implement a substantive arrangement for crisis assessment. Capital works in PCH are due to be completed end of January 2024 which will give the care group opportunity to access to dedicated space in PCH ED. May 2023 Update - Please note this timescale is for the medium term solution. An update on substantive arrangements will be provided 30 Sept 2023.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	Crisis and Liaison Staff risk assess the patient and depending on need will remain with them in the room at all times.	Mental Health & Learning Disabilities	30.09.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSR.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	The current room has been stripped of ligature points as far as is reasonably practicable but is not an anti-ligature environment so is reliant on risk assessment and observation of the patient.	Mental Health & Learning Disabilities	30.09.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	Hand held panic alarms have been ordered and will be delivered to Crisis Team w/c 12th June 23	Mental Health & Learning Disabilities	30.09.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	The Care Group is working closely with colleagues at Prince Charles Hospital as part of the estates planning processes and an update on substantive arrangements for unscheduled/crisis assessment will be provided to HIW assessment 30 Sept 2023.	Mental Health & Learning Disabilities	30.09.2023		Fully complete (Awaiting approval)	Status relates to the substantive arrangements for unscheduled/crisis assessment in PCH
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Work stream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning. Information both in and out of hours describes mitigants and escalation.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	In alignment with the Access and Admission work stream and Safe Discharge work stream drivers, process mapping has been undertaken and flow diagrams regarding passing patient information between CMHT and Inpatient for admission and discharge have been completed and shared across the MHLd care Group.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct work streams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	February 2024 - Reorganisation of MHLd Care Groups has commenced with shadow directorates from 01/02/2024. December 2023 Update - Reorganisation of the MHLd Care Group in progress.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	The oversight for this recommendation will be via the Medical Productivity Group.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSR.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	The care Group Medical Director is leading on the development and progress of a Medical Workforce Productivity Committee with the purpose of developing a pan care Group medical workforce plan to ensure the delivery of safe High quality care. "This programme of work is focusing on: •Medical recruitment •Medical retention •Design of new roles •Monitoring of job planning •Management of temporary roles"	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Medical Workforce Productivity Group is now established with CTM wide membership and terms of reference agreed and following first meeting in May 2023. Work streams agreed for •Recruitment and retention •Unplanned care •Diverse workforce and Vacancy rates agreed as the Initial Outcome measure.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Following the June 2023 Medical Workforce Productivity Group, staffing levels were identified as Baseline WTEWTE Apr-23WTE May-23 Consultants45.4(100%)15(32%)15 (32%) Speciality Doctor26(100%)11 (42%)13 (50%) While there are at present significant rates of vacancy across the MH medical workforce, the Care group is successfully maintaining a cohort of Locum Doctors as a mitigating measure while the recruitment and retention programme scales up. At present (June 2023) the Care Group Medical Director is assured that there are locum doctors covering all vacant substantive posts." In addition the Medical Workforce Productivity Group has agreed timescales for delivery of actions within the Recruitment and retention; Unplanned care & Diverse workforce Work streams.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSR.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	The care group will monitor staffing, recruitment and retention issues and the effectiveness of the approaches detailed through a monthly Medical Staffing and Workforce meeting.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Workforce issues such as vacancies and sickness are reported, by clinical service group at monthly Integrated performance meeting	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 30 The health board must consider how it can work with therapies staff: a) to act on the concerns raised; b) to enable them to undertake their role to adequately manage the needs of patients during their recovery phase prior to discharge.	The oversight for this recommendation will be via the Safe and Therapeutic Environment Work stream.	Mental Health & Learning Disabilities	30.09.2023		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 30 The health board must consider how it can work with therapies staff: a) to act on the concerns raised; b) to enable them to undertake their role to adequately manage the needs of patients during their recovery phase prior to discharge.	"As part of the pan CTM Quality Improvement Programme, an event was held on 26th April to consider in partnership the options to provide occupational therapy facilities including but not limited to the provision of: •Development of MDT with access to AHPs and Therapists •Access to sufficient ADL Equipment •Activities schedules •Facilitated Ad-hoc access to recreational facilities The work stream will review current facilities and scope out potential new areas and facilities. Whilst the work stream is further developing the OT team have been provided with temporary arrangements for therapy space, which has enabled them to continue to deliver the service, with reduced numbers for group sessions."	Mental Health & Learning Disabilities	30.09.2023	Revised Completion Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	The oversight for this recommendation will be via the Skilled and Motivated Workforce Group.	Mental Health & Learning Disabilities	31.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	At Therapies Governance meeting on 18/05/2023 the Health Board reviewed HIW recommendation 31, and is in agreement that a multi-professional review of demand and capacity of the MH therapy workforce is required and will be undertaken. This review will entail a (not exclusive) range of Allied health Professionals including Psychology, Art Therapy, Physiotherapy, Dietetics and SALT. This review of the therapies workforce is underway and is considering: •Strategic workforce drivers •National guidance •Quality standards •Demand and capacity The Occupational Therapy review and subsequent job planning exercise has been completed and the Deputy Head of OT reports that the Occupational Therapy workforce is at full capacity and as such is able to meet demands for assessment, treatment and review that are presented on the Adult Inpatient units.	Mental Health & Learning Disabilities	31.03.2024		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSR.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	The remaining demand and capacity review will include engagement with staff working within each of the Therapies disciplines, as staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service review. This review will conclude in the development of a MH Therapy workforce proposal for consideration.	Mental Health & Learning Disabilities	31.03.2024		Fully complete (Awaiting approval)	February 2024 Update - Consultant Clinical Psychologist is leading on this action from a psychological therapies perspective and the recommendation is on track to be completed by 31/03/2024.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	This review has many interdependencies with the improvement programme work streams and as such will have a completion timescale of 31 March 2024	Mental Health & Learning Disabilities	31.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	In the interim the Health Board has appointed an 8c psychologist to work as Clinical lead for the Adult Inpatient service with a remit of developing the available skills within the inpatient workforce, building their psychological safety and resilience; and providing robust clinical challenge when required within the MDT	Mental Health & Learning Disabilities	31.03.2024		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period - 8c Clinical Psychologist Adult Inpatient Lead commenced in post from October 2023
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	In addition the recently instituted morning inpatient "board rounds" provide an opportunity for Multidisciplinary discussion and care planning and a conduit for making clinical enquiry of the psychology resource when then are not actually on site	Mental Health & Learning Disabilities	31.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	The Clinical Teams are further able to discuss risk formulations and complex clinical need at the monthly Complex Case Peer Review meeting, chaired by the Head of Mental Health Psychology & Psychological Therapies	Mental Health & Learning Disabilities	31.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	AHP and psychological therapies in acute services have a long tradition of offering training placements to clinical psychology trainees, counselling psychology trainees, art psychotherapy trainees and psychology undergraduate yearlong placements students. This has created additional capacity to ensure a tiered approach to working with people in acute care. This additional capacity has enabled more patients to be offered protocol based psychological interventions.	Mental Health & Learning Disabilities	31.03.2024		Fully complete (Awaiting approval)	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	For the wider nursing team training on Compassionate Care, and Psychologically Informed Practice has been arranged and delivered to the RMN and HCA workforce in acute services, while further training is being planned and commissioned with a third sector provider to deliver ASSIST suicide prevention training to the workforce by October 31 2023	Mental Health & Learning Disabilities	31.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	The oversight for this recommendation will be via the Skilled and Motivated Workforce Work stream. Please refer to the response to recommendation 8.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	In addition to the core learning skills for mental health staff and informed by the outcome of the wider in-patient improvement work streams a full training needs analysis will be completed to identify further opportunities for skills development.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	The HB standard for all mandatory training is 85% minimum, and is considered to be a prudent and appropriate target, with consideration of predictable staff turnover and anticipated unavoidable challenges to training.	Mental Health & Learning Disabilities	31.08.2023	Revised Completion Date 31/10/2024	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	In light the scale of improvement required, in addition to the organisational mandatory and statutory training requirement, the Mental Health care group are focusing only on a core set of Mental Health specific skills including WARIN, CTP and PMVA training, and any Mental Health Act /statutory training that is immediately identified through on going learning.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	The care group is developing a Service Improvement Team (SIT) the service lead of which will gather intelligence from the wider Audit programme, unmet need process, wider learning and staff feedback through PADIR to develop a training needs analysis.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	The Care Group will focus on increased compliance within the time scale 31 August 2023 review, but outside this will revisit the fuller training needs analysis this in 12 months' time (31 May 2024) with a fuller understanding of the lessons from the Inpatient improvement work streams.	Mental Health & Learning Disabilities	31.05.2024		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 33 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	The oversight for this recommendation will be via the Skilled and Motivated Workforce Work stream. Good staff experience is critical to the development of the care group and to high quality patient outcomes.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 33 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	"The Care Group will: •Establish a programme of Wellbeing Activists in each team to work as champions for this agenda. •Implement the learning from the Ty Llidard and Maternity Services improvement work on staff engagement •Work with people services and occupational Health to determine blockages to assess service and possible mitigants •Develop mechanisms to demonstrate appreciation and celebrate success •Seek to understand the root causes of staff distress and explore solutions"	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 33 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	The care group uses a range of methods to seek feedback and input from the staff group. A programme of feedback and analysis of a regular staff wellbeing survey is coordinated by the Health Board Peoples Services, a senior Business partner of which works alongside the care group leadership team. Triangulation of these methods will enable the care group to more fully evaluate impact of the measures implemented.	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 34 The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	The oversight for this recommendation will be via the Ward Assurance Group. A programme of digitised audits across the community and inpatient teams is underway.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 34 The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	The Clinical Service Groups will use Sharing Information/learning arrangements within the services e.g. QSRE, team meetings, 7 minute briefings to maintain a staff awareness of quality assurance work. In addition the Health Board electronic audit system will provide the opportunity for audit outcomes to be visible for staff, patients and visitors at ward level.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period. Manual audits are being undertaken until audits can be digitised.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 35 The health board must ensure that the audit process is reviewed within its mental health services, and that a robust and sustainable audit action management plan is implemented (as applicable), to ensure actions are monitored and to assure itself that implemented improvements are being sustained.	The oversight for this recommendation will be via the Research and Audit Group. A new Research and Audit group has been developed with the ward assurance group reporting to it. Please see response to recommendation 34 for comment on ward assurance. In addition to ward assurance audits, the Research and Audit Group will develop a broader Care Group audit plan. The Care Group is developing a dedicated service improvement team to support the delivery of the present clinical audit/ Quality Improvement. Activity that is taking place. Job descriptions are currently being developed with the expectation that recruitment will be completed by the end of July 2023.	Mental Health & Learning Disabilities	31.07.2023	Revised Completed Date 21/11/2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 35 The health board must ensure that the audit process is reviewed within its mental health services, and that a robust and sustainable audit action management plan is implemented (as applicable), to ensure actions are monitored and to assure itself that implemented improvements are being sustained.	This resource will be work in partnership with the clinical teams to embed both a culture of improvement and shared learning. Engagement with staff at all levels will be a key objective of this team.	Mental Health & Learning Disabilities	31.07.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	The oversight of this recommendation will be via the Policies Group. The newly established Policy Review group will have an operational scope to: •Review & RAG of all existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review Following agreement of Terms of reference at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024		Overdue	June 2024 Update - Though all policies and procedures are now under review by the expert groups, the changes caused by the restructure is causing added complication as teams and services moved and merged across locality (e.g. MH Liaison SOP). February 2024 Update - Remains in progress
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Mental health policies will follow the agreed operational process for ratification. All NH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 in date and approved 13 Expired 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" (recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024		Overdue	December 2023 Update - The HB has revised its process for the ratification of policies which will lead to more timely ratification and will enable all policies and procedures to be ratified by 01/06/24. There are 39 expired MH policies/ procedures. These have been prioritised for updates. The Mental Health Policy Review Group will monitor this review schedule at each meeting. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	The oversight of risk registers will be dualy via the Care Group Quality Safety Risk and Experience Group and the Performance, Planning and Finance Group. Accountability for the management of risk registers at Clinical Service Group will be via operational leaders	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	The organisational risk register includes risk with a score of over 15. The organisational risk register has been reviewed across the Health Board. Aggregate workforce shortage and training risks are included for CTM. Specific Mental Health risks including clinical records and environmental risks are recorded on the organisational risk register. Risk registers with scores over 12 are monitored at Care Group level via Quality Safety Risk and Experience Group – (see Appendix 1 for governance arrangements), and all other risks are monitored via the Clinical Service Group performance arrangements. The Head of Quality and Safety will lead an operational care group governance meeting to monitor compliance with Putting Things Right, action plans and risk review timescales. Agenda item in performance meeting at senior nurse level in order to encourage escalation and culture of owning risks and mitigation as local level.	Mental Health & Learning Disabilities	30.11.2024		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	Risk identification and Risk management (through organisational risk registers) is a core competency of all managers and training in this area is being delivered to all staff who monitor risk registers within the governance framework	Mental Health & Learning Disabilities	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 38 The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental health Governance lead will establish a working group with the Lead Nurses and Local Authority heads of service to develop a mechanism for multi-agency incident reporting.	Mental Health & Learning Disabilities	30.06.2023	Revised Completion Date 31/10/2024	Overdue	February 2024 Update - Update from Business Intelligence Team that they have explored ways for a social worker to be able to access the incident module of Datix, however a solution has not been found. Action agreed: SOP to be developed to describe the process for feedback, learning and actions to be shared with social workers as applicable. Previous Update - The Mental Health Care Group is exploring a way for social workers to be able to report incidents directly through Datix with the Health Board Governance Team and ICT team. This has been delayed by issues with allowing non HB personnel access to HB and NHS systems and organisational changes to the CTM governance and Datix teams. In the meantime, a process for reporting and feeding back on social worker identified incidents in multi-agency meetings and so that learning can be shared will be implemented.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 39 The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.	"The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. Following rollout of new 'Datixweb' functionality, Datix reviews cannot be closed without providing the reporter with feedback. Monitoring of incident closures will be via the Quality, Safety, Risk and Experience Group."	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 40 The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental Health Care Group will develop a Communication and Learning framework that entails: •A Standard operational Policy for cascade/escalation of information Ward/Board/Ward (attached Appendix 6) •Bimonthly Quality, Safety, Risk and Experience (QSRE)meetings where learning is shared between all Clinical Service group (CSG) senior teams •Monthly CSG QSRE for escalation and dissemination of wider learning by Senior Nurses and MDT. Monthly "Clinical Lead" meetings for escalation and dissemination of wider learning to ward managers and Team leaders •Monthly team/ward meetings for escalation and dissemination of wider learning, and sharing of local Quality improvement and audit information. This will be an universally agenda meeting with action points noted. •7 minute briefings /LASER used as a mechanism to share learning in team/ward meetings; safety briefings on wards; and to individual staff email accounts. •Each clinical area (inpatient and community) will have designated training board/information space for the sharing of learning / local audit/ educational resource •Quarterly Post Grad learning Sessions to enable Multi-disciplinary Shared learning The Head of Quality and Safety, in partnership with service leads, will coordinate the sharing of learning, uniformity of approach and resources and content.	Mental Health & Learning Disabilities	30.06.2023		Fully complete (Awaiting approval)	
Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A- Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to demonstrate suitable daily checks of emergency equipment have been conducted in accordance the health board's policy/requirements.	There is a plan to include the resuscitation trolley on the Health Board AMaT (Audit Management and Tracking) system, whereby it will be a requirement that the Lead Nurses in Unscheduled Care and planned Care undertake a 3 times weekly assurance audit that the checks have been completed.	Unscheduled Care	01.11.2023	Review Date - March 2024	Fully complete (Awaiting approval)	June 2024 Update - Complete. AMaT audit in place for assurance completed by Senior Nurses. February 2024 Update - The audit tool has been developed and awaiting final approval - Senior Nursing Leadership audit tool to provide the assurances of audits undertaken by the Ward/Department Managers. Partially Completed - review date March 2024 (AMaT tool awaiting final approval).

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: - to improve mandatory staff training compliance in respect of resuscitation training - to promote patient safety in the interim until compliance has improved	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - ED *Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. *An Ba Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. *A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCSWs Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ILS and PILS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	Review Date - June 2024	Partially complete (Overdue)	February 2024 Update - CDU compliance ILS 40% (RN), BLS 68% and ED compliance ILS 43.75%, BLS 76%. It is important to note the RN's undertake ILS training and therefore BLS is not required - ESR Mandatory Training requires updating. Please note there has been 10 wite New Starters in the last 6 weeks, hence reducing the compliance rate - there is a plan to improve. Partially Completed -- review date June 2024 (new recruitment has reduced trajectory of compliance-as described). Previous Update - 65% compliance aim November 2023 with 100% compliance February 2024.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	HMP Parc Prison to ensure Covid 19 swabs are performed in a timely manner.	All staff to be reminded of working within CTM COVID -19 guidelines alongside Public Health Wales advice. All staff to be reminded of the importance of providing / undertaking COVID 19 swabs when required in a timely manner	Primary Care & Community	31.05.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	A review of the current GP management process to be undertaken. To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	HMP Parc Prison should ensure that when a decision has been made to transfer a patient to hospital there are no delays due to staffing issues.	Ensure there is a robust process in place to provide monitoring and support for the patient whilst awaiting transfer to hospital.	Primary Care & Community	31.08.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	HMP Parc Prison must make it clear on the medical record if a review has been made remotely, face to face or via telephone.	Staff to be reminded of the importance of robust comprehensive documentation which evidences accurately the care provided to each patient and how the care was provided. An audit of the documentation for all patients will be undertaken. The results will be shared with the team and an action plan to address identified areas of improvement. NMC Code in relation to record keeping / documentation. A work stream to develop a rolling programme of audit will be undertaken. This will include - spot check audits to ensure continued compliance. A dataset of all audit results to enable prison level audit, feedback and performance and quality reporting information for evidence of driven improvement interventions. Review of current training access and materials.	Primary Care & Community	30.09.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	When Healthcare requests GP advice via a task there is a corresponding entry in the clinical record for continuity of care.	Staff to be reminded of the importance of this being sent to all clinicians. Compliance will be monitored via monthly record audits. An audit of the documentation for all patients will be undertaken. The results will be shared with the team and an action plan developed to address identified areas for improvement. NMC Code of Conduct in relation to record keeping/ standards/ documentation. A work stream to develop a rolling programme of audit will be taken forward - this will include spot check audits to ensure continued assurance; a dataset of all audit results to enable the prison level audit, feedback and performance and quality reporting information for evidence driven improvement interventions. Review of current training access and materials. Deliver a reflective and learning session to highlight the importance of ensuring documentation is completed accurately and thoroughly evidence and reflect patient centered care.	Primary Care & Community	31.10.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	HMP Parc Prison should review NEWS 2 escalation policy on requesting an ambulance when someone is severely unwell with sepsis.	All staff to be reminded of the escalation policy. A work stream to understand the current training needs in relation to skills required within the role. This will include- clinically deteriorating patients. Measuring vital signs and use of NEWS training. Acute life threatening events recognition and treatment training. Nursing in adult prison settings training. News Training. Ensure there is a process in place for monitoring of staff training compliance.	Primary Care & Community	30.11.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	HMP Parc Healthcare must ensure that all medication recommended is supplied.	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include- flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc. may be required.	Primary Care & Community	31.08.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/154	25.09.2023	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Maternity and Neonatal colleagues are piloting QR code system for checking resuscitation trolley. Children's ward plan to implement same. See further information below. Digitalisation of equipment checks presentation	Children & Families	30.11.2023	Revised Completion Date 03/03/2024	Fully complete (Awaiting approval)	April 2024 Update - The QR code daily resus checking is fully implemented on the children's ward in POW. Using the QR code has digitalised the record keeping making it easier to track, store and retrieve compliance data. December 2023 Update -By end Nov 2023,QR code still piloted in maternity. 6/12/23 Daily checks undertaken 100% November 23. Revised implementation date due to the ongoing pilot in of the QR code across a number of audits in PCH - A status review against the required action will be completed by the end of March 2024.
Healthcare Inspectorate Wales (HIW)/2023/154	25.09.2023	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	All patient safety audits to be captured via AMAi system monthly and compliance monitored at the CYP monthly safety and effectiveness service level meetings.	Children & Families	31.10.2023	Revised Completion Date June 2024	Fully complete (Awaiting approval)	April 2024 Update - The QR code daily resus checking is fully implemented on the children's ward in POW. Using the QR code has digitalised the record keeping making it easier to track, store and retrieve compliance data. Patient safety audits continue on AMAi and compliance is reported monthly to CYP Patient safety and effectiveness group. In addition to this the daily resus trolley check is reported every morning and afternoon on the daily activity and acuity. December 2023 Update (Date of Review: 12/12/23) - As maternity colleagues continue with their pilot - Children's ward have established their own QR code. The CPO lead is responsible for ensuring staff are aware of how to record. This will be piloted in Paediatrics for 6 months commencing 1/1/24. Patient safety checks undertaken on AMAi audit monthly. Reported to patient safety and effectiveness group implementation date revised until June 24.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	CTM UHB continues to work in partnership with Cardiff and Vale UHB in the Regional Network for stroke services and have collaborated on cross-health board workshops to share and learn from good practice for service development, including patient education. The Health Board will continue to engage in the national network for stroke to ensure that we work together with other Health Boards across Wales to develop and share good practice and learning for the benefit of our patients and teams. Work continues in our GP Practices to target patients at increased risk of stroke and we continue to build on this as part of CTM2030 and our Acute Clinical Services Plan. Governance and reporting have been refreshed and strengthened, with learning fed back through the CTM UHB Stroke Operational Group and Stroke Performance Board into the Stroke Strategy Group for implementation across the Health Board area.	Unscheduled Care	01.04.2024	Ongoing 2024/25	Overdue	Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW.	Unscheduled Care	01.04.2024	Ongoing 2024/25	Overdue	Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and PHW should work closely with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support. CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan.	Unscheduled Care	01.04.2024	Ongoing 2024/25	Overdue	Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	Significant improvement work has been undertaken within the Unscheduled Care Group (USC) in relation to immediate release of emergency vehicles, with the introduction of the Cwm Taf Morgannwg Emergency Pressures Escalation Cards. Since April 2023, there have been no refusals of immediate release request and the USC group continue to work in collaboration with WAST colleagues as part of the joint review process to review community delays that may have led to an adverse outcome in order to quantify harm and share learning.	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Achieved and ongoing
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily Safe2start meeting which provides assurance around site based escalation, staffing, patient safety and clinical priorities. The meeting allows the identification of clinical priorities, including stroke patients, and time frames for movement to appropriate inpatient beds. All patient flow constraints are discussed and risk is shared across the acute inpatient wards and community sites in order to balance risk within the Emergency Department. This remains an action-focused meeting, with clear ownership and delivery prior to the afternoon meeting. As part of this work, under the 6 Goals national programme, the Safe2start template has been revised to include SAFER, Red2Green and both internal and external delay metrics. There was a delay in launching the new template due to access required into SAFECARE to display nurse staffing levels, this is being worked through by informatics colleagues with the new template expected to be completed and implemented by November 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Optimise, a programme of work under the national Goals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Unscheduled Care	01.11.2023	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/Use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.	Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.	Unscheduled Care	01.04.2024	Ongoing 2024/25	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cymru. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS Exec colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our speciality demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	des-24	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	2024/25	Overdue	Revised Due Date - In 2024/25 timescale dependent on resource availability Timescale in 2023/24-exact timescale dependent on resource availability

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within work stream 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams having direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon Safe2Start site based meeting. This piece of work is Optimise and focuses of value added care. This work is ongoing and is large scale transformation with a detailed project plan and times lines for implementation that are monitored via 6goals Board.	Unscheduled Care	01.04.2024		Overdue	November launch. Full implementation 24-25.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	aug-24	In progress	Revised Review - August 2024. Ongoing implementation. Review - March 2024. Implementation October 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Stroke Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and query arriving at our emergency departments. In addition, we are currently reviewing our nurse specialist provision in order to create capacity to better support the early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	Jan-25	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below "table removed for AMaT purposes"), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	Ongoing targeted improvement	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	Ongoing 2024/25	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	Ongoing 2024/25	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	Ongoing, January 2025	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	Ongoing, January 2025	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.	Brainomik has been implemented within CTM UHB across all acute sites. This allows the stroke consultant on call to view CTs and CT angiograms from home on a mobile device and so reduce the delays in decisions on thrombolysis and thrombectomy.	Unscheduled Care	01.01.2024		Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	Ongoing 2024/25	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the National Clinical Guideline for Stroke updated in April 2023.	Due to the National Clinical Guideline changing again this will be refreshed and added to our CTM SharePoint site as a direct link for clinical staff. This updated guidance will also be re-circulated to all front line clinical teams and included in staff safety briefings and local governance meetings over the coming months.	Unscheduled Care	01.01.2024	October 2024	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.	Significant work has been completed to ensure ED staff across CTM UHB have time to train and are assessed as competent to administer thrombolysis treatment. The ED team has a designated stroke lead to support this. This is delivered through induction, ED training and simulation exercises.	Unscheduled Care	01.10.2024	Ongoing	Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing as workforce changes.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	Ongoing 2024/25	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.	CTM UHB clinicians are engaged with the Thrombectomy Wales Oversight Group and will continue to contribute to these discussions.	Unscheduled Care	01.04.2024	Ongoing	Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.	Within CTM UHB, thrombectomy decisions are recorded in the written notes and discussions with Southmead Bristol are recorded electronically via referapatient.org.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this is continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.	The ESD service is well established working out of Prince Charles Hospital. The expansion of ESD across the whole of CTM UHB has recently been implemented following HB Investment. This service is reviewed in relation to capacity and patient outcomes via the stroke programme board structure.	Unscheduled Care	01.12.2023		Fully complete (Awaiting approval)	June 2024 Update - Achieved and ongoing.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	Ongoing 2024/25	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.	As part of the 6 Goals national programme for improvement, significant improvement work is focused on board rounds and the early identification of internal and external delays. These are captured on the electronic white board to allow us to perform thematic analysis in order to positively impact frequent delay issues. An escalation process for delays has been proposed as part of the integrated discharge delivery board, linking directly to oversight and improvement actions associated with pathway of care delays. The Red2Green and SAFER principles are being embedded into all board rounds pan-CTM to support timely patient review, planning and discharge when clinically optimised. This work is ongoing under the Optimise project and will be achieved on both stroke wards as per the project plan.	Unscheduled Care	01.11.2024	Ongoing 2024/25	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.	As previously stated, work is underway as part of the 6 Goals national programme for improvement to ensure early identification of any internal or external delays. Reflecting these on the electronic white board allows us to perform thematic analysis in order to positively impact delay issues themes. The Red2Green and SAFER principles are being embedded into all board rounds pan-CTM to support timely patient review, planning and discharge when clinically optimised.	Unscheduled Care	01.11.2024	Ongoing 2024/25	In progress	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.	A significant improvement project has been established in CTM UHB as part of the 6 Goals of Urgent an Emergency Care Programme, with an improved integrated approach to discharge and implementation of Discharge to Recover then Assess pathways (D2RA), overseen by the integrated discharge delivery board. A referral and trusted assessor process has been introduced, as well as an integrated discharge hub which co-ordinates and streams all referrals. Data regarding discharge is inputted on Electronic Whiteboards, which is an integrated system accessible to social care partners. This data is used to escalate delays as well as inform our pathway of care delays on associated improvement actions. An Integrated Discharge Policy and Procedure was agreed in April 2024 by sovereign agencies and the Regional Partnership Board. The policy was written collaboratively and based on Welsh Government Guidance: Hospital Discharge Guidance December 2023, All-Wales Optimal Hospital Patient Flow Framework, D2RA Principles and Standards and Trusted Assessor Role Guidance. A comprehensive integrated training and roll out plan is in place which includes quality audits to ensure compliance and effectiveness.	Unscheduled Care	01.03.2024		Fully complete (Awaiting approval)	June 2024 Update - Achieved and Ongoing cycle of improvement.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.	As part of the implementation of D2RA, a supported discharge notification (SDN) has been created to identify patients who require support from a social worker. These cases are triaged in the discharge hub. Proportionate assessment in an acute setting is promoted through the use of the trusted assessor model. The SDN is used to highlight when a proportionate assessment is not appropriate and social work intervention is necessary. Delays for assessment and allocation are monitored regularly and escalated through the Discharge Board. A targeted improvement plan has been created to address delays in assessment overall. Trusted Assessors are being trained to screen SDNs to ensure that SW allocation is appropriate to patient needs and supports a straight OT service model through the integrated proportionate assessment.	Unscheduled Care	01.12.2023		Fully complete (Awaiting approval)	June 2024 Update - Achieved and Ongoing.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	As part of the D2RA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include NCA processes.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (**table removed for AMA1 purposes).	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	Ongoing	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in PDW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	Ongoing 2024/25	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in PDW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	Ongoing 2024/25	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	Ongoing 2024/25	In progress	
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should consider strengthening its promotion of the Help Us to Help You campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.	This is a Welsh Government action but the Health Board will support cascade of messaging.	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	This is a WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.	This is a Welsh Government/WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.	This is a WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	This is a WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.	This is a Welsh Government action but the Health Board will support as required	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/156	25.09.2023	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital (Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421))	We recommend the health board review all relevant policies to ensure they are in line with current guidance	All Paediatric policies are available on Cern Taf Morgannwg (CTM) SharePoint site. The Children and Young People Care Group (CYP) will re-establish a monthly policy-working group where policies will be reviewed to ensure they are in line with current guidance.	Children & Families	31.12.2023		Fully complete (Awaiting approval)	Updated HIW Improvement Plan (Appendix C) as at May 2024. Actioned April 2024 May 2024 Update - Lead Nurse for acute services has been leading group to cleanse and update guidelines and Standard operating procedures. This summer a new CTM SharePoint site will be launched to replace the current staff intranet. This will provide a more accessible platform for staff to access guidance. A flowchart is now available for the approval of new guidelines/policies. A quality assurance checking form has been developed to ensure robust governance prior to submission for approval. January 2024 Update (Date of Review: 04/01/2024) - Progress continues on Sharepoint. December 2023 Update (Date of Review: 06/12/23) - Reviews in progress April 2024. Review of all paediatric policies and procedures underway across CTMUHB. This is being cleansed on Sharepoint.
Healthcare Inspectorate Wales (HIW)/2023/156	25.09.2023	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital (Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421))	The health board should display information on healthy eating and smoking cessation.	Health promotion board on display on Childrens ward. Healthy diet and smoking risks, with signposting for additional advice and support will be added to the health promotion board.	Children & Families	31.12.2023	Revised Due Date August 2024	Overdue	May 2024 Update - The above iteration was actioned December 2023- However the children's ward is currently undergoing refurbishment of the painting and decorating in the area new display boards are being purchased and the Health promotion elements of the action will be a priority on completion of the estates works. New timescales added. December 2023 Update - In progress 12/12/23 - Doctors have been assigned poster presentation for health promotion. Nursing staff completed this action Dec 2023. Health promotion boards on smoking cessation and healthy eating completed on health promotion board 31/12/23.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The hospital communal gardens areas must be tidied and maintained to provide a more pleasant and appealing environment for patients.	The Facilities department have a schedule for garden maintenance works within Angleton Clinic. This will be carried out in the Spring where plants and bulbs will be planted. The Angleton team have also been working closely with the third sector organisation Mental Health Matters who have and will continue to support the maintenance and gardening. This will also provide an opportunity for the patients to be involved as a therapeutic activity.	Mental Health & Learning Disabilities	01.04.2024		Fully complete (Awaiting approval)	Action updated as at May 2024 - Completed 10/05/2024, see Appendix 8 In Progress Estimated Completion Date April 2024 See Appendix 1
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Angleton Clinic has a dedicated Physiotherapist. We have identified an area within Angleton Clinic to be used to support physical exercise, patient health and promotion. Appropriate equipment has been identified and is in place.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 2
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should consider reinstating the hospital's dedicated wheelchair accessible vehicle to promote timely patient care.	Angleton Clinic has always had access to a Wheelchair accessible vehicle however unfortunately it was involved in an accident and wasn't repairable, a replacement is on order.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 3
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must undertake measures to improve mandatory Welsh language training compliance.	Welsh Language Awareness training levels to reach a minimum of 85% whilst working toward 100% Ward 1 is currently 100% Ward 2 is currently 78.5%	Mental Health & Learning Disabilities	01.01.2024		Fully complete (Awaiting approval)	April 2024 Update - Ward 1= 92% Ward 2=91.18% Previous Update - In Progress Estimated date for completion January 2024 See Appendix 4
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must implement measures to ensure the active offer of Welsh is appropriately delivered in the hospital.	Admission paperwork has been updated to ensure that the patient or relative is asked what their preferred language is on admission and this is clearly documented. A section has been added to the Inpatient Management Plan to identify patients' preferred language. Welsh speaking staff now have the appropriate uniform and/or lanyard displaying that the staff member is a Welsh speaker.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 5a, 5b + 5c
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should ensure the provision of suitable areas where patients can be visited on the wards in addition to the Angleton atrium area.	There is a private visiting area/room along the corridor in Angleton Clinic for visitors that wish to have privacy when visiting their loved ones. If visitors wish to visit their family member on the designated Ward they are welcome to do so within their loved one's personal bedroom. This has been raised and discussed within the carers/families recent meeting.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 6a + 6b

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must implement a robust programme of governance oversight which ensures that the hospital's established audit processes and checklists are fully completed within set timescales to ensure the safety of patients, staff and visitors.	All Checks have since been revised. On the advice of the reviewing team the magnetic door checks are now once a day as opposed to three times a day which was leading to gaps. The kitchen fridge temperature check form was showing an expectation of 3x daily checks however the expectation is 2x daily checks which led to gaps. This has now been corrected and the results uploaded to AMAT. Legionella Flushes are being carried out on a weekly basis by the Ward Domestic Team. All checks form part of the Ward Manager weekly check list and Senior Nurse monthly checklist. The Senior Nurse will escalate any concerns immediately and address these at the monthly Ward Managers meetings. Ward Managers will then share the information discussed and address these issues within the wider nursing team staff meetings. Ward managers have put Audits/compliance as a fixed agenda item on ward staff meetings.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 Appendix 7, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i + 14
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must implement a programme of governance oversight which ensures that the hospital's maintenance issues are promptly and effectively recorded, addressed and signed off.	A new process has been put in place which is managed by the Directorate Support Manager. We now have one central estates log for all areas within Angleton Clinic which can be accessed via the discharge drive. The Directorate Support Manager inputs the issue reported into the estates log and will escalate any issues to estates. Directorate Support Manager will monitor outstanding jobs and ask estates for updates regularly to ensure all jobs are signed off appropriately. ~~Any outstanding estates issues will be put on the Health and Safety Huddle report and update at the Health and Safety Meeting~~	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 8a + 8b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	•The hospital's outstanding maintenance and environmental issues must be reviewed and rectified to ensure the comfort and safety of patients, staff and visitors. •The health board must undertake a full environmental audit of the Angleton clinic to identify and address any additional maintenance issues.	A new estates monitoring process is currently in place to ensure any outstanding issues are reviewed and rectified to ensure the comfort and safety of patient's staff and visitors.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - CTM gardeners have completed work to the ward courtyards and will be routinely maintaining the areas. Previous Update - Completed 28/12/2023 See Appendix 8
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	•The hospital's outstanding maintenance and environmental issues must be reviewed and rectified to ensure the comfort and safety of patients, staff and visitors. •The health board must undertake a full environmental audit of the Angleton clinic to identify and address any additional maintenance issues.	A full environmental audit within Angleton Clinic will be completed to address and identify any further additional maintenance issues.	Mental Health & Learning Disabilities	01.01.2024		Fully complete (Awaiting approval)	Action updated as at May 2024 - Completed 10/05/2024, see Appendix 10a and 10b April 2024 Update - Environmental audit was undertaken of both wards and all environmental issues identified reported to estates and placed on the estates log. This is reviewed regularly and any outstanding issues escalated. Previous Update - In Progress. Estimated date for completion Jan 2024
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must implement robust measures to improve IPC environmental audit compliance on Ward 2.	Environmental audit completed within Ward 2 Angleton Clinic. Audit completed on AMAT, current compliance 85.3%	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 10
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	•The health must implement robust measures to ensure patient foods are regularly checked, suitably stored and appropriately labelled so that the opening and expiry date can be viewed. •Medications must not be stored in the ward kitchen areas.	Following inspection an email has been sent to ALL staff on both wards highlighting the need to ensure that there is no: •Unsealed, unlabelled, expired communal patient foods •Unlabelled non-prescription medications on the top of the kitchen cupboard. Ward Manager weekly check put in place to ensure ward kitchens are kept to a high standard. Senior Nurse monthly spot checks now incorporate kitchen/fridge checks.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 11a, 11b, 7e and 7f
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must undertake measures to improve Ward 1 staff compliance with mandatory safeguarding training.	Ward 1 and Ward 2 Safeguarding Adults Level 2 Training has been addressed to increase compliance. Currently Ward 1 at 95% Ward 2 85.71% ~~The HR compliance standard is 85% but both wards will aim for 100% compliance~~	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 12a + 12b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must review the outdated Medicines Management policy and provide guidance for staff on the storage of medications to support staff in their roles and ensure patient safety.	The health board has updated the policy which was published 15/11/2023.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 13
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must: •Strengthen quality governance and leadership and provide clear guidance to staff to ensure the hospitals clinical audit processes are consistently completed. •Ensure that instances when temperatures fall outside recommended guidelines are appropriately recorded and promptly escalated to support patient safety.	Ward audit is completed on a weekly basis by Ward Manager any issues identified are then addressed within the Ward Managers Staff Meeting. All staff have been informed of the escalation process if the room temperature spikes above 25 degrees, new Daily Clinical Room and Fridge Temperature list in place.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7h + 14
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must: •Ensure patient venous thrombosis and adverse reactions assessments are consistently completed to support patient safety. •Implement additional training, governance oversight and action planning for staff to ensure this process is consistently completed.	All prescribing staff have been reminded of the importance of completing the assessments. Angleton Clinic is supported by a designated pharmacist. The MH lead pharmacist has reminded all pharmacy staff who attend the ward to highlight any missed sections e.g. Allergy, VTE and report these to the medical team for review. Completing the assessments will now be included in the induction of new medical staff. The charts and compliance with the recommendations will now be checked during every ward round.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 15a + 15b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must review patient observation records documentation to ensure it provides enough space for staff to record sufficient detail.	Therapeutic observation forms have been amended to ensure sufficient space is available for staff to provide sufficient information.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 16
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should conduct further discussions with staff to review the hospital's current staffing templates and ensure staffing levels support safe and effective patient care.	The Head of Nursing has recently completed a review of all CTM MHLD inpatient wards. This review has considered changes to shift patterns and recommends that 12-hour shifts are trialled and evaluated. A pilot proposal is being developed.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must undertake a review of the quality and variety of patient food provided at the hospital to ensure that it meets patient satisfaction and dietary requirements.	The current menu for Angleton Clinic has been put in place by the catering Lead to meet the nutritional standards and offer a variety of food for Angleton Patients.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 18a, 18b + 18c
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must review any outdated or undated policies to provide clear guidance to staff and support them in their roles.	As part of another HIW improvement plan the MHLD Care group has a Policy Review group which has an operational scope to: •Review & RAG of all existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review Terms of Reference have been agreed for the policies group with the process for ratifying policies and procedures reflecting the recently revised organisational process for ratification. The HB has revised its process for the ratification of policies, policies now need a 6-week consultation pan CTM, endorsement via Operational Management Board and then final ratification at QSC. This process will lead to more timely and efficient ratification of the MHLD policies.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 22a + 22b
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are supported to attend the training.	Mandatory Training has been part of our improvement plan in 2023. Mandatory Training is a fixed agenda item on the monthly Ward Managers meeting. The Senior Nurse checks all mandatory training levels monthly and reports back to Ward Managers this is fed back to the ESR Ward Champion who will then support and encourage staff members to access the mandatory course required and complete. All staff are given time to complete ESR Mandatory Training. ~~ESR is updated automatically and Ward Managers ensure the mandatory training database is also updated~~	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 18
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure that family/carer meetings take place within set timescales to ensure their feedback is regularly captured and addressed as appropriate.	Family/Carer meetings were 3 monthly, this has now been increased to every 2 months to ensure discussions are taking place and feedback is captured.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 21
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should consider ways to formally and routinely capture patient feedback in order to drive quality improvement.	Angleton Clinic have recommended the Patient feedback form in conjunction with Therapy colleagues to encourage completion wherever appropriate. This will be carried out weekly during protected patient time. Feedback will be passed on to the Senior Nurse through the Ward Managers and will be included in the Senior Nurses CSRE report.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 22
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage staff feedback.	Ward meetings are held monthly, unfortunately there was an increase in sickness within Angleton Clinic including the Ward Manager and Clinical Lead therefore this led to cancellation of staff meetings. If this situation occurred again the Senior Nurse would now hold the meetings. Ward managers to set dates for monthly staff meetings, dates to be shared with staff well in advance. Timetable to be put in place.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7h + 23
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure that hospital systems and processes can be suitably filtered to extract ward specific data to support effective supervision, governance oversight and shared learning.	The incident management system Datix Cloud IQ can be filtered down to show specific data relating to areas, incident type and severity. The Head of Nursing is working with the Patient Care and Safety Business Intelligence officer to ensure all Lead Nurse, Senior Nurse and ward Managers have access to and training on Datix dashboards.	Mental Health & Learning Disabilities	31.01.2024	Revised Due Date 10/07/2024	Overdue	June 2024 Update - Working with Corporate and Patient Care Safety to align DATIX to new structure. Action updated as at May 2024 - Update 10/05/2024 The Head of Nursing continues to work with the Datix team regarding this action. The new care group structures have created some delay. Revised completion date set for 10/07/2024. April 2024 Update - In progress. Work is ongoing between the head of nursing and the Datix team. Previous Update - In Progress Due for completion end of Jan 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure ongoing senior management scrutiny of the hospital's systems and audit processes to ensure key and current issues are being effectively escalated, and appropriately action planned to prevent recurrence.	On the Senior Nurse spot check list a column has been added to clearly show actions/escalations carried out. This information is shared within the Ward Managers meetings and discussed, the action going forward this is then shared with the wider nursing team through Staff meetings and handovers. The Senior Nurse will share any persistent issues through their QSRE report to the locality QSRE which will then be further escalated if necessary through the Lead Nurses QSRE to the directorate. The Cascade and Escalate Standard Operating Procedure document describes the process.	Mental Health & Learning Disabilities	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7f + 25
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.	The Health Board has reviewed the current ward environment. With consideration of the ward footprint, clinical need and bed capacity within the Adult Mental Health Directorate it is not possible at present to provide a fully single bedroom inpatient provision. To mitigate potential impact of the present arrangements the nursing teams ensure that all shared rooms are single sex, with identified curtained private space for each person. The specific need for single rooms is identified at point of admission/assessment, with consideration of individual need i.e., gender, sexual orientation, or physical need/risk, and care plan developed as required. The nursing team identify patients who wish to have shared rooms e.g. for company. If requested, an individual room will be provided when available and if there is no other pressing clinical need.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.	The Health Board undertakes a fair and equitable recruitment process, in order to ensure that all staff are employed based on the qualities, values, skills and the experience they demonstrate during recruitment. It is, of course, not lawful to discriminate or make such decisions based on gender. The Royal Glamorgan Hospital (RGH) Senior Nursing team work across adult and older persons wards and will support each ward to ensure that there is an optimal skill, and when possible, gender mix. All shift requirements are monitored at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate Prevention and Management of Violence and Aggression (PMVA) trained staff on shift. Daily Huddle Documentation; Evidence 1 There is opportunity to alter staff skill and when necessary, gender mix to address needs of an individual e.g. if patient is sexually disinhibited or targeting staff due to gender. In extremis the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and CAMHS Mental Health wards, and there have been examples of recent good practice.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.	It is a priority of the Health Board to support the communities we work with to make positive decisions about their health, and we maintain a commitment to support all patients and staff to give up smoking. Since the "Smoke-free Premises and Vehicles (Wales) Regulations 2020" came into force in the Mental Health Unit (MHU) in September 2022, smoking on there has been prohibited. Following implementation, the significant challenges this presented to individuals who found smoking cessation measures to be ineffective or unwelcome were noted, and after discussion with staff and patients the Mental Health Smoking Cessation group agreed that in the RGH MH unit we would create small designated outside smoking areas for restricted use. This seemed to be well received by the patient group, but following an anonymous concern being raised with the Health Inspectorate Wales in summer 2023, this arrangement was halted while the measures were reviewed. Following presentation of a mitigating paper to the Health Board Executive Leadership Group, a "Derogation in compliance" was agreed for a period of six months while the Mental Health Care Group develop options for a permanent solution across all Mental Health sites. It is recognised by the Health Board that this temporarily contravenes the Smoke-free Premises and Vehicles (Wales) Regulations 2020. Mental Health Directorate Smoking Mitigation Paper; Evidence 1.1 Practically, on the RGH MHU, this means that there is an availability of managed smoking sessions at designated times in a space within the footprint of the MHU on the patios/terraces directly off the ward corridor. This is an arrangement that is clearly documented within the care plan of all patients who identify this as being their wish following smoking cessation assessment. The conditions and restrictions of the designated smoking area are made clear to all patients and signposted across the wards. Ash trays are being purchased for designated smoking area, there is a bin currently in place as an alternative. Patio Photo; Evidence 2 Patio Photo; Evidence 3 There is routine discussion within the patient community groups around smoking arrangements and support by the patient groups of self-regulation of cleanliness of such areas by smokers. This is checked by ward staff regularly and extraordinary cleaning requested of facilities if required.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that Welsh speaking staff wear the appropriate lanyards and badges to help identify them as Welsh speakers.	The Health Board is committed to making the "Active Offer" around services in the Welsh language, as defined in the Welsh Language Measure 2011. A review is underway to identify all Welsh speakers across the MHU. Competence at all levels will be noted and improvement encouraged through Personal Development (PADR). As the routine use of lanyards by Nursing staff in clinical areas is prohibited due to Infection Prevention and Control measures, the Health Board supplies all staff who have a competence in Welsh language with insigniad uniforms that identify them to those who wish to communicate in Welsh. For ease of recognition, this identifying uniform will be displayed to patients and visitors on Information Boards in each of the clinical areas. Welsh Language Notice; Evidence 4 Welsh Language Notice; Evidence 5	Mental Health & Learning Disabilities	28.02.2024		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSRE and QSC 30th May 2024.
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that a full review is undertaken on the appropriateness and reliability of the current personal alarm systems used.	At time of the HIW inspection (November 2023) there was an Standard Operating Procedure (SOP) in place that directed that a dual personal alarm system was in place on the RGH MHU for all clinical staff. This was due to a recent increase in the frequency of incidents whereby the panic alarm failed to activate when tested. MHU Dual Alarm SoP; Evidence 6 A full diagnostic review of the "all call" system was undertaken in November 2023, with the system noted to be returned to a serviceable and operational state. This issue however remains on the Directorate Risk Register for the immediate future and incidents of alarm failure will be reviewed and reported via the Datix system. The SOP also remains in place on the MHU. A review of any activation failures will be undertaken by the MHU inpatient Senior Nurse and Assistant Directorate Manager for inpatient services for discussion at Directorate Quality Safety Risk and Experience meeting (QSRE) in June 2024. Subsequently a decision will be made by the Adult Mental Health Senior Leadership Team as to whether the Safe System of working for a dual alarm system can be stepped down or will remain in place with the risk remaining on Directorate Risk Register.	Mental Health & Learning Disabilities	30.06.2024		Overdue	June 2024 Update - update due in August 2024.
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must address the environmental issues and resolve them in a prompt and timely manner.	The ward 22 damaged chair, with exposed foam filling which is not compliant with the relevant legislation has been condemned and removed with a temporary replacement now in place. A specialist furniture manufacturer has provided a quotation for new seating within the interview room and a Statement of Need submitted. Ward 22 Interview Room Photo; Evidence 7 Psychiatric Intensive Care Unit (PICU) missing ceiling tiles have now been replaced. PICU Ceiling Photo; Evidence 8 Water damaged ceiling tiles in the Ward 22 office have all been replaced. There remain 6 water damaged tiles between the lounge & dining room awaiting replacement which have been logged with Estates Department. These have been prioritised by Estates as non-urgent, as they are considered decorative rather than safety sensitive, and the progress on replacement is monitored weekly by the Inpatient Deputy Directorate manager Ward 22 Ceiling Photo; Evidence 9 Ward 22 Ceiling Photo; Evidence 10 After consultation with a specialist furniture manufacturer the Inpatient Senior Nurse confirmed the suitability of the dining chairs currently in place in Ward 22. The dining room chairs are multipurpose and need to be moved between dining room and lounge for group discussions/activities and therefore need to be of a manageable weight. The Adult Mental Health Senior Leadership Team acknowledged that the weight of the current chair would allow them to be picked up and potentially brandished as a weapon, however this risk would not be completely eradicated unless the chairs were of a weight that would disadvantage patients with mobility restrictions and potentially increase risk of injury to staff when moving for cleaning purposes. The nursing team mitigate risk of furniture being used in this way through individual risk assessment and maintaining observation of these areas when in use. Ward 21 bedroom rails and privacy curtains have been replaced. Ward 21 Curtain Photo; Evidence 11 There are long standing difficulties with inadequacy of wastewater/ sewage capacity within the RGH MHU site. As a result, the PICU Extra Care Area (ECA) utilises a Sani-flo macerator system to move waste from ECA to the main sewage system. This can result in issues when foreign objects are placed in toilet in ECA. Groundwork investigations report that a permanent solution to connect ECA to main sewage system would require extensive excavation works with significant capital spend and	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that COSHH equipment is stored correctly.	All wards on the MHU have flammable lockers where all laundry detergents are stored. It is the responsibility of all Health Board staff to be aware of and undertake their responsibilities when using COSHH materials. The Inpatient Senior Nurse has emailed a reminder to all staff including HCSW about COSHH and requirement re storage. Standards for storage of COSHH materials; Evidence 13 Checks on the environment are undertaken by ward managers as part of weekly environmental checks (Ward Managers Assurance Audit) and matters of concern addressed with staff at the time or escalated in line with MHU Maintenance SOP; Evidence 12	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that out of date medication is disposed of appropriately.	Following the HIW Review in November 2023, all medication cabinets across the MHU were inspected and no further out of date medications were found. Review of all medication dates and returns to pharmacy is monitored through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 14 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly executive reports and action taken as required.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that MAR charts are fully completed.	Inpatient Senior Nurse and Mental Health pharmacist will revisit the role of pharmacist technician to ensure that review of MARS charts will be included in their routine checks. An email has been sent by the Clinical Director to all medical team to reaffirm the documentation standards required on clerking and reviewing medication. A sample of MARS charts are reviewed through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 15 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the wards and in clinical rooms.	Reminder email from Senior Nurse reminding staff of agreed standard Safe Storage of medication; Evidence 16 Security arrangements of medication trolley are reviewed through the "Ward Managers Assurance Audit" which is undertaken monthly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required. The present Health Board Observation Policy was scheduled for review in March 2022 and while awaiting approval as part of the ongoing review of Clinical Policies, is still in place as a live clinical document. Within the Policy there is clear direction on the nature of case recording to be undertaken.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that observation records include details on patients behaviours.	Safe and Supportive Observation & Engagement Policy; Evidence 17 The Inpatient Senior Nurse has emailed all nursing staff to remind them of the agreed standards within the policy . Observation and Engagement standards; Evidence 18 Following reiterating of the standards a "spot" audit of no less than 10 Observation records across a 2 week period will be undertaken by the Inpatient Senior Nurse and reported to Adult Mental Health Directorate QSRE in March 2024.	Mental Health & Learning Disabilities	30.04.2024		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSRE and QSC 30th May 2024.
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that there are more variety of choices for patients with specific dietary requirements.	All Health Boards in Wales follow a menu which is based on The All-Wales Catering & Nutrition Standards. The Health Board Catering Service works with clinical teams to adapt the patient menus to patient specific requirements. The present patient menu changed in September 2023 to a two-week rolling menu which replaced an 'a la carte' style menu. The new menu was reviewed by the All-Wales dieticians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing teams seek feedback from patients via the Inpatient Community Group and "Have Your Say" suggestion boxes (which are regularly monitored). This feedback informs discussions with the wider service i.e. Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Team recognise the need to increase the frequency of the menu review and change and are currently working on the new version for 2024.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that use of Section 17 leave is recorded.	The Section 17 Leave policy is awaiting revision as part of the ongoing review of Clinical Policies. The inpatient expert group will undertake this review with a documentation standard devised and included. This will be communicated to all staff by Senior Nurse informing staff of agreed standard. In the interim the Senior Leadership team have agreed that as a minimum there will be a clear record in the patient notes of each departure from and return to the ward for all patients including those under Section s17 leave. A "spot" audit of the interim standards no less than 10 patient records across a 2 week period will be undertaken by the Inpatient Senior Nurse and reported to Adult Mental Health Directorate QSRE in March 2024. Following development and dissemination of the Policy standards a "Spot" audit undertaken will be undertaken and reported Adult Mental Health Directorate QSRE in June 2024.	Mental Health & Learning Disabilities	01.06.2024		Overdue	June 2024 Update - update due in August 2024.
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that policies are reviewed and kept up to date.	The Health Board Equality and Diversity policy has been reviewed and will be being superseded by a Strategic Equality Plan (SEP). The SEP is in final draft and will be approved by Executive Board in March 2024.	Mental Health & Learning Disabilities	31.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must review staffing levels to ensure they meet the demands of the patient group.	The Mental Health Head of Nursing has recently concluded a thorough nursing establishment review that has considered levels of acuity and demand across the Mental Health inpatient units. This review acknowledged the changing picture of inpatient work and environments since the last Mental Health inpatient staffing review in 2017 and recognised the challenges of maintaining a motivated and engaged workforce when pressures within these clinical settings are increasing. Using principles drawn from All Wales Mental Health Work stream on the implementation of the Nurse Staffing Levels Act, the report makes recommendations about amendments to skill mix and enhancement of Nursing leadership roles the better to improve opportunities for recruitment and particularly staff retention. The Staffing review report will be presented to the Mental Health Nursing Workforce meeting on 25 January 2024, for consideration by Director of Nursing on subsequent actions. Considerations of staffing levels day to day are a core role of the Ward Managers and Senior Nurse, with all shift requirements monitored initially at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate staff on shift. Review of clinical need is a dynamic process that involves all members of the Nursing team, and staffing levels are increased in response to increased levels of acuity e.g. 1:1 patient observations to maintain safety or a need for intensive personal care. At this time, there is an organisational acknowledgement of the particular challenges to recruitment of unregistered nurses into Mental Health posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate. While there is a high degree of scrutiny around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that staff vacancies are filled, and future Initiatives are explored to encourage recruitment into the hospital.	Recruitment of band 5 registered nurses remains a challenge and the HB is taking steps to ensure that all vacancies are being filled. The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are currently exploring the financial implications and opportunities of the recommendations. The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maximise SSP opportunities for recruitment. Service user information about Duty of Candour is available across the units. Duty of Candour Information; Evidence 19 A Duty of Candour E-training module is provided for all staff on the Health Board Electronic Staff Record (ESR). All nursing staff across the MHU will undertake this training, with a target of 85 % compliance for Adult Mental Health units by March 2024. The Inpatient Senior Nurse will ensure compliance at Adult Mental Health, integrated performance meeting in April 2024.	Mental Health & Learning Disabilities	09.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure that staff are reminder of the requirements of Duty of Candour and that all staff receive appropriate training.	The operational guidance around the use of the ECA is clear that it is to be used as a planned or urgent intervention within the low stimulus environment. This is a resource for individuals who are presently inpatients and as such have a bed within the unit. It will not be used to provide additional bed capacity. This has been agreed by the RGH senior leadership team and circulated to all staff. Any instances of breach of this standard will be reported through the Datix system and escalated by the Inpatient Senior Nurse to the Adult Mental Health Directorate QSRE. Present guidance on the use of ECA will be revised and formalised by the Senior Nurse by 31 January 2024.	Mental Health & Learning Disabilities	31.01.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must make sure that staff feel consulted, involved, and understand decision making processes by senior staff that affect them, and that staff feel confident in sharing ideas and contributing to change.	All patient transfers that take place in working hours are informed by consultation between the ward managers/ Nurse in Charge of both the transferring and receiving ward. This core information is shared with clinical staff through the twice daily handover. In order to ensure that there is clarity of communication, the Nursing team will develop a Ward Transfer proforma for communication of essential clinical information on transfer. The Adult Mental Health Directorate recognises that staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service improvement and as part of the Mental Health Care Group is implementing the learning from the Ty Llidard and Maternity Services improvement work on staff engagement. The Directorate will use Sharing information/learning arrangements within the services e.g. QSRE, team meetings, 7 minute briefings to maintain staff awareness of decision making around clinical and operational matters. The Inpatient Senior Nurse will lead on development of the Ward Transfer proforma in collaboration with a working group of qualified and Health Care Support Workers in in order to ensure that all key communications are considered, and the process addresses the concerns about miscommunication of decision.	Mental Health & Learning Disabilities	28.02.2024		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSRE.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	Paintwork has been re-painted.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Paintwork has been completed. Action can be closed.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	Finance secured and replacement blinds ordered.	Children & Families	01.02.2024		Fully complete (Awaiting approval)	Previous update - Complete. April 2024 Update - New blinds now in place. Action can now be closed.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	AMAT environmental audit undertaken monthly.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete-new blinds in place. April 2024 Update - Environmental audit in place on the AMAT system. Action can be closed.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	Tirion to be added to the RGH site rolling maintenance programme for paintwork.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	Previous update - Complete April 2024 Update - Added to ongoing maintenance programme. Action can be closed.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	Environment included within rolling programme of Purposeful Visiting annually.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	Previous Update - Complete April 2024 Update - Tirion purposeful visit complete. No further environmental issues identified. Action can be closed. Previous Update - Complete

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable. The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.	Poster to be displayed depicting iaith gwaith logo up in birth centre areas for service users to identify welsh speakers.	Children & Families	01.12.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete, posters in place.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable. The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.	Identify all welsh speaking members of Tirion staff to ensure appropriate uniform with iaith gwaith logo.	Children & Families	01.02.2024		Fully complete (Awaiting approval)	April 2024 Update - As previous update, no Tirion core staff are welsh speakers. The specialist midwife in attendance during the HIW visit/inspection has now been given appropriate lanyard to identify her as a welsh speaker. This action can be closed. February 2024 Update - Complete, no Tirion core staff are Welsh speakers. Specialist midwife Welsh speaker now has appropriate identity.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable. The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.	Maternity services digital booking system includes and collects data relating to language/ communications needs and ethnicity to enable the service to understand the diversity within local communities.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The Welsh Language team have undertaken a visit to the Tirion footprint, and all signs, resources and information are available in welsh. This action can be closed. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable. The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.	Implement use of an iPad to support translation and interpreting services for non-English speakers.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - There is an i-Pad available at Tirion to support translation and interpreting services for those who are non-English speaking. This action can be closed. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable. The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.	Specifically looking at setting up an event in partnership with the University of South Wales to engage with students from overseas.	Children & Families	01.03.2024		Fully complete (Awaiting approval)	June 2024 Update - This can be closed. The Welsh Language team have supported a walk-around at Tirion and we are fully compliant with Welsh language requirements. All women are supported to identify their language of choice/need at the outset of pregnancy using the All-Wales Handheld Records, and through the digital self-referral system. Where women identify additional language/communication needs there is access to use of translator/interpreting services. The Consultant Midwife for Population Health is developing a framework around the EDI agenda as part of a wider piece of work to increase awareness of, and respond to the diversity of local communities. April 2024 Update - This action is ongoing and requires financial investment to support this event. The Women's Experience Midwife is currently scoping this and looking for grants/funding to support the event. February 2024 Update - Ongoing.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable. The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.	Programme of community-based engagement through Baby Shower events for all prospective service users to attend, which is supported by Tirion birth centre team.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Baby Shower events have been drafted into the CTMUHB Maternity & Neonatal Engagement Plan, however this action is ongoing and requires financial investment to support future events. The Women's Experience Midwife is currently scoping this and looking for grants/funding to support the event. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board must conduct a baby abduction drill at Tirion Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members.	Updating of the 'Security of the Newborn' guideline in progress, to include auditable standards of an annual baby abduction drill.	Children & Families	01.02.2024		Fully complete (Awaiting approval)	June 2024 Update - This action can be closed. There have been 2 baby abduction drills undertaken at Tirion (including all appropriate stakeholders). The Security of the Newborn guideline has been updated and includes the auditable standard of at least annual baby abduction drill in each acute clinical area (including Tirion). This should be ratified in the next Postnatal Forum and Guideline Group and then available via Wisdom. April 2024 Update - The draft 'Security of the Newborn- guideline is currently out for consultation and due to be discussed with the intention to ratify in the next Postnatal Forum (awaiting date tbc). The draft guidelines includes an auditable standard of an annual baby abduction drill in each acute maternity setting. February 2024 Update - Final draft to be sent out for consultation on 19/02/2024 for ratification. This will include KPI for annual baby abduction drill on each site.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board must conduct a baby abduction drill at Tirion Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members.	Baby Abduction drill planned: Table-top baby abduction drill & local baby abduction drill.	Children & Families	01.12.2024		Fully complete (Awaiting approval)	April 2024 Update - Tirion and RGH have completed both a table-top baby abduction drill/discussions with Tirion staff (14.12.23), and the RGH site have supported a full multi-disciplinary baby abduction drill (22.01.24). This action can now be closed. February 2024 Update - Complete - 14.12.23.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board must conduct a baby abduction drill at Tirion Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members.	Baby Abduction drill planned: Full baby abduction drill	Children & Families	01.01.2024		Fully complete (Awaiting approval)	April 2024 Update - Tirion and RGH have completed both a table-top baby abduction drill/discussions with Tirion staff (14.12.23), and the RGH site have supported a full multi-disciplinary baby abduction drill (22.01.24). This action can now be closed. February 2024 Update - Complete - 23.01.24.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Annual report of outcomes and experience from Tirion birth centre shared at service-wide audit/governance meeting.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The annual Tirion report for 22/23 has been shared at a service-wide governance meeting. The next annual Tirion report is currently being compiled, and will be shared at a service-wide audit/governance day upon completion. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Where negativity regarding the model of care is identified, learning via patient story and feedback/reflection by staff is undertaken.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The service share families' stories at all key departmental meetings, and these have included stories from families who have used services at Tirion FMU. There are no current examples of negative feedback from staff. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Family stories shared at departmental meetings/forums.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The service share families' stories at all key departmental meetings, and these have included stories from families who have used services at Tirion FMU. This action is complete. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Tirion 'marketing' video developed and shares family's experiences of using Tirion.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should audit, update and share guidelines and policies related maternity care.	Current policies/guideline which expired in 2023 have been extended for a further 12 months via the maternity and neonatal improvement Board governance process.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Ongoing review and updating of guidelines continuing. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should audit, update and share guidelines and policies related maternity care.	Guideline Service Group produces an annual plan of work to ensure timely review of guidelines.	Children & Families	01.01.2024		Fully complete (Awaiting approval)	June 2024 Update - This can be closed. There is a comprehensive governance and assurance process including a Guideline Group and Clinical Forums, which includes the monitoring of both new guidelines, and those requiring updating/ratifying. April 2024 Update - ongoing January 2023[4]
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should audit, update and share guidelines and policies related maternity care.	Staff updated via email and staff social media Communications to ensure awareness of extension of these guidelines.	Children & Families	01.01.2024		Fully complete (Awaiting approval)	June 2024 Update - This can be closed. All current clinical guidance is available via Wisdom intranet/Internet. There is oversight of those guidelines coming out of date/requiring updating. April 2024 Update - Communications to staff via email, monthly newsletters and governance meetings. January 2023[4]
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	The health board should audit, update and share guidelines and policies related maternity care.	There is a maternity/ gynaecology/SH guideline group which monitors guidelines which are coming out of date.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - guideline group in progress monthly. Action can be closed. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure that the young people receive treatment specific to their individual diagnosis and that this is documented clearly within their patient records. Care-plans are audited on a monthly basis. Outcome measurements support tracking quality-of-care against individual patient care needs. The audit asks he following questions; •Is the new care plan being used? •Is it in the YP's voice/words? •Is it outcome focused? •Has it been reviewed? •Is there evidence of an MDT approach? Learning areas are discussed in team meetings and disseminated electronically to the multi-disciplinary team.	Each young person has an individualised care plan in line with their recovery care outcomes and inclusive of their holistic care needs.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must improve the appearance of the garden areas for the therapeutic benefit of the young people and ensure ongoing maintenance is undertaken going forward. The Ty Lliard team have been working with the HB Head of People's Experience and have arranged for a voluntary organisation support with the general maintenance of the garden areas.	The Facilities department have a schedule for garden maintenance works, additionally the local management team carry out monthly environmental checks and request additional garden maintenance as required.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 2
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure that the language preference of each young person is identified and recorded in a place that is easily accessible for staff to be aware.	The part A referral form provides a prompt to document the young person's language preference. This is filed at the front of each patient record for ease of reference. See attached, language preference highlighted in yellow. Medical secretaries to monitor full completion of the referral document prior to saving on the patient file. The Part A contains all patient demographics and is filed at the front of the medical record by the ward clerk.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 3
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure the equality and diversity policy is updated and shared with staff once the policy has been ratified.	The health board will update the Equality and Diversity policy.	Mental Health & Learning Disabilities	01.05.2024		Fully complete (Awaiting approval)	June 2024 Update - Approved by QSC & QSR. In Progress Estimated to be completed by May 2024
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	The nursing team undertake daily environmental checks to support in early escalation of any maintenance concerns.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Operational procedure in place to guide staff members on the reporting system for environmental maintenance.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Facilities log maintained to reflect reports and required actions.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Senior Nurse to escalate environmental maintenance concerns via Quality Safety Risk and Experience report	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Locality manager can escalate any issues via Health and Safety meeting	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must provide clarity and guidance on staff responsibilities to ensure effective cleaning of the outside areas and staff toilets.	Maintenance of the outdoor garden furniture has been added to the daily environmental checklist that is undertaken by nursing staff. Completion of the daily environmental checklist is audited monthly and learning disseminated via nurse meeting.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must provide clarity and guidance on staff responsibilities to ensure effective cleaning of the outside areas and staff toilets.	Cleaning schedule of the staff toilets was increased to twice daily on 06/11/2023	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must provide clarity and guidance on staff responsibilities to ensure effective cleaning of the outside areas and staff toilets.	IPC added to the nurse meeting agenda.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure a system is in place to inform staff that the re-usable medical equipment has been cleaned and is therefore safe to use.	SOP created to support guidance on cleaning re-usable medical equipment between use. All reusable medical equipment will be cleaned between each patient contact and marked with the green "I am clean" verification tape.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 5 + 6
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure that all staff are aware of the IPC lead and their role and responsibilities so that staff can appropriately escalate any concerns they may have.	All staff have mandatory level 1 and 2 IPC training. Guidance now displayed outlining the name and contact details for the IPC lead. IPC added to the nurse meeting agenda.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 7
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must review the use of the laundry room to improve its condition and lower the temperature to make the room more bearable for staff to use.	The issues identified have been resolved, the fan has been cleaned and the door adjusted. Portable air conditioning units have been purchased and can be used in this room to lower the temperature.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 8 + 9
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure the medicines management policy is updated and shared with staff once the policy has been ratified.	The health board will update the medicines management policy.	Mental Health & Learning Disabilities	01.05.2024		Partially complete (Overdue)	June 2024 - Policy to be shared at CSRE in August 2024. June 2024 - The health board has updated the policy which was published 15/11/2023. In Progress Estimated to be completed by May 2024
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must remind staff of the importance of undertaking and documenting such checks.	The fridge temperature checks are subject to monthly audit. Audit findings are part of the weekly nurse meeting agenda. Minutes are disseminated to the wider nursing team.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 10
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must provide an update to HIW on actions taken since the inspection to ensure medication is being stored at the correct temperature.	Clinic room temperature checks operational from the 13.09.23. Compliance is audited on a monthly basis and learning areas disseminated via nurse meeting. Portable aircon units have been purchased and to be used if the clinic exceeds 25 degrees. SOP created to guide staff on the management of retaining the clinic temperature below 25 degrees.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 11 + 12
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure all potentially harmful materials are locked away and stored appropriately at all times.	The unit now benefits from a new clinic whereby all cupboards are lockable. All cleaning materials usable by nursing staff have now been stored correctly.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 13
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must provide training to staff to clarify the expectations on staff in terms of reporting adverse drug reactions, for example, to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme.	Prescribed medications are discussed and reviewed by the multidisciplinary team (MDT). Such discussions include potential adverse and therapeutic effects that require monitoring and clear documentation within the MDT records. Those identified at risk of adverse reactions are medically managed accordingly and the individual patient care-plan reflects such management. Ty Lliard receives support from a dedicated mental health pharmacist who attends the unit and is available to assist staff adverse drug reactions.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must reflect on this feedback and review with staff and the young people whether any changes to the menu choices and their frequency are required.	The re-assessed nurses are trained in paediatric immediate life support that covers management of adverse drug reactions. The Ty Lliard dietitian met with the young people to collaboratively review the menu. The menu has since been revised in line with the young people's preferences and nutritional requirements. This will continue to be reviewed via the weekly community meeting.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 14
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure that staff regularly inform the young people about their rights in line with the Mental Health Act Code of Practice for Wales, particularly following a change in the young person's circumstances.	A prompt to support timely and fluid reviews of each young persons understanding of their rights as an informal or detained patient is now included in the patient care-plan. The care-plan will be collaboratively reviewed on a weekly basis by the young person and named nurse.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 15
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure that staff regularly inform the young people about their rights in line with the Mental Health Act Code of Practice for Wales, particularly following a change in the young person's circumstances.	Care-plans are subject to monthly quality checks by the ward manager, findings are captured on AMAT and disseminated via nurse meetings. The minutes of nurse meetings are disseminated to the wider nursing team.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure mental capacity assessments undertaken on the young people are completed using the capacity assessment forms available and stored appropriately within the patient records.	The MHLd care group will develop a standardised Mental Capacity Assessment form.	Mental Health & Learning Disabilities	01.05.2024		Fully complete (Awaiting approval)	June 2024 Update - Completed 04/01/2024 (see Appendix 21) In Progress Estimated to be completed by May 2024
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	While it may be the case that 12-hour shifts may not be appropriate for Ty Lliard, the health board must reflect on this feedback and continue to discuss this issue with staff to identify alternative solutions to help allay staff concerns and improve their work life balance.	The Head of Nursing has recently completed a review of all CTM MHLd inpatient wards. This review has considered changes to shift patterns and recommendations have been made to trial and evaluate the use of 12-hour shifts	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	Registered nurses are included in the shift-by-shift assessment of acuity. This supports the planning of additional resources to meet patient need.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	The funded nurse establishment is in line with the Quality Network Inpatient CAMHS standards. Overtime, bank and agency backfill is supported where numbers fall below funded establishment.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	Weekly acuity is assessed using Levels of Care. This supports the reporting of patient acuity within the unit.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	Nurse staffing levels added to nurse agenda to ensure that this provides a forum for staff to discuss any concerns they may have in relation to safe staffing levels.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	Any concerns about staffing levels can be escalated through the senior nurse Quality Safety Risk and Experience report.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	The Head of Nursing holds weekly drop in sessions where staff can raise issues or concerns, including those related to staffing.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Lliard (Ref: 03362)	The health board must ensure that all staff receive training in the duty of candour to help them understand their responsibilities in helping meet the new legal requirements.	Advice sheet shared with full multidisciplinary team, this has been captured via online voting buttons to support in tracking staff members understanding of the standards and where any additional support maybe required. Roles and responsibilities under duty of candour added to the multidisciplinary team staff induction. To support assurance of learning and development, the new staff induction is subject to 3 monthly audits.	Mental Health & Learning Disabilities	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 16, 17 + 18
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Cwm Taf University Health Board acknowledges the findings and we recognise improved and robust assurances are required to improve the quality of patient experience and deliver Safe and Effective Care. Plans are in progress to implement Same Day Emergency Care (SDEC) services with part of this being a front door Frailty Model (Acute Care of the Elderly-ACE) as part of the EU reconfiguration work. This will facilitate early identification of our frailty patients and avoid unnecessary long waits in the EU. The implementation of the above units will reduce the potential overcrowding in the Ambulatory Area where patients are waiting for inpatient beds. There has already been significant progress in the last 9 months with the implementation of the gynaecology, surgical and trauma assessment units aligned to inpatient areas that has diverted patient flow from the EU. Further work is going to develop processes and pathways whereby all GP expected patients will transfer directly to the assessment units and avoid the EU footprint. There is an options appraisal being considered to relocate the GPAU, whereby the GP expected patients will not attend the EU. As part of the work described there are Standard Operating Procedures (SOP) in place where patients requiring immediate resuscitation will transfer immediately to ED in order that patient care and safety is maintained.	Unscheduled Care	01.01.2024	Revised Due Date April 2024	Overdue	Extended to April 2024 due to construction delays and development of SDEC Pathway, where all GP referred patients will be directed and streamed. Frailty Model implemented December 2023, with the successful appointment of 1 Consultant, 2 Advanced Nurse Practitioners, further medical recruitment is ongoing. Following this there is early identification of Frailty Patients within the ED Department with streaming to the inpatient Frailty Ward as required.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	An Ambulatory Care SOP was approved (August 2023) and specifically outlines the number and acuity of patients that can be safely nursed within the designated area and clearly documents the level of escalation required by staff to maintain patient safety, dignity and privacy and staff well-being.	Unscheduled Care	01.09.2023		Overdue	SOP for Ambulatory care remains in place and Huddles continue across the department with a clear focus on patient safety.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	ED Patient Huddles were implemented (April 2023) and this process is a MDT approach to review the priorities within the areas of the EU and escalate concerns to support patient flow and ensure a positive patient experience. The safety huddles are mobile across the vast footprint, to demonstrate clinical presence, leadership and offer a snap shot of patient safety. Across each acute site we have implemented a Safe to Start meeting (since November 2021), this is a formal process with a clear audit trail of site patient flow activity, escalation levels, patient priorities and concerns. This process is a MDT approach including clinical service colleagues undertaken twice a day and is a whole system approach to the patient flow, governance and the professional agenda.	Unscheduled Care	01.09.2023		Overdue	Safe to start meetings continue on site twice daily with regular review of any patient safety concerns and safe staffing is maintained.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	Revised Due Date December 2024	Overdue	Delayed due to major capital works on site to December 2024.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024		Overdue	Awaiting date from Welsh Government following a successful bid for Funding. This will supply an extra toilet and showering facilities.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	Until the planned reconfiguration is completed, the health board is required to provide HIW with details of the action taken to promote the privacy and dignity of patients accommodated in the Ambulatory Care area and 'surge' areas.	The Ambulatory Care area has four single assessment rooms that are available for assessment of new patients and available for patients waiting who require further medical review, nursing intervention and treatment. Alongside this there is a max fax room, and three ambulatory room that support 3 patients in each. The Senior Nurse, ED Clinical Lead and Senior Nursing Team are working closely with the MDT within the EU to ensure there is understanding of their roles and responsibilities and to utilise the designated private rooms to support clinical care for patients affording privacy. To escalate to Senior Staff when there are barriers to achieve this to identify alternative solutions to ensure privacy and dignity. Temporary dignity screens are available to use within the designated waiting rooms to support the improvement. The nursing team have been reminded to close doors of assessment rooms and waiting areas including the use of screens as appropriate reiterating that this is integral to the fundamentals of nursing care.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to promote the comfort of patients accommodated in the Ambulatory Care area for extended periods of time.	Following the previous review by Health Inspectorate Wales there has been significant investment in recliner chairs that have been placed in the Ambulatory Care area, with further plans to purchase the same type of chairs that extend into a bed, thus will support comfort for patients delayed in the EU. There has also been investment in new seating within the main waiting area of the EU that offer both comfort because of the extra padding but also comply with IPC guidance. Any patient waiting for an inpatient bed who is high risk is identified and escalated as part of the ED Patient Huddle/Safe to Start to ensure an appropriate chair/bed/mattress is provided. The Senior Nurse has ensured that the detail described is included in the daily staff brief and the department monthly meeting to ensure staff are aware of their responsibility and escalation when there are barriers or concerns.	Unscheduled Care	01.12.2023		Fully complete (Awaiting approval)	4 new recliner chairs have been received in March 2024 in Ambulatory Area.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to review the provision of washing and toilet facilities within the EU, so these are appropriate and sufficient to meet the assessed needs of patients.	It is recognised that the current environment is not a purpose built Ambulatory Care Area and the concern identified is already on the Risk Register. - Staff improvise well with the available resources to ensure patients have their hygiene and toileting needs met. This includes accessing the single assessment rooms to ensure the required care is delivered. The new pathways described in Action 1 will support this improvement long term. - As described in the above action, any patient who is unable to independently transfer to the designated toilet or supported by the nurse is escalated via the EU Patient Safety Huddle and Safe to Start in order that the patient is prioritised for an inpatient bed. The Senior Nurses across the PCH site work closely and dynamically with the EU team to identify bespoke ways of influencing/supporting patient flow in order that the identified patients are prioritised. This includes evoking the Patient pre Emptive transfer, "sitting" patients out on inpatient wards to facilitate an earlier/prompt transfer from the EU. The Head of Nursing and Senior Nursing Team are continually present operationally working proactively with the nursing teams to facilitate identification and prioritisation of these patients.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 April 2024 – as above delayed as awaiting date from Welsh Government. Funding approved for extra toilet and showering facilities-specifically Ambulatory Area of ED
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to meet the assessed mobility needs of patients accommodated in the EU.	As described in Action 1 the SDEC and Frailty pathways will support this action proactively and positively to support the deconditioning of patients waiting in the EU. The Nurse Director for Unscheduled Care with support from the Head of Flow has been leading work across the wards and ED/CDU teams have attended the training days for "REDGREEN" in June 2023, with further training planned whereby preventing deconditioning. -P1 Paralysis is integral to the quality improvement work. This targets the review and prevention of iatrogenic harm through wasted opportunity to add value to the patient's hospital journey. This not only supports earlier discharges but improves patient outcomes. This also furthers MDT support for frailty at the front door with significant investment in physiotherapy staff to assess mobility needs in the EU. A Quality Improvement Project is being commenced whereby frailty is identified immediately on attendance to ED and appropriate assessment and signposting will be applied. This supports the new Frailty Pathway described in Action 1. A Frailty Consultant has been appointed for the PCH site and is key to the new models being introduced to support improved flow out of ED. 2.0 wte Frailty Advanced Nurse Practitioners have been appointed and awaiting start dates and will support the new pathway work as well as work closely with the ED team to improve knowledge and skill set. The Stay Well at Home Team are present 7 days in the EU to support early mobility assessments, are trusted assessors and facilitate early discharge. The acuity in the different areas of the EU is reviewed in Safe to Start, where acuity is identified as high, staff are redeployed to the areas to support. This information is documented in order that an audit trail is present. During the HIW visit the internal escalation of the site was a level 4 with a risk of 16 and 20-there is evidence of staff being redeployed to the Ambulatory Area of EU. This forms part of dynamic staffing within the EU where staff are move flexibly by the senior nurse and head of nursing based on patient needs and acuity.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 2 Frailty ANPs appointed-October 2023 Review patients at the front door and streamline access to frailty ward Optimise rolling out formally across the HB-this is the CTMUHB project that encompasses Red2Green and Discharge to Recovery Then Assess Pathways. Daily sitreps available electronically-for audit purposes and action.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve the signage within the EU to help patients and their carers find the X-ray department and other areas independently.	Cwm Taf University Health Board acknowledges the findings and we recognise improvements are required to provide assurances that there is good communication for patients to reduce any anxieties they may have in an unfamiliar environment. Due to the huge construction being undertaken very close to the EU and radiology footprint, signage can be challenging but is an absolute priority in order that patients do not become confused and understand the communication/signage that is in place. The senior leadership team are reviewing all current signage following the completion of significant works between radiology and EU (completed 03.10.2023). In the meantime, temporary signage has been created to support patients as they move throughout the EU footprint, as there is work ongoing across Cwm Taf University Health Board to have consistent signage for the public served by the whole HB.	Unscheduled Care	01.09.2023		Partially complete (Overdue)	Temporary signage has been created to support patients as they move throughout the EU footprint, as there is work ongoing across Cwm Taf University Health Board to have consistent signage for the public served by the whole HB.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the systems in place to improve patient flow through the EU.	We are currently reviewing through large organisational change, the operational structures that will be key to patient flow and ensure senior leadership is present on site and pan CTM Health Board. Through the 6 goals programme work we are progressing improved patient flow as this is a multi-professional/whole system approach involving our Local Authority colleagues. The 1 Whiter Board has been introduced across the organisation and this is key to patient flow and implementation of Red2Green as a quality metric for patient care. This will increase bed capacity through more efficient and sustainable processes where we explore value added time, measure internal and external delays and focus on marginal gains in length of stay. Consequently, this will improve flow through EU. As part of this work the senior team are also exploring the continuous flow model to review if this would be suitable for roll out across CTM. The ED Team use the Myrddyn IT System which is monitored by the responsible teams and reviewed as part of the ED Patient Safety Huddles. When it is identified that Triage Times are beginning to increase, there are internal escalation processes in place to ensure timely support and assessment of patients which additional staff being deployed to support. The ED Clinical Team will adopt a Rapid Assessment and Triage (RAT's) model to support any delays in triage, hence there will be senior assessment and streaming at the front door of patients. EU has recently recruited 2.8 wte Patient Flow Coordinators to support timely patient flow and escalation of patient flow delays. The USC group have developed updated Escalation Cards to support actions and provide assurances that ambulance delays are avoided. There are rigorous escalations in place, and when any patient is delayed over 4 hours an internal investigation is undertaken to provide assurances that no harm has occurred.	Unscheduled Care	01.03.2024		Overdue	This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to reduce the likelihood of patient information recorded on the board used in the Ambulatory Care area being seen by patients and visitors.	This has been reviewed with immediate effect and only patient initials to be used for patients in the waiting room. Patients physically situated in EU ambulatory, initial and surname used to identify location and interventions required. The Senior Nurse for EU has reiterated the above actions and included in her daily briefs with the EU team.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to provide patients with regular updates on their care and treatment.	The importance of timely and clear communication is fundamental to patient experience and this has been highlighted to the MDT as part of focus groups and staff training. Patients waiting in excess of 24 hours for a bed to be highlighted to NIC and Unit manager, clear communication with patient and relative (where necessary) to explain care plan and expected outcomes. Twice daily EU Senior Nurse walkarounds are undertaken to identify long wait patients, with appropriate clinical escalation as well as site escalation to maximise resource prudence and optimise length of stay as per the quadruple aim. For those patients waiting in the general waiting room-it is a key responsibility of the triage nurse and the assigned HCSW to provide regular updates-30 minute-1 hourly rounding's are undertaken to monitor the area, replenish fluids, identify any issues/concerns and provide updates.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this we have extended our Patient Advocate Liaison Service (PALS) team offering to support patient with regular updates at front door as also ED volunteers support this. We have also implemented Civica to capture Patient Reported Experience Measures (PREM's) within the ED and we are developing this into themes and trends to inform action plans for improvement.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to deliver the 'Active Offer'.	Cwm Taf University Health Board acknowledges the findings and we recognise action has to be taken to deliver the "Active Offer" as good communication has to be equitable for all our patients. Ensuring bilingual provision greatly impacts the experience of care Welsh-speaking patients have and in many cases Welsh language provision can also lead to better clinical outcomes. Following the previous HIW review signage within each major's space was updated to ensure information relating to patients EU journey and next steps were bilingual. The EU & CDU Senior Nurse is meeting with the HB's Welsh translator to ensure Welsh service users are identified and their needs met. Providing the Welsh language to service users without our Welsh speakers needing to ask. Bi-lingual development of an EU & CDU leaflet to ensure patient care trajectories are understood by those accessing EU services. The Senior Nurse has reiterated to the teams the importance of staff receiving the correct uniforms who are Welsh Speaking as the icon is easily visible to our patients to support equitable and positive experience. The "Active Offer" checklist has been re-circulated to the team in EU and the site as a whole.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Completed EU Senior Nurse has met with the HB's Welsh translator to ensure Welsh service users are identified and their needs met. Providing the Welsh language to service users without our Welsh speakers needing to ask. The EU are awaiting the bi-lingual version of an EU leaflet to ensure patient care trajectories are understood by those accessing EU services. The team have also published bi-lingual uniform posters, to highlight staff members to service users.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to involve patients as much as they want to be in decisions about their care.	Within the department we ensure Multi-disciplinary decision making, inclusive of patient choice it at the forefront at all times for patients whilst in our care. Ongoing nurse-patient advocate and champion nurses identified across site to assist in this delivery, the improvement work being undertaken across the site is shaped around "nothing about me, without me." Which reinforces patients being involved in decisions about their care.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure patients do feel discriminated against when accessing services.	The Head of Nursing chairs a monthly focus group (a meeting that operationalises the governance agenda for the whole site) to discuss and reinforce the use of the equality and diversity agenda. Including the nine protected characteristics as recognised by the Equality Act. There has already been the development of gender neutral facilities within the PCH site, but as work continues, this will be progressed further. For example: toilet facilities and hygiene maintenance areas are label free. Recent appointment of a Learning Disability specialist nurse, who attends Safe to Start, ensuring patients are identified and their care outcomes have a truly holistic approach. Access to a variety of mechanisms to ensure communication is maximised for individualistic needs, already in place. Sharing of CTMUHB values and behaviours through communication across the MDT is regular and form part of each staff communication. This is also key to the staff appraisal process. Service users have the access to PALS service and putting things right to escalate any concerns. As well as access to clinical team members. In recognition of patient needs champion nurses are in place for pregnancy loss, learning disabilities, dementia, Welsh language and further emerging roles. The opportunity for staff to attend training days to improve knowledge and experience to progress this agenda.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this as part of the Civica PREM's inclusion and discrimination feedback is captured and if this is a theme will inform any ongoing actions for improvement.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to complete suitable risk assessments of the Mental Health Assessment rooms and the Triage rooms and develop action plans as appropriate to mitigate any risks identified.	Multiple MDT meetings being held with the care group service managers, clinical leads, nursing leaders, and personal safety advisor to identify risk across the EU footprint and ensure appropriate and timely escalation occurs. If patient are awaiting Mental Health review these are escalated via morning Safe to Start meeting with multi-professional colleagues. A risk assessment for ligature risk has been developed and awaiting approval-this will also be utilised across the inpatient wards.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure suitable risk assessments are completed and recorded in relation to patients developing pressure damage and in relation to patient falls. Suitable care plans are to be developed and implemented.	18 months ago the EU had the highest incidence of avoidable pressure damage across the Health Board. Targeted work has been implemented to ensure the mandatory risk assessment is undertaken immediately on arrival to ED in order that appropriate intervention is put in place. This is captured via the AMAT audit tool in which we can see an improving trend. A Senior Nurse for Professional Education was appointed in March 2022 as part of the new Nursing Workforce Model. The staff member is integral to supporting staff education around pressure area care including completion of the Pressure Ulcer Training Module on ESR. A new pressure ulcer booklet has been devised by the Critical Care Team to support staff training and development. Each staff member has been provided with a copy and their compliance is being monitored. Pressure damage scrutiny meetings are in place and improvement work across PCH including ED with notable improvements in ED. All members of the nursing team are able to attend pressure Damage Scrutiny to support learning, this has been successful to date. A Tissue Viability Nurse has been resourced to work in ED once a week to support staff education and training to improve the standard of assessments, care planning and implementation of care. We have purchased a camera for all clinical areas in PCH including ED, with robust guidelines in place and includes support from Medical Illustrators to ensure consent and supports grading of pressure damage. This can be accessed in and out of hours. The internal data has demonstrated continuous improvement in pressure area assessment and care in ED with significant reduction in avoidable pressure damage as well as identifying pressure damage present on arrival to ED. Pressure area audits are undertaken via AMAT and monitored hourly using the "Patient Safety Checklist". Any trends identified are discussed in the ED monthly meeting and the PCH monthly Focus Group meeting to ensure lessons are learned widely. Two Formal Study Days have been undertaken in the last 18 months and the Fundamentals of Care has been key to the agenda. There are 2 further Study Days arranged (by the Senior Nurse for Professional Education) for October and December - these will incorporate Work Stations and Pressure Area Management is included.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure patients in the Ambulatory Care area have an adequate means to summon assistance, subject to a suitable risk assessment of this area.	Any broken nurse call button has been identified, reported to Estates and fixed. 20 remote call buttons have been procured and in line with IPC guidance for use across the EU. The Senior Nurse has introduced a daily audit to ensure that all nurse call buttons are available for patient use and in correct working order.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this the Welsh Government funding achieved will support integrated nurse call bells in Ambulatory Care.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with the health board's policy for hand washing to help reduce cross infection.	IPC is a key priority for the MDT due to the clinical nature of the EU and the unknown attending. The report has been shared with the MDT to highlight the issues identified and the increase awareness of our personal responsibility as health professionals to ensure compliance with IPC policies and procedures. IPC champions have been identified in the EU. Increased signage is available across the EU to raise awareness. Increased auditing of hand hygiene is being undertaken and trends monitored. Targeted training for the MDT and this is supported by the Senior Nurse for Professional Education. Training compliance is monitored weekly via the Unscheduled Care Workforce Meetings-trends are monitored and actions for improvement. The nurse director commissioned an IPC audit with significant improvement demonstrated, compliance has increased to 90%.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure: •Controlled Drugs used in the EU are subject to regular stock checks •Temperatures of fridges in the EU used to store medication are regularly recorded.	The Nurse in Charge and Unit Manager to check before Safe to Start, Senior Nurse to spot check daily. Allocation of staffing to reflect daily responsibilities as well as daily check lists. Since the previous HIW review of EU, a dedicated pharmacist has started who supports this work and data is captured via the AMAT audit tool. Non-compliance with this is captured via safe to start and a data is generated.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the action taken to repair or replace the locks on the medication cupboards in the CDU.	There was an immediate make safe and both locks escalated following visit and have been repaired/replaced.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure all staff who need to be are made aware of Patient Safety Notices relevant to their work area.	Patient Safety Alerts are circulated from the Corporate Patient Safety Team and in turn via the Unscheduled Care Governance Team. The alerts and actions required are cascaded to the EU and CDU MDT to cascade accordingly. The alerts are discussed and minutes available; in the department's monthly governance meetings. The Head of Nursing shares all alerts at the monthly Focus Group (a meeting that operationalises the governance agenda) and minutes. Any actions/evidence required is returned to the Corporate Patient Safety Team. The new EU Newsletter is used to share alerts with the MDT.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure patients have their pain assessed and regularly evaluated.	Initiation of pain score audits by band 7 champion. Senior Nurse EU and CDU have sent wide communication to all staff around the recording and evaluation of pain scores. Pain team to continue with routine pain audits as per AMAT and this is also capture via the patient safety checklist.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to: •provide patients with meals that are nutritionally balanced, appear appetising, served at a suitable temperature and that meet patients' individual preferences and needs •provide patients with hot drinks at regular intervals •provide patients with suitable assistance to eat and drink.	A full review of the catering model for CTMUHB is underway. With particular attention to the provisions and supply offered to patients within the EU. The menus introduced will ensure the nutritional analysis exceeds All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatient' for both nutritionally well and nutritionally vulnerable patients. The HB's Catering Model has been re-circulated in order that staff understand their roles and responsibilities; key to the model is preparing the patients before the catering trolley attends the EU.	Unscheduled Care	01.09.2023		Overdue	April 2023 New catering model implemented with a wider range of food offered to patients across the ED. Ceramic and metal crockery now offered along side access to fresh water in the waiting room and across the Ambulatory Care Unit.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure patients' clinical and care records are readily available to staff when required.	Notes trolley instigated within Ambulatory care to ensure accessibility for clinical staff. Clinical lead to establish full access for medical team of electronic systems and Unit Manager for nursing staff.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to review the staffing arrangements within the Triage area and the Ambulatory Care area. The health board is encouraged to engage with staff given the feedback and comments received by HIW in this regard.	Opportunity recognised for the fulfilment of a twilight triage staff member to offer cover within paediatrics and adult areas, covering surge for triage and ambulatory. - Immediate roster review has been initiated. We flexibly deployment of staff occurs within the department in order to meeting the tier 1 target of <15min wait for triage. The senior leadership team are also exploring E-Triage to allow digital enablers to initially assess all patient attending the EU, improving patient safety and allowing triage resources to be used for higher acuity patients.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to respond to the less favourable staff feedback and comments described throughout this report.	Staff are actively encouraged to disclose concerns and well-being worries to the Nurse in Charge, Unit Manager or Senior Nurse. Senior Nurse is a national advocate for civility saves lives and promoting psychological safety. CTM has strong MDT presence and leadership-BAME and a confidential email address to raise any concerns-this has been re circulated. -Staff are encouraged to attend training days to raise awareness-10.10.2023-Empowering Culture Intelligence. This is part of 'Speaking up Safely' which was shared and discussed in the nursing focus group held 28th September 2023.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DoLS (CDU) training.	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug 23 fire training for staff is as follows:- ED-RN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024		Overdue	Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. ED MCA compliance is 56% and Fire is 76% (MCA overall compliance is reduced as a result of a number of newly recruited Registered Nurses and Health Care Support Workers, yet to complete training). There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Monthly mandatory training study days and reports now include V & A, Dols, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration-action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024		Overdue	Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to support staff with health and wellbeing matters and raise staff awareness of the help available.	We recognise improved and robust assurances are required to demonstrate compassionate leadership and management, where our staff feel listened to and supported. Civility saves lives 'TEDaK' style delivery dates booked for 9th October 2023 and 4th December 2023 – site wide. Senior Nurse to acknowledge any staff well-being concerns and manage workload and allocation to best optimise staff outcomes. Implementation of new administrative role to free the Nurse in Charge up to offer real-time leadership and offer psychological safety. Formal debriefs are undertaken with psychologist support. Workforce & OD have a plethora of well-being and mindfulness that can be accessed-regularly cascaded to the teams as well as bespoke access to the Clinical Psychologist who is currently in touch with the MDT.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to ensure staff do feel discriminated against at work.	There is continued work to progress the equality and diversity agenda headed by our Workforce & OD colleagues. Staff are encouraged to attend training days to raise awareness; for example-10.10.2023-Empowering Culture Intelligence.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to increase staff confidence that when they raise concerns, these will be addressed.	EU staff notice board and EU newsletter under development. Departmental meeting planned for 4th October 2023. Band 7 meetings monthly. This also forms part of speaking up safely and the ongoing work around civility saves lives and psychological safety which is being championed by the senior nurse for EU. We also have a well-being champion who is available to support staff to raise concerns.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the implementation of the patient feedback system and how staff will be made aware of the system and how feedback will be used to make informed decisions regarding the service provided.	We recognise improved and robust assurances are required to demonstrate that patient feedback systems are in place on order that patient experience can be continually reviewed and improved. Two new PALS officers have been recruited, and will specifically work within the EU footprint to support patient feedback and explore patient experience. The implementation of CIVICA-SMS (text) Service for ED Survey is in final stages of approval (Concerns Team). We are progressing the use of QR Codes to signpost patients promptly will be included in the above work. Boards are in development for each clinical area pan CTM which will allow patients the opportunity to 'Have their Say'. Volunteers have been recruited to support EU-patients and families, the service will commence mid October 2023. PCH Acute Services currently receives 1)Patient experience, comment report, 2)Monthly heat map, 3)Survey analysis, 4)Have your Say-as part of CIVICA.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved - as part of the Civica roll out in ED Patient Reported Experience Measures' are captured themes and trends are shared. This form part of an action plan for improvement if there is a key area overserved where improvement is required. This is shared in the Head of Nursing monthly focus group. It also forms part of the QSR meetings and a 'you said, we did' board is being developed.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to develop suitable action plans as a result of audit activity.	The HB would like to provide assurances that the audits undertaken using AMAat automatically identifies areas for improvement and signposts immediately to the action plan for completion. The action plans shown on the system are reviewed weekly by the senior EU and CDU Senior Nurses to ensure actions are completed-outstanding actions are shown as a "red flag" alert if there are any delays in completing-these are escalated to the Lead, Head of Nursing and Executive Directors. Trends identified from audits in EU and CDU are shared with the teams during the monthly meetings. The Head of Nursing reports improvements/deterioration from audits during the Unscheduled Care QSR meeting and discuss the improvement plans in place-"the so what". The EU team discusses the audit results and improvement plans as part of the monthly governance meetings.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	a) Review of Day assessment activity has been undertaken identifying areas where midwifery hours could be re-allocated to cover the night roster (48 hours a month).	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 16/01/2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	b) Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 15/01/2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	c) Contact has been made with the Assistant Director of Nursing and People's Experience to explore potential recruitment of overseas midwives. Awaiting meeting to discuss.	Children & Families	01.02.2024		Partially complete (Overdue)	Meeting arranged with Assistant director of nursing and peoples experience, All Wales International recruitment manager and Workforce development and efficiency manager for the 21st of may 2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	d) Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate.	Children & Families	31.03.2024		Partially complete (Overdue)	Started November 2023, expected completion end of March 2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	e) Continue to work closely with people services to ensure that the All Wales Attendance at work policy is adhered to and absences are managed appropriately. Senior management meet with HR monthly to discuss Long Term Sickness (LTS) and attend meetings with individuals on LTS at certain intervals and at formal triggers.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	This work is ongoing, in view of the volume of work, the completion date has been extended, all staff with flexible working arrangements have been notified, submissions of new flexible working requests and partnership working with Unions people services. Meetings are taking place on a monthly basis.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	f) Work is in progress analysing the staff establishment alongside the birth-rate plus report to ensure appropriate allocation of staff.	Children & Families	01.02.2024		Partially complete (Overdue)	A meeting took place with the lead nurse for Perioperative services and Finance to explore the feasibility for perioperative services to cover emergency and elective theatres 24/7, costings did not align with funding. The financing is now being revised to cover 3 elective theatres in the first instance, with meetings being arranged for May 2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	g) Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024	Revised Due Date February 2024	Partially complete (Overdue)	Commenced September 2023. Due for completion February 2024.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	h) The Service is moving from the Birth-rate + acuity app to the Health Board's 'Safe Care' acuity system which links with Allocate Health Rosters and ensures wider Organisational scrutiny.	Children & Families	01.03.2024		Fully complete (Awaiting approval)	This as been implemented since February, and this is a work in progress and continuously evaluated.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	i) Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool.	Children & Families	31.01.2024		Partially complete (Overdue)	Review of safe care tool has been undertaken to ensure that red flags according to NICE safe staffing 2015 are included in the tool
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	j) Work with the Corporate Communications department to develop a Communications Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024		Partially complete (Overdue)	
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	k) Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	l) Review of specialist and operational roles and required commitment for clinical aspects of role to enhance short fall in acute areas as well as staff currently released on secondment.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	m) Senior Manager on call out of hours to support the staff on duty and ensure that staff available are redeployed to the areas of greatest need or transfer out if closure of the unit is necessary.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place from 22/01/2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	n) Initiate formal workforce staffing safety briefing twice a week to ensure oversight and forecast of staffing requirements of staffing requirements across the service and sites to allow timely intervention where possible.	Children & Families	13.01.2024		Fully complete (Awaiting approval)	In Place since January 2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	o) Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	p) A corporate nursing and midwifery dashboard is being developed to consistently capture vacancies, sickness, annual leave = to be shared in Care Group Nursing & Midwifery Workforce Productivity Meetings.	Children & Families	30.01.2024		Partially complete (Overdue)	In Progress, meeting's have taken place to collate maternity data for the dashboard
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	q) The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place 16/01/2024
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	r) Rotation of Staff from well-established areas to ensure consistent safe staffing across the service and weekly review, meetings in place.	Children & Families	31.01.2024		Fully complete (Awaiting approval)	In place, this is ongoing on a shift-by-shift basis and also. Also longer term, staff that are in well established areas are rotated for longer placements to areas where staffing is more challenging to ensure that the service is being reviewed as a whole.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	s) Temporary cease midwifery rotation to other areas.	Children & Families	13.01.2024		Fully complete (Awaiting approval)	Rotation into community on hold
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	t) Review annual leave to ensure consistent levels of annual leave at any given time. This a feature on the Allocate e-roster tool.	Children & Families	31.01.2024		Fully complete (Awaiting approval)	Timescale 31.1.24 & Monitoring in place. Monitoring in Place at ward and directorate level and reported via WESSEE and SWAG forums
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	u) The Health Board continues to work with Welsh Government and Health Education & Improvement Wales to develop a Perinatal Workforce Plan as part of the Maternity and Neonatal Safety Support Programme.	Children & Families	11.01.2024		Fully complete (Awaiting approval)	Timescale 11.1.24 & ongoing national meeting attendance. This in ongoing, CTM are represented on this national work and will continue to do so for the duration of the programme.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9 11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	v) Review night time rosters to determine whether any cultural concerns which may impact attendance at work.	Children & Families	31.01.2024		Partially complete (Overdue)	Discussions have been had with the e-roster department to evaluate how we can extract this data, however this seems challenging. A positive effect of limiting access to the roster has the limited ability for staff to manipulate the roster to work with specific groups and avoid Cliques from forming. Staff are being encouraged and supported to raise concerns they have regarding incivility and poor workplace culture.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift	w) Bank & Overtime Hours offered to midwives.	Children & Families	17.01.2024		Fully complete (Awaiting approval)	Bank and overtime hours have continued to be offered to staff, PCH has also signed up to use Agency staff
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service. Control of Substances Hazardous to Health (COSHH)	a) Locks to be replaced on all COSHH cupboard – Estates colleagues contacted during the inspection. Locks changed on 4 cupboards.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 15.1.24
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	The health board is required to provide HIW with details of the action taken to safely secure COSHH substances used on maternity unit to help prevent unauthorised access.	b) 1 x Lock ordered for further cupboard awaiting delivery.	Children & Families	19.01.2024		Fully complete (Awaiting approval)	Completed
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	The health board is required to provide HIW with details of the action taken to safely secure COSHH substances used on maternity unit to help prevent unauthorised access. Control of Substances Hazardous to Health (COSHH)	c) Domestic Supervisors have shared a safety briefing with her team, to ensure they are aware of the requirement.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 12.01.24
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	The health board is required to provide HIW with details of the action taken to safely secure COSHH substances used on maternity unit to help prevent unauthorised access.	d) Continued oversight through monitoring through the AMaT ward audit schedule.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	The health board is required to provide HIW with details of the action taken to safely secure COSHH substances used on maternity unit to help prevent unauthorised access. Control of Substances Hazardous to Health (COSHH) The health board should review visiting arrangements and communicate timings with families ahead of admission.	Visiting hours within Cwm Taf Morgannwg are in line with other Health Boards in Wales. In response to the service user feedback, an extraordinary My Maternity My Way meeting was held on 22nd January 2024 to discuss visiting and birth partner arrangements. In response to suggestions from service users, visiting hours will be extended for birth partners from 4th March 2024. Visiting hours for the nominated birth partner is being extended until 10pm at night. The service will also facilitate a 30 minute settling in period for partners on transfer to the postnatal ward. Changes to visiting arrangements are advertised via social media, website, communication via all midwifery teams and posters within antenatal clinics (community and hospital).	Children & Families	04.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Questionnaires The health board should ensure that patient concerns are taking into consideration based on patient comments throughout the report.	The service regularly reviews themes and trends from Patient Reported Experience Measures (PREM). Overall women and birthing people report a high level of being treated with kindness / understanding / dignity and respect. The service shares stories for learning where women and birthing people feel they have not been treated positively through audit, supervision and governance sessions. The annual PREM report was shared at the Health Board Quality and Safety Committee in May 2023 with plans in place to share again in May 2024. The service is developing a social media campaign to support women and pregnant people to identify signs and symptoms of VTE. Members of staff who are named in concerns / negative feedback are supported to complete customer care training, discussions are also held with clinical / educational supervisors. The Ombudsman supported training for concerns management to team leaders and senior midwives on 11th November 2023. Proactive feedback is sought throughout the ante and postnatal period via PREM (CIVICA). Feedback is analysed and thematically reviewed monthly. Feedback is monitored via service level assurance groups, and Maternity and Neonatal Safety Board in accordance with the Maternity and Neonatal Assurance and Escalation Framework. GMC/NMC attended audit and governance day on 11th October 2023. Lunch and learn facilitated by NMC on 14th September 2023. Both discussion were around professional standards and behaviours. Myth busting – NMC facilitated session on the approach taken when investigating concerns 14th November 2023. Further NMC session planned 29th April for newly qualified midwives.	Children & Families	01.03.2024		Overdue	Due date 1st March 2024 and under continual review
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	UNICEF Baby Friendly Initiative The health board must work to achieve the UNICEF Baby Friendly Initiative reaccreditation.	There are dedicated infant feeding co-ordinators in place across the perinatal services who are working together toward BFI reaccreditation. The service is currently undertaking a number of audits in readiness for re-assessment which is planned for April 2024. Recent PREM data shows that infant feeding experience is positive. The service has implemented a feeding voice partnership.	Children & Families	01.05.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Pain relief The health board should ensure that appropriate pain relief is given in a timely manner.	The ward manager is responsible for ensuring women receive timely analgesia. A service user audit is underway to further explore the concerns raised. The results of which will be shared via clinical supervision, practice development, audit and governance days.	Children & Families	31.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Mixed cohort wards Whilst we understand that due to staffing issues, mixed cohort wards are a necessity to manage risk, the health board should ensure procedures are in place to ensure they are only used as a last resort.	Mixed cohort wards occur not due to staffing issues, but as a result of acuity, flow and capacity. Whilst ideally ante, postnatal and transitional care should be delivered in separate areas, there are occasions where the midwife in charge is required to review all areas to ensure that there continued flow and timely transfer to and from the Intrapartum areas.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place and reviewed daily
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Informed choice The health board should ensure that all patients are fully aware of all obstetric treatment choices and their risks and benefits, and informed consent should be gained.	The service has invested in Birthrights training for midwives and obstetricians on 11th July 2023 which included choice and informed consent. Informed consent and decision making training was facilitated by the CTM legal team, at a service audit and governance day which took place on 8th February 2023. BRAIN, informed consent and decision-making are referenced within clinical guidelines. Informed decision-making features within PROMPT and Fetal Surveillance training. An induction of labour Quality improvement collaborative is underway which monitors women and birthing people's experience of informed decision-making. A range of decision-making tools are being developed around indications for induction of labour. Annual PREM data (2022-23) showed that over 80% of women and pregnant people had definitely or mostly been given enough information to help them make choices about their pregnancy care, health and well-being.	Children & Families	01.07.2024		Partially complete (Overdue)	In place and monitored via PREM. Audit July 2024
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Equality of access The health board is required to provide HIW with details of how it will ensure that mothers and staff members are not disadvantaged due to their protected characteristics under the Equality Act (2010)	Consent audit added to the Consent audit plan for June 2024. Equality and Diversity training for all staff in place. Rates of training were reviewed during the inspection and revealed high levels of compliance. We work in partnership with our trade union, workforce, occupational health and organisational development colleagues to ensure our people are supported. Service partnership forums are in place to ensure any concerns are escalated and discussed. The Care Group are working with Diverse Cymru and cultural competence training has been arranged for senior leaders on 10th April 2024. Following this session, the training will be rolled out across service groups and develop a cultural competence plan for submission in July 2024.	Children & Families	01.07.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Locked doors The health board is required to provide HIW with details of further action it will take to ensure measures are in place to maintain the safety of babies across its maternity services to prevent baby abductions.	The doors were rectified immediately following the inspection and are now secure. During the inspection the service provided evidence of a recent abduction drill. Abduction drills are annually facilitated and a further drill planned for 2024 as part of the annual audit plan.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed January 2024
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Record keeping The health board must ensure that regular documentation audits are conducted, and learning takes place from the findings.	Annual record keeping and documentation audits are in place, actions are monitored via the Health Board AMAT system. Midwives undertake record keeping and documentation audits as part of clinical supervision for midwives.	Children & Families	01.05.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review of Day assessment activity has been undertaken identifying areas where midwifery hours could be re-allocated to cover the night roster (48 hours a month).	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 16/01/2024
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 15/01/2024
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate.	Children & Families	31.03.2024		Overdue	Started November 2023, expected completion end of March 2024.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Continue to work closely with people services to ensure that the All Wales Attendance at work policy is adhered to and absences are managed appropriately. Senior management meet with HR monthly to discuss Long Term Sickness (LTS) and attend meetings with individuals on LTS at certain intervals and at formal triggers.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Work is in progress analysing the staff establishment alongside the birth-rate plus report to ensure appropriate allocation of staff	Children & Families	12.01.2024		Overdue	In progress February 2024
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024		Overdue	

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Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool	Children & Families	31.01.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Work with the Corporate Communications department to develop a Communications Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review of specialist and operational roles and required commitment for clinical aspects of role to enhance short fall in acute areas as well as staff currently released on secondment.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Senior Manager on call out of hours to support the staff on duty and ensure that staff available are redeployed to the areas of greatest need or transfer out if closure of the unit is necessary .	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place from 22.01.24
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Initiate formal workforce staffing safety briefing twice a week to ensure oversight and forecast of staffing requirements of staffing requirements across the service and sites to allow timely intervention where possible.	Children & Families	13.01.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	A corporate nursing and midwifery dashboard is being developed to consistently capture vacancies, sickness, annual leave - to be shared in Care Group Nursing & Midwifery Workforce Productivity Meetings.	Children & Families	30.01.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start' .	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Rotation of Staff from well-established areas to ensure consistent safe staffing across the service and weekly review, meetings in place.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Temporary cease midwifery rotation to other areas	Children & Families	31.01.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review annual leave to ensure consistent levels of annual leave at any given time. This a feature on the Allocate e-roster tool.	Children & Families	31.01.2024		Overdue	Due date 31.1.24 & Monitoring in place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	The Health Board continues to work with Welsh Government and Health Education & Improvement Wales to develop a Perinatal Workforce Plan as part of the Maternity and Neonatal Safety Support Programme.	Children & Families	11.01.2024		Overdue	Due date 11.1.24 & ongoing national meeting attendance
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review night time rosters to determine whether any cultural concerns which may impact attendance at work.	Children & Families	31.01.2024		Overdue	Due date 31.1.24, continues under review
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Bank & Overtime Hours offered to midwives.	Children & Families	17.01.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Agency midwifery introduced to support.	Children & Families	01.03.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Visibility of management Based on the negative comments in the staff survey, there should be serious consideration of the allocation of duties to the midwifery staff. This should include daytime shifts for middle managers i.e. band 7 and above on the wards. This will promote an understanding of the problems on the unit, improve communication and create more cohesion.	Operational and specialist midwives are rostered to support clinical activity.	Children & Families	01.03.2024		Overdue	

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_ 9-11 January 2024 (ref: 03600)	Datix reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	All moderate and above are reviewed by the MDT and SMOT. A review of all no and low level incidents is underway to explore any emerging themes, trends and ensure that the service is addressing any concern / incident in a robust manner. A wider review of governance process is underway to ensure that there is sustainability and assurance in accordance with the Duty of Quality and Maternity and Neonatal Assurance Escalation Framework. The review was discussed in the Maternity and Neonatal Safety Board in February 2024, the outcome of this work and any recommendations will be presented at the Maternity and Neonatal Safety Board in April 2024.	Children & Families	01.04.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_ 9-11 January 2024 (ref: 03600)	Discussion and staff survey results The health board must ensure its senior leaders continue to encourage supportive and inclusive relationships so that staff feel valued, respected, and confident to speak up and raise concerns. It is vitally important that the health board engage more with its staff and work together to become a more cohesive team who communicate, consult, and make decisions together to improve the working environment for all and to optimise patient care.	Partnership forums are in place with staff side colleagues to ensure any concerns are addressed in a timely manner. Quarterly meetings are in place to review the caring for you action plan with colleagues and staff side representatives. Learning needs analysis in place to support team and individual development and learning opportunities. Consultant midwife for Quality Improvement and Innovation in post. Annual quality improvement plan in place. 75 midwives have completed introduction to quality improvement training. 26 members of the multi-disciplinary team have completed improvement in practice training. Further improvement in practice training is planned in March and April 2024. 'QI Wednesdays' are facilitated by the Consultant Midwife for QI and innovation to share ideas for improvement which has positive engagement. Clinical midwives and support workers are involved in several QI projects such as BSOTS, Neurodiversity, Postnatal Contraception, Female Genital Mutilation, Booking by 10 completed weeks, ATAIN, smoking cessation, physiotherapy, induction of labour. By September 2024, all midwives will have completed QI training. Evaluation of QI sessions are completed on each occasion and are very positive. Engagement forums in place led by Head of Midwifery and Senior Midwifery Manager (last meeting 23rd February). Next Head of Midwifery and Band 7 meeting 18th March with trade union representatives. Band 7 and 8 away day development sessions held throughout 2023. Maternity support worker away day being developed for Summer 2024.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place and reviewed monthly
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_ 9-11 January 2024 (ref: 03600)	GDPR The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to provide assurance that documentation is stored in line with GDPR.	This was rectified at the time of the inspection. The ward manager monitors this daily.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed and monitored daily.
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Ysbyty Cwm Rhondda Ward B2_ 11-12 April 2024 (Ref: 03467)	Provide HIW with details of the action taken to ensure a call bell system is put in place as soon as possible.	Discussion with operational estates manager who has confirmed funding has been agreed to replace the system and a plan is in place to replace.	Primary Care & Community	30.06.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Ysbyty Cwm Rhondda Ward B2_ 11-12 April 2024 (Ref: 03467)	In the interim, provide HIW with details of a robust system where patients are checked regularly to ensure they are safe, and their needs are met.	Risk assessment in place to provide assurance on reducing the risk of patient needs not being met.	Primary Care & Community	30.06.2024		Partially complete (Overdue)	Completed and ongoing monitoring until new call bell system is in place.
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Ysbyty Cwm Rhondda Ward B2_ 11-12 April 2024 (Ref: 03467)	Provide HIW with details of a robust system where nurses can alert other staff in the event of an emergency.	Staff members are to be provided with personal safety alarms. These alarms will ensure that during an emergency event on the ward they would be able to alert all staff in the ward area.	Primary Care & Community	26.04.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the ionising radiation protection policy, nuclear medicine procedures and radiology employer's procedures are reviewed for consistency, to remove duplication and ensure accuracy. Consideration should be given to having one set of procedures that cover radiology and nuclear medicine.	Discrepancies between the Ionising Radiation Protection Policy (IRPP) and Employers Procedures (EPs) will be addressed and the documents will be consolidated into one set of procedures. The nuclear medicine procedures will be incorporated into these.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that the relevant employer's procedure and IRPP are reviewed to ensure the process for entitlement is consistent between the two documents and accurate with current practice.	Both of these documents will be reviewed for consistency and current practice.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the entitlement documentation for all staff includes their scope of practice for all of their duty holder roles.	Entitlement records are being completely overhauled with the introduction of an Entitlement Certificate for each individual which will detail entitlement for individual IR(ME)R tasks.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that: •Entitlement documentation is completed in full, with appropriate information on entitlement •Training records of the staff should be updated to ensure that staff competences were assessed by an appropriate individual who has been delegated the task by the employer.	Entitlement records are being completely overhauled with the introduction of an Entitlement Certificate for each individual which will detail entitlement for individual IR(ME)R tasks. This will remove the additional 'date of entitlement'. Training records are being updated to ensure correct authorisation of training.	Diagnostics, Therapies, Pharmacies and Specialities	30.09.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the medical referrers are sent a letter of their entitlement as required by the IRPP.	This item is under review by Clinical Director and other parties to define how this requirement will be addressed.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to review the use of the DAG for the administration of radiopharmaceuticals and update this to reflect the entitlement process for individuals entitled to administer radiopharmaceuticals.	Delegated authorisation guidelines (DAGs) are being phased out and encompassed within the individual entitlement certificates. Any terminology changes will be made during this process.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that the: •Employer's procedure includes instructions on how to evidence patient identification checks have been made where there are multiple exposures or operators involved. •Completion of referral forms are clear where there are multiple operators and contact points.	Employers procedure will be updated to cover this situation.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the relevant employer's procedure includes the process for verifying pregnancy and breastfeeding status when the patient is unable to respond and the subsequent agreement of the practitioner.	Employers procedure will be updated to cover this situation.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must review the information in the written employer's procedures and the nuclear medicine procedure for providing written instructions and information to the patient for accuracy and to remove duplication. Consideration should be given to having a single procedure only.	Employers procedures will be updated with any duplication addressed. A single document will capture all procedures.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to consider the differences between IR(ME)R audits and clinical audits and ensure that appropriate procedures reflect this difference and ensure that feedback from IR(ME)R audits are communicated with the MPE.	Employers procedure will be updated to address this.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the employer's procedure for the reporting and investigation of accidental and unintended exposures is updated to include: •Delete references which were not relevant to the procedure. •Update the definition of a significant accidental or unintended exposure to reference the guidance supported by HIW. •Refer to the notification criteria required by HIW.	Employers procedure will be updated to address this issue.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the: •Employer's procedure for practical training for practitioners and operators is reviewed and includes the relevant nuclear medicine tasks and equipment as appropriate. •The record of staff competency and scope entitlement procedure is reviewed alongside the employer's procedure and includes the correct forms which are used in staff training records.	Employees procedure will be update to provide clarity with a standard approach in all documentation.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the employer's procedures reflect the use and scope of MARS for recording training records of practitioners.	Employers procedure will be updated to reflect that the use of the Medical Appraisal Revalidation System (MARS) is used for the training records of practitioners.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the employer's procedure relating to justification and authorisation: •Is reviewed and updated to refer to the duty holders and their scope using appropriate terminology with reference to IR(ME)R and to clarify the lines of responsibility for justification and authorisation. •Reflects the processes used in nuclear medicine.	The Employers Procedures (EP's) are being updated to cover all areas in radiology, including Nuclear Medicine	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the written employer's procedure and the nuclear medicine procedure for paediatrics are reviewed and updated for accuracy of terminology and to be clear on the age range that it applies to.	The Employers procedure (EP) is being updated to reflect current legislation with the correct age for paediatrics in both procedures	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to eliminate the duplication between the QA handbook and the other nuclear medicine QA procedures and consolidate these within the QA handbook as appropriate.	There are separate Quality Assurance (QA) books provided by the Medical Physics Expert (MPE) for general radiology and nuclear medicine. This duplication has arisen as the new nuclear medicine camera has a CT element. We will combine the Quality Assurance (QA) handbooks and work with the Medical Physics Expert (MPE) to achieve this.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	
Healthcare Inspectorate Wales (HIW)/2024/185	14.04.2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is required to review the referral forms alongside the procedure for the completion of referral forms to ensure that the method for the completion of forms is consistently applied. Ideally the documentation should be standardised to aid completion.	The POW referral form is going to be replaced with the CTMUHB electronic form. We acknowledge that in the meanwhile we will make sure our EPS are followed regardless of the referral form submitted and will be vigilant during the transition period.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024		In progress	

JAG (Joint Advisory Group on GI Endoscopy) Update – July 2024

Emily Bowden – Service Manager
Matthew Flage – Operational Support Manager

Joint Advisory Group (JAG)

Joint Advisory Group on GI Endoscopy

Accreditation is a supportive process of evaluating the quality of clinical services by guiding services through a quality framework. Accreditation promotes quality improvement through highlighting areas of best practice and areas for change, encouraging the continued development of the clinical service. Accreditation is a voluntary process for services to engage in.

Having developed standards with a multi-professional group of clinicians, managers and patients, services participating in JAG accreditation work to an accreditation pathway which involves self-assessment and quality improvement against the standards. Accredited services submit evidence annually to demonstrate that they are continuing to meet the standards and have a 5-yearly on-site assessment carried out by our experienced assessment team.

1. Quality Improvements & Accreditation Pathways, 2. Tracking Process, 3. Assessments

The standards

The standards have been established with the gastrointestinal (GI) community and are intended to provide patients/service users, healthcare professionals and senior leaders with assurance of the quality of the service provided. The standards cover all aspects of a high-quality clinical service and are organised into four domains:

Clinical quality - The clinical quality domain encompasses the service's role in safe and effective diagnosis, treatment and ongoing management. Key to this is the service infrastructure including leadership and governance.

Patient experience - The patient experience domain encompasses the service's role in providing efficient and patient-centred care for all patients, which includes reviewing waiting times, facilities and the environment.

Workforce - The workforce domain focuses on effective training and support for staff, including the recruitment, retention and continued professional development of team members.

Training - The training domain reviews the support and development of trainee endoscopists, including appraisal and competencies. Services that do not provide training in endoscopy, typically those in the independent sector, are only assessed against the first three domains.

Princess of Wales Hospital (POW)

- JAG accreditation at risk – unaffordable interim solution to deliver JAG complaint decontamination model
- Team currently has all evidence required for JAG accreditation
- Final evidence submission for re-evaluation is 29/07/2024
- Long term solution for new decontamination unit being finalised

Prince Charles Hospital (PCH)

- New Endoscopy (JAG designed) Suite opened.
- GRS (Global Rating Scale) – is beginning to be worked on and evidence is being accumulated.
- 1st lists in 3rd theatre commencing September 2024 (mobile endoscopy unit will cease at this point)
- Working group to be set up, discussed in PCH Endoscopy Users Group meeting 24/07/2024.
- Decontamination Unit to be handed over to HSDU September 2024.

Royal Glamorgan Hospital (RGH)

- New Band 6 position starting who will take a lead on JAG.
- Internal JAG preparation meetings now established to work through gap analysis.
- All JAG audits complete, will be presented during audit day.
- GRS (Global Rating Scale) being progressed, with a working group starting September 2024.

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Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

August 2024

NWSSP Audit and Assurance Services

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Appendix A – Tables showing detailed progress against audit plans



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

Disclaimer notice - please note

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cwm Taf Morgannwg University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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 05 August 2024. This report provides information on the status of progress of our reviews.
- 1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

- 2.1 Since the June meeting of the Committee one report has been finalised, six reports are in draft, and we have ongoing fieldwork in relation to seven reviews. A summary of the position of the finalised report, 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
PCH – Delivery of key project objectives	-	4	1	5	Reasonable

3 Delivering the Plan

- 3.1 Our work in 2024/25 includes a programme of work in relation to PCH. The plan is on the agenda for this Committee.

4 Feedback

- 4.1 A post audit questionnaire is issued to the key health board staff that we have worked with alongside our final report. This is one of our ways of getting feedback on the audit process so that we can look to make improvements. In 2023/24 we received very few responses to our questionnaires. We will work with the Health Board to see how we can improve this return rate.

5 Other activity

Joint Commissioning Committee (JCC)

- 5.1 We have had a number of planning meetings with officers of the JCC to discuss our work programme for 2024/25. Scoping meeting on 06.09.24 for Mental Health directorate review brought forward from 2023/24 programme.

Meetings

- 5.2 We continue to meet regularly with the officers of the Health Board, Counter Fraud, and Audit Wales colleagues.
- 5.3 We also regularly observe the Board and committees of the Board to help ensure we have an understanding and gain valuable insight into the activity of the organisation.

Appendix A – Programme of work**Table 2: Status of reports included in annual opinion for 2023/24 as draft**

Plan Ref.	Review	Rating	Status	Notes
4	Estates condition	Limited	Draft	Part of all Wales review - Updated draft report issued 18.10.23. Following management feedback, updated report issued 23.07.24.
-	Follow up – Patient pathway appointment management	Limited	Draft	Draft report issued 09.05.24
23	Follow up – medical variable pay	Reasonable	Draft	Draft report issued 24.05.24
25	Follow up – reasonable offer	Reasonable	Draft	Draft report issued 17.06.24
-	PCH – Delivery of key project objectives	Reasonable	Final	On August Committee agenda.

Table 3: 2024/25 Core programme of work for Q1-Q2

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
-	Embedding the quality framework - Brought forward from 2023/24	Reasonable	-	Aug	Draft	-	-	Draft report issued 30.07.24. Debriefed 02.08.24.
T07	Information provision – Intelligence led organisation	Reasonable	Q1	Oct	Drafting	-	-	Fieldwork completed. Report and file under review. Taken longer/annual leave
-	PCH – Supply chain partner management – Brought forward from 2023/24	-	-	Aug	WIP	-	-	Waiting for information to complete. Understand management annual leave.
T10	Duty of candour	-	Q1	Oct	WIP	-	-	Fieldwork started 12.07.24
T18	Capital systems	-	Q2	Oct	WIP	-	-	Fieldwork started 10.07.24
T19	Energy management	-	Q2	Oct	WIP	-	-	Fieldwork started 10.07.24
T20	Charitable funds	-	Q2	Oct	WIP	-	-	Fieldwork started 29.07.24

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T27	Follow up – Facilities governance arrangements	-	Q1	Oct	WIP	-	-	Fieldwork started 19.07.24.
T31	Follow up – Financial savings	-	Q1	Aug	WIP	-	-	Fieldwork started 28.06.24. Delayed due to annual leave on both sides.
T28	Follow up – Performance management – 4 hour target	-	Q2	Oct	Planned	-	-	Brief agreed. To start in September.
T29	Follow up - INNU	-	Q2	Oct	Planned	-	-	Brief agreed. Planned to start 14.08.24.
T33	Follow up – SLA arrangements	-	Q2	Oct	Planned	-	-	Brief agreed. Management request to delay start until Autumn due to new staff members.
T16	Additional medical pay	-	Q1	Oct	Planned	-	-	Brief agreed. To start w/c 05.08.24.
T15	New PDR process	-	Q1	Oct	Planning	-	-	Scoping meeting on 10.07.24. Brief being

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
								drafted, awaiting additional information.
T17	Medical job planning	-	Q2	~~Oct~~ Dec	Planning	-	-	Scoping meeting on 24.07.24. Brief being drafted. Management request to start Sept/Oct.
T22	Vaccination policy implementation	-	Q2	Oct	Planning	-	-	Management requested scoping meeting delayed until 08.08.24
T23	Regional integration fund	-	~~Q2~~ Q3	~~Oct~~ Dec	Planning	-	-	Scoping meeting 06.09.24. Management request to delay until Sept due to new staff in post
T01	New care group model	-	Q2	Dec	Planning	-	-	Initial discussion planned for 05.09.24.

PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report

July 2024

Cwm Taf Morgannwg University Health Board



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Review reference:	CTM-SSU-2324-04
Report status:	Final
Fieldwork commencement:	March 2024
Fieldwork completion:	June 2024
Draft report issued:	June 2024
Management response received:	July 2024
Final report issued:	July 2024
Auditors:	NWSSP: Audit & Assurance - Specialist Services Unit (SSu)
Executive sign-off:	Sally May, Director of Finance
Distribution:	Tim Burns, Assistant Director of Strategic & Operational Planning Jeremy Holifield, Responsible Officer, Prince Charles Hospital Construction Programme
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.

Disclaimer notice - please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cwm Taf Morgannwg University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The objective of this audit was to review the performance of the Prince Charles Hospital (PCH) Redevelopment Programme against the key performance objectives of time, cost and quality.

Overview

Based on the findings of the audit, **reasonable assurance** has been determined in respect of this discrete area. The opinion was derived from the following:

Time:

The overall programme had been extended by 21 working days – with the contractor anticipating a further delay to this programme of 12 working days beyond the current approved programme. Given the length of the construction programme and intrusive nature of the works, these are not considered material.

Cost:

At the time of reporting, the forecast outturn cost position was anticipating an overspend of £993k, with £2.4m of contingency remaining. The outturn cost was predicated on:

- The VAT reclaim remaining at the lower interim assessment – a reduction in reclaim of circa £1m.
- That remaining high risks £3,672,684 do not materialise in full.
- Welsh Government approve the use of any future gain share arising – currently the total estimated gain share was included at £3.68m.
- Design costs for section 7 remain at the Project Manager’s assessed cost of £1.2m - rather than the £1.8m claimed by the Supply Chain Partner.

Recognising that increased controls have been introduced to manage the cost position, noting that the UHB may not be able to manage overspends within its own resources (e.g. discretionary capital programme), it is recommended that appropriate risk management arrangements are put in place for potential overspends.

Quality:

Positive progress has previously been reported on all prior audit recommendations, which demonstrated

Report Classification



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance Summary ¹

Assurance objectives	Assurance
1 Time	Substantial
2 Cost	Reasonable
3 Quality	Reasonable

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

management commitment to learning lessons and continuously improving.

The overall of quality of the works were not identified as a concern and issues raised were also resolved in a timely manner.

There had been an issue with the architectural service in relation to design fees to date, amounts claimed and forecast costs relating to the introduction of section 7 to the current phase of works. At a point, the architect suspended services due to some of the issues but had latterly reinstated the service whilst section 7 specific issues were resolved. These issues require resolution as a matter of priority to determine the likely impact on cost and programme.

Further details and remaining recommendations are provided within **Appendix A** of this report.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Financial risk management measures should be explored for the potential overspend at the programme.	2	Operation	Medium
2	Delays/ costs attributed to the Section 7 design and construction works should be agreed.	2 & 3	Operation	Medium
3	The remaining risk position should be reviewed and updated.	2	Operation	Medium

1. Introduction

- 1.1 This audit originated from the 2023/24 integrated audit plan for the PCH Redevelopment Programme, agreed with management and approved by the Audit and Risk Committee.
- 1.2 The Prince Charles Hospital (PCH) Phase 2 Ground and First Floor works had been developed with six sections of works with a total approval of £220m (which includes an allowance of £23m for inflation) and completion anticipated in June 2026.
- 1.3 Prior audits from the 2023/24 integrated audit plan have focused on discrete risk areas, whereas this audit focused on the overall performance of the programme against the key performance objectives of time, cost and quality.
- 1.4 The potential risks considered in this review included:
 - The time performance of the programme is not being managed adequately.
 - The programme is not being managed within agreed cost parameters.
 - The quality of works and services provided on the programme may not be subject to the required level of scrutiny and challenge.

2. Detailed Audit Findings

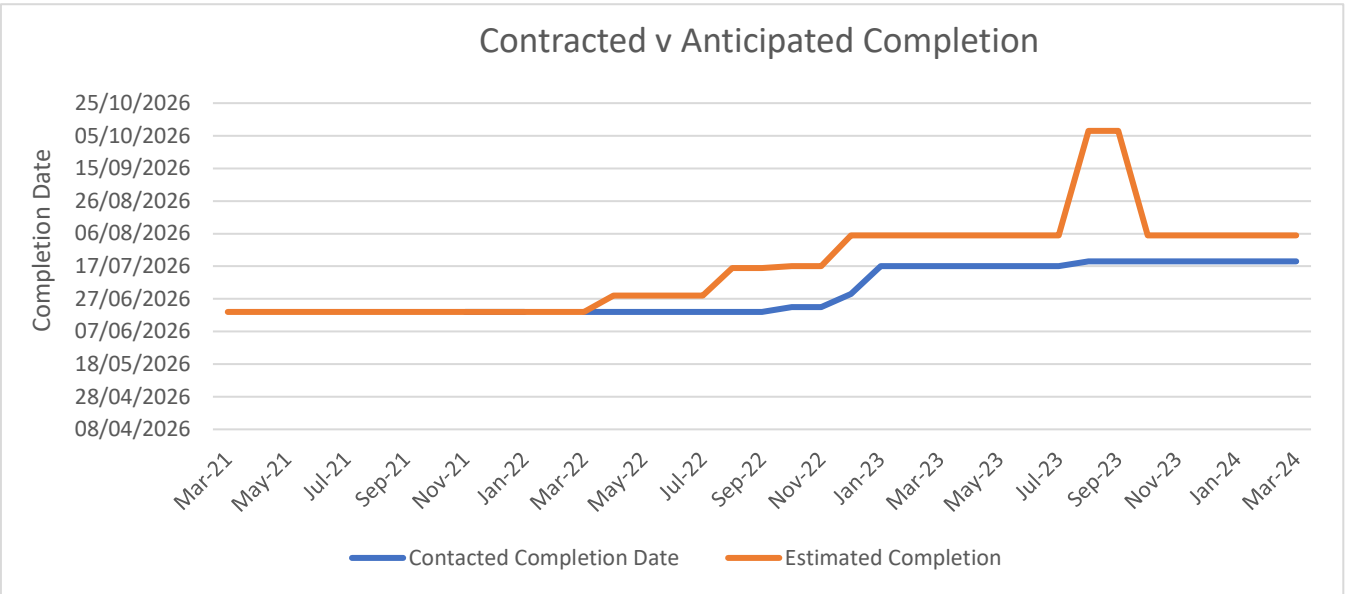
- 2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed within Appendix A.
- 2.2 At a programme audit, levels of assurance are determined on whether the programme achieves its original key delivery objectives and that governance, risk management and internal control within the areas under review are suitably designed and applied effectively.

Time: to evaluate the programme's adherence to established timelines and milestones. Ensuring that key dependencies and the critical path were identified and routinely monitored - including an assessment of any delays to date.

- 2.3 The programme of works includes six sections. At the time of review, the following was noted in respect of each section:

Section	Status
1	Complete 8 th April 2022
2	Complete 6 th December 2022
3	Anticipated Completion 16 th September 2024
4	Anticipated Completion 14 th April 2026
5	Anticipated Completion 5 th August 2026
6	Complete 21 st March 2023
Overall	Anticipated Completion 5 th August 2026

2.4 An assessment of the movement in both the Supply Chain Partner’s anticipated completion date and the contractual completion date outlines the following:



* Note that the Supply Chain Partner anticipated delay in July 2023 was fully mitigated by the overlapping of sections 4 & 5.

- 2.5 Since commencement in November 2020, the overall programme delivery had only been extended from 22nd June 2026 to 20th July 2026 – a total of 21 working days extension. These were attributed to additional public holidays in the period, removal of furniture/equipment and additional asbestos removal. The Supply Chain Partner was currently anticipating a further delay, over and above the extension awarded, to the 5th August 2026, however this had not been assessed to date. Given the value, size and intrusive nature of the work, this was not considered unreasonable.
- 2.6 The design element of a further section (Section 7) was originally anticipated to be completed as part of the next phase (Phase 3) of the PCH Redevelopment Programme but had been brought forward to the current phase with the support and release of funding by Welsh Government. The programme for this design element of work had yet to be agreed – the 18-month proposed programme having been rejected by the Health Board – see also the [Cost](#) and [Quality](#) section of this report.
- 2.7 Based on the minimal impact on the programme to date, **substantial** assurance has been determined.

Cost: an assessment of the adequacy of financial management arrangements and reporting to ensure that costs were managed within agreed budgets – including the cost impact of any changes to the original requirements.

2.8 The latest progress report prepared by the external Project Manager (submitted April 2024), highlighted the cost position as a red risk – this having remained

unchanged since April 2022 and attributed to a variance in the anticipated and assessed VAT reclaim percentage.

2.9 The latest cost position can be summarised as follows:

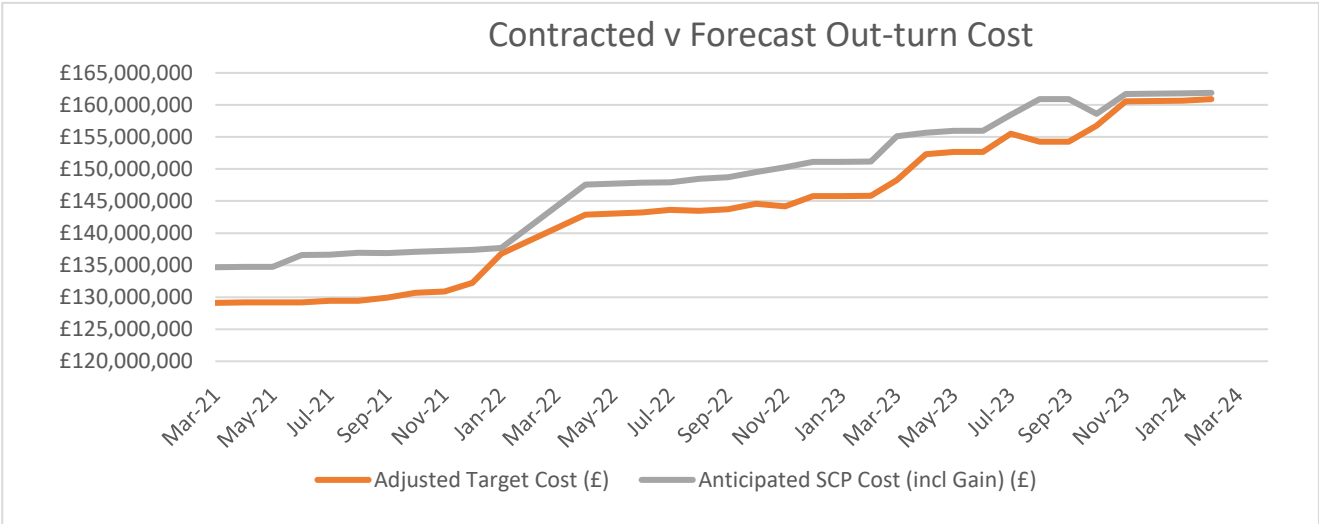
	Business Case	Forecast Outturn
Target Cost (i)	129,789,879	129,789,879
Changes (i)		33,489,083
Anticipated Changes (i)		1,039,778
Less SCP Gain Share		-909,897
Less UHB Gain Share		-3,679,944
	129,789,879	159,728,899
Fees	8,651,054	10,200,698
Non-Works Costs	653,284	786,193
Equipment*	10,083,636	12,205,195
Provisional Sums (ii)	11,802,000	142,000
VAT Reclaim (iii)	-11,976,611	-11,875,630
Contingency (iv)	11,552,403	2,399,701
Additional Contingency (iv)	169,668	
	160,725,313	173,587,056
VAT	33,736,948	37,180,009
SCP Gain Share		909,897
UHB Gain Share (v)		3,679,944
Inflation (vi)	22,925,761	5,910,626
Additional Section 7 Works (vii)	2,886,903	
	220,274,926	221,267,532
Overspend		992,606

* It is suggested that Fees, Non-works and Equipment is subject to a separate audit review in 2024/25.

2.10 The current forecast was that the programme would be delivered over the approved funding allocation by approximately £992,606. This was based on some key assumptions which may subject to change (see full details below) and recognised that circa £2.4m of contingency remained, equating to 21% of the original contingency with 41% of the programme remaining (i.e. 172 weeks in to a 294-week programme). Given the current outlook and potential pressure on remaining contingencies if further risks materialise, it is recommended that appropriate risk mitigation arrangements are put in place to manage this financial risk, recognising that the amounts involved may not be manageable within the UHB's discretionary capital allocation and would be reliant on Welsh Government funding to meet the original objectives. **(MA 1)**

2.11 The overall costs have been impacted by:

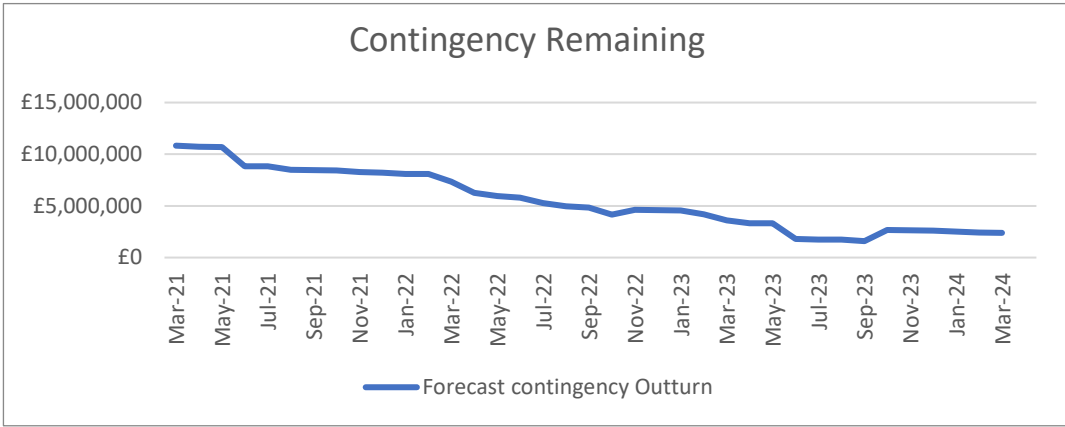
(i). **Target Costs & Changes** - The overall target cost and Supply Chain Partner forecast outturn cost was reported as follows:



The Target Cost for the works had been adjusted upwards by £34.53m, this was represented by £11.8m for provisional sums, £14.9m for inflation and the remaining £7.8m relating to unforeseen changes (or a 5.7% increase on works costs). This may be considered reasonable for a programme of this size/ nature.

- (ii). **Provisional Sums** - A sum of £11,822,000 was included for cost elements that could not be adequately priced at the time of agreeing the target cost. As at March 2024, these sums were shown as fully instructed, and applied by changes to the Target Cost. The outturn cost position on these elements was £14,185,134 – with the increased costs funded from contingency.
- (iii). **VAT reclaim** - The VAT reclaim estimate provided within the Full Business Case was based on the VAT adviser’s assessment of 34.18%, with the latest interim VAT reclaim determined as 31.08%. This was reported as a cost pressure on the programme of circa £1m and was reflected within the current forecast outturn cost.

(iv). **Risk & Contingency** - The assessed contingency for the period to date was as follows:



Noting that two sections (sections 4 & 5) are not due to complete until mid-2026, there was potential for there to be pressure on remaining contingencies in the period (reported as £2,399,701).

To assist in actively managing the contingency, it was recognised that annual budgets were assigned for contingency. Noting the timing of the audit, the 2024/25 contingency budget had been set at £1,133,020 with only £10,000 committed to date.

The last review of the programme risk register was undertaken in October 2023, with remaining high risks quantified at £3,672,684 – more than the available contingencies remaining. Noting the potential pressures outlined, the risk register should be regularly revisited to determine whether any changes are required to the reported risks, probability and/or associated costs. **(MA. 3)**

(v). **Gain Share** – At NEC contracts, ‘gain share’ refers to a collaborative incentive mechanism that encourages cost savings and efficient programme management by sharing the benefits of cost savings between the Health Board and the Supply Chain Partner up to a pre-defined cap. At the three completed sections to date, the Health Board had benefitted as follows (subject to agreement of the respective final accounts):

- Section 1 - £296,111
- Section 2 - £72,467
- Section 6 - £192,478

The outturn cost position assumed a total UHB gain share across all sections of £3,679,944. This was reported as positively impacting the reported outturn cost but will be subject to the Supply Chain Partner performance on

the remaining sections. Additionally, the retention of any gain share will require Welsh Government approval.

(vi). Inflation - Inflation at the programme had been claimed at £14,907,583, from a pre-construction estimate of £22,925,761. As the programme enters the latter stages of construction the potential additional costs for inflation may also increase as we move further away from the original market tested prices. The inflation position is being monitored with NWSSP: Specialist Estates Services to anticipate the future requirement/ impact.

(vii). Additional Section 7 Works – As noted previously, section 7 works were originally anticipated to be completed as part of the next phase (Phase 3) of the PCH Redevelopment Programme, but Welsh Government funding was secured to bring forward the design element of the section 7 works to the current phase. The Project Manager rejected the Supply Chain Partner's assessment of costs of £1.8m, with their own assessment being in the region of £1.2m. This remained unresolved at the time of audit, despite the design work having been initially instructed in March 2023 and largely concluded at the time of review. The current forecast outturn cost was assessed based on the Project Manager's assessment **(MA. 2)** It should also be noted that, based on the Supply Chain Partner's assessment, that the section 7 works element had increased from the Programme Business Case estimate of £22.4m with an 87-week programme to £37.3m with a 224-week programme. The works element for Section 7 was not currently part of the approved/ funded elements for this phase but was of concern for the overall deliverability of the programme.

2.12 In conclusion, as is usual within construction projects, increased controls have been applied as the remaining contingencies deplete, to avoid potential overspends/ cash flow issues. Based on the controls in place and the current forecast overspend, **reasonable** assurance has been determined, however the cost pressures outlined will need to be closely managed through to completion.

Quality: to assess the extent to which programme deliverables (both products and services) meet or exceed predetermined standards and/or requirements.

2.13 Generally, the quality of work had not been an issue, with issues rectified in a timely manner as observed at the PCH Redevelopment Programme: Supervisor Role audit report issued in December 2023 and providing substantial assurance. The audit confirmed that robust systems were in place to ensure the quality of works and that issues were resolved in a timely manner.

2.14 Recently, the Supply Chain Partner's architect had suspended services due to the Project Manager withholding payment for unsubstantiated fees during November and December 2023. At the time of review, the Project Manager had yet to receive sufficient information to allow payment of the £85k being claimed. **(MA 2)**

2.15 It is understood that services have been reinstated for all sections with the exception of section 7. **(MA 2)**

Appendix A: Management Action Plan

Matter Arising 1: Outturn Cost (Operation)	Impact
At the time of the current review, the Cost Adviser indicated that there was an expectation that the programme would be delivered circa £993k over the approved funding allocation. This overcommitment was primarily subject to: • Final confirmation of the VAT reclaim percentage, with the current outturn based on the lower interim assessment of 31.08% reclaimable (as compared to an estimate of 34.28% at the business case). • The outturn cost position assumes that existing and forecast gain shares will be retained by the UHB totalling £3,679,944 – however this would be subject to Welsh Government approvals. • Identified risks are currently costed at £9,733,332 with high risks valued at £3,672,684 – this was more than remaining available contingencies of £2,399,701. Should remaining high risks emerge, there could be potentially further pressures on the programme funding position. Recognising the uncertainties outlined above, and that the programme had a significant period to completion, appropriate strategies should be considered for the potential additional funding requirements – particularly noting that the amounts involved may not be manageable within the UHB's discretionary capital allocation.	Potential risk: • Cashflow risk – that the programme and Health Board will not be able to meet their debt obligations as they become due.
Recommendations	Priority
1.1 The Health Board should evaluate and source possible funding options (if full, partial, or no additional funding is realised) as a matter of priority. This may also include an evaluation of wider options e.g. continuation, reduced scope etc.	Medium

1.2	The current programme funding risks should be noted at the programme risk register.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	Acknowledged. Discussion fronted by UHB VAT advisers, on behalf of the Health Board, is ongoing with HMRC about VAT recovery and they are confident that recovery will be as predicted in the business case. Notwithstanding, attention has been given to possible other sources should HMRC not change their position, such as gainshare. At a meeting with NWSSP SES on 19/6/24, it was agreed that the overall out-turn position would be monitored and reported on in the Cost Adviser's monthly reporting.	2 months	Responsible Officer, Prince Charles Hospital Construction Programme
1.2	Noted. The risk presented by the VAT recovery rate matter above will be quantified in the risk register.	2 months	Responsible Officer, Prince Charles Hospital Construction Programme

Matter Arising 2: Section 7 works (Operation)	Impact
Welsh Government had approved £2,886,903 of additional funding to bring forward the design element of Section 7 works from Phase 3 of the overall programme to the current phase (Phase 2). At the time of review, the proposed fees presented by the Supply Chain Partner for the design element of these works equated to £1.8m with a programme more than 18-months. Neither the cost nor programme were accepted by the Project Manager, based on their own assessment of costs being in the region of £1.2m. This remains unresolved, despite the SCP being instructed to progress the design element in March 2023 and 1:200/ 1:50 drawings having been fully signed off. Based on the design completed, the Supply Chain Partner had estimated that the cost had increased from £22.4m at Programme Business Case to £37.3m and the associated programme increased from 87 to 224 weeks. The Supply Chain Partner had subsequently been instructed to market test this scope with a scope reduction exercise to be undertaken thereafter. Separately, the SCP appointed architects initially suspended their services in response to the withholding of payments on design elements for Section 7 – the Project Manager having determined that the amounts were not sufficiently substantiated to allow payment under the terms of the contract. Whilst architectural services have been reinstated, they remain suspended for Section 7 and disputed costs remain unresolved. These matters require resolution as a priority so as not to delay the overall programme. The latest progress report recognised a potential impact on 'design', however the self-assessed performance indicator reported 'programme' as green. It is accepted that it is difficult to assess the time and cost implications until the matter is resolved, however it may be prudent to review the performance indicator accordingly. The associated risk had been raised within the progress reports but should also be recognised at the programme risk register with appropriate remedial action.	Potential risk: • Remaining elements of work yet to be instructed are unaffordable.

Recommendations		Priority	
2.1	The dispute on design fees for Section 7 should be agreed as a matter of priority.	Medium	
2.2	The performance indicator for the 'programme' should be updated to reflect potential delays that may arise from the issues relating to Section 7.	Medium	
2.3	The programme risk register should include risks pertaining to the Section 7 design fee, disputed/ withheld fees and the increased cost/ programme associated with the works.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	Agreed. Discussions ongoing.	3 months	Responsible Officer, Prince Charles Hospital Construction Programme
2.2	Agreed, noting 'design' performance indicator (not 'programme' indicator) updated accordingly since the time of audit fieldwork and issuing of draft report.	2 months	Responsible Officer, Prince Charles Hospital Construction Programme

2.3	Agreed.	2 months	Responsible Officer, Prince Charles Hospital Construction Programme
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Matter Arising 3: Risk Register (Operation)		Impact	
A good risk register is a critical tool in project management, particularly in complex and invasive construction works. The risk register is intended to operate as a living document that is regularly updated, allowing for continuous monitoring and control of risks throughout the project lifecycle. The risk register was last updated in October 2023, reducing the total risk costs by £656,085 to £9,733,332. At the time of reporting, the high risks alone constituted £3,672,684 of total risks. Noting that programme contingencies are currently being reported as £2,399,701, and that three sections are now complete, it would be prudent to review the risks, probability and/or associated costs.		Potential risk: Risks are over/ under stated.	
Recommendations		Priority	
3.1	The risk register should be reviewed for accuracy and updated to reflect the status of the programme.	Medium	
Agreed Management Action		Target Date	Responsible Officer
3.1	Actioned since the time of audit fieldwork and issuing of draft report. Risk Register reviewed and updated in May 2024, High risk currently £835,548. Contingency £1,720,376.	N/A	N/A

Matter Arising 4: Insurances (Operation)			Impact										
The contractor is required to demonstrate the continuance of insurances for the duration of the construction period. It is the responsibility of the externally appointed Project Manager to verify the same. The latest progress report submitted in April 2024 outlines: <table><tr><td></td><td>Expiry Date</td></tr><tr><td>Employers Liability Insurance</td><td>30th March 2023</td></tr><tr><td>Third Party Liability</td><td>30th March 2023</td></tr><tr><td>Contractors 'All Risks' Insurance</td><td>TBC</td></tr><tr><td>Professional Indemnity Insurance</td><td>24th October 2023</td></tr></table>				Expiry Date	Employers Liability Insurance	30 th March 2023	Third Party Liability	30 th March 2023	Contractors 'All Risks' Insurance	TBC	Professional Indemnity Insurance	24 th October 2023	Potential risk: The interests of the UHB are not adequately protected.
	Expiry Date												
Employers Liability Insurance	30 th March 2023												
Third Party Liability	30 th March 2023												
Contractors 'All Risks' Insurance	TBC												
Professional Indemnity Insurance	24 th October 2023												
Recommendations			Priority										
4.1	The externally appointed will verify that contractor’s insurances remain current and update the progress report accordingly.		Low										
Agreed Management Action		Target Date	Responsible Officer										
4.1	Noted and agreed. Project Manager will ascertain insurances are extant.	2 months	Responsible Officer, Prince Charles Hospital Construction Programme										

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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PCH Redevelopment Programme Integrated Audit Plan 2024/25

July 2024

Cwm Taf Morgannwg University Health
Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



1. Background

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

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

The UHB made a provision for the Audit fee within the Phase 2 Business Case – accordingly, this paper updates the original plan and provides clarity on the potential coverage for 2024/25.

2. Methodology

This paper sets out the risk-based audit plan for 2024/25 – subsequent year’s requirements will be risk assessed and agreed with management. The proposal has been drafted in compliance with the Public Sector Internal Audit Standards.

For the purposes of this plan, key source information has been utilised as provided during the recent 2023/24 audits. The current programme anticipates:

Section	Status
1	Complete 8 th April 2022
2	Complete 6 th December 2022
3	Anticipated Completion 16 th September 2024
4	Anticipated Completion 14 th April 2026
5	Anticipated Completion 5 th August 2026
6	Complete 21 st March 2023
Overall	Anticipated Completion 5th August 2026

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

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

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

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

3. Outputs

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

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

4. Recommendation

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

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

The Audit & Risk Committee is asked to note the attached audit plan for 2024/25.

Appendix A: Audit Plan 2024/25

Assurance/Approval	Outline Scope	2024/25												
		April	May	June	July	August	September	October	November	December	January	February	March	Total
Programme/Project Milestones														
Phase 2: Construction Phase	Section 1: Complete 08/04/22													
	Section 2: Complete 06/12/22													
	Section 3: Anticipated Completion 16/09/24	Construction												
	Section 4: Anticipated Completion 14/02/26	Construction												
	Section 5: Anticipated Completion 05/08/26	Construction												
	Section 6: Complete 21/03/23													
General Programme-Level Assurance														
Validation of Management Action	Assurance of Timely/ Appropriate Management Action													
Delivery of Key Project Objectives	Time Cost Quality													
Governance	Defined Arrangements Effectiveness of Operation Adequacy of Management and Control Arrangements Approvals Readiness to Proceed Adequacy and effectiveness of work streams													
Functional Assurance														
Financial	e.g. Approvals Budget setting Financial Monitoring/Management Use of Project Bank Accounts Cost Control Risk Management (and associated costs) Ongoing Cost Management Management of UHB Costs													
Technical	e.g. Programme Management Determination of Target Cost Tender Evaluation Validation of costs to date Calculation of Pain/Gain Adequacy of site surveys incl. Construction Environmental Management Plan, Green Information Management System, EPS Licence arrangements etc. Compliance with Framework Conditions Utilities Management Compliance with third party agreements Agreement of the Final Account													
Design	e.g. Design Brief Affordability Management of Derogations Impact of Value Engineering / Affordability Analysis Compliance with Design Warranties Sign Off/Approvals Change Management													
Change Control	e.g. Change Management Arrangements Delegated Authority Case for Change Approvals Change - Cost control													
Equipment	e.g. Procurement Use of single tender actions/National frameworks etc Specification/User requirements													

Assurance/Approval	Outline Scope	2024/25												Total
		April	May	June	July	August	September	October	November	December	January	February	March	
	Warranty/Guarantees Delivery/Installation & Commissioning													
Supply Chain Partner Management	e.g. Resource Management Performance Management Site Records/ Controls Monitoring & Reporting Responsiveness Handover													
Advisers	e.g. Appointments Contractual arrangements Fee Management Monitoring/Reporting Performance													
Quality	e.g. Site Supervisor role Planning Conditions Design Review & Approval BREEAM Performance Management													
Information	e.g. Information Management Systems													
Stakeholders	e.g. Stakeholder engagement Fire Service engagement													
Non- Opinion Assurance														
Attendance at Key Meetings														
SRO/Deputy SRO Support														
General Advisory Support														
Audit Committee Prep & Attendance														
														£ 55,773.30

Technical Resilience Final Internal Audit Report

June 2024

Cwm Taf Morgannwg University Health Board

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Review reference:	CTM-2324-20
Report status:	Final
Fieldwork commencement:	3 April 2024
Fieldwork completion:	24 April 2024
Draft report issued:	1 May 2024
Management response received:	3 June 2024
Final report issued:	7 June 2024
Auditors:	Martyn Lewis IT Audit Manager
Executive sign-off:	Stuart Morris, Director of Digital
Distribution:	Paul Chilcott, Lead Infrastructure Architect
Committee:	Audit and Risk Assurance 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.

Disclaimer notice - please note

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The purpose of the review was to provide assurance that there is enactment of technical resilience and awareness of fault domains to ensure the Health Board is maximising the potential for resilience within the architecture.

Overview

We have issued Reasonable assurance on this area.

Digital services are provided using a resilient architecture, and there have been recent improvements with a new room within Prince Charles Hospital and a move towards a hyper converged environment. However, we note that DR site provision does not enable full capacity. There is some testing of aspects of resilience and there are recovery plans and instructions in place, although these have not been updated to reflect the new environment.

There is a good process for backing up Health Board data, and we note recent improvements to this. Where incidents occur there is a process for investigation and learning lessons to reduce future recurrence.

The key issues requiring management action are:

- fully testing the resilience position;
- ensuring appropriate DR plans and instructions are in place for all aspects; and
- defining a priority for emergency service provision and restore order.

Report Opinion

		Trend
 Reasonable assurance	Some matters require management attention in control design or compliance.	None
	Low to moderate impact on residual risk exposure until resolved.	

Assurance summary¹

Objectives	Assurance
1 Resilience Design.	Reasonable
2 Resilience Testing	Reasonable
3 Recovery Plan	Limited
4 Back Ups	Substantial
5 Continual Improvement	Substantial

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
3	Resilience Testing	2	Operational	Medium
4	Disaster Recovery Plan	3	Operational	Medium
5	Application DR Plans	3	Operational	Medium
6	Restore / Resilience Priority	3	Operational	High

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') a review of technical resilience has been undertaken in order provide assurance of the Health Board's ability to maintain acceptable service levels through, and beyond, severe disruptions to its critical processes and the IT systems which support them.
- 1.2 In an environment where technology outages impact an organisation's ability to operate, and customers require services to be 'always on', near-instantaneous recovery is often required with minimal data loss. The environment is made up of inter-related layers, each with its own risks and resilience requirements:
- **Infrastructure** – the foundation layer consists of components such as power, network connectivity, physical security and environment controls, and data centres providing the hosting environment.
 - **Environment** – the infrastructure supports the environment and is the storage and compute functions of the systems (cloud, physical or virtual servers).
 - **Platform** – the environment supports the platform which is the operating systems, databases, and the management of storage and compute resources that host the applications.
 - **Applications** – the software tools which allow the organisation to perform its business and operational processes.
- 1.3 The potential risks considered in the review were as follows:
- i. Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
 - ii. Loss of key processing or networking services.
 - iii. Legal and regulatory breaches.
 - iv. Reputational damage and/or financial loss.
- 1.4 The scope of the review was limited to Health Board hosted applications and the critical enabling infrastructure on which they are dependent. Infrastructure and applications hosted and provided by other organisations such as the PSBA (Public Sector Broadband Aggregation) and WCP (Welsh Clinical Portal) were not included.

2. Detailed Audit Findings

Objective 1: Resilience is designed into the delivery of the technical infrastructure, the design has been enacted appropriately and applications ensure the designed resilience is used.

- 2.1 The Health Board's digital services are provided from two main sites, a primary site in Prince Charles Hospital (PCH), and the second being Royal Glamorgan Hospital (RGH). We note that each hospital has dedicated rooms for IT infrastructure items relating to the site. Improvements have recently been made to the PCH site with the establishment of a new, dedicated datacentre room.

-
- 2.2 A third site, Princess of Wales Hospital (PoW) is being changed from hosting Swansea Bay University Health Board services, with these having now disaggregated and services for PoW users being provided from the Health Board's sites. The PoW site is being developed as a disaster recovery (DR) site for CTM. As such, the provision of services enables geographical resilience.
 - 2.3 Provision at the main site (PCH) is from two rooms separated across site in different fire zones, and at the secondary (RGH) from two rooms. However, we note that these are next to each other.
 - 2.4 We reviewed the resilience in place for the key sites within the Health Board and note the following:
 - 2.5 Both the primary and secondary sites have dual power feeds with generator support and the racks are fed by two power distribution units (PDU).
 - 2.6 There is uninterruptible power supply (UPS) in place for all key areas. This is a mixture of room and rack based at PCH, and room based at RGH. There is redundancy in the power and UPS supply as a single aspect can be lost without impact on service, thus indicating an N+1 redundancy (where a single item can fail without impact on service). We note that both the UPS and generators are regularly tested, and we understand that the runtime for the UPS at PCH was 2 hours.
 - 2.7 Cooling is provided, with the new room at PCH having three computer room air conditioning (CRAC) units which operate as two active and one on standby, thus providing N+1 redundancy, and the older room having eight wall mounted units. We understand that the room can be sufficiently cooled using six, so providing N+2, with a similar position at RGH.
 - 2.8 The contents of the rooms are documented, and rack content audits are undertaken which enables the team to track both equipment location, and power and cooling needs.
 - 2.9 There is dual networking in place, with resilient routing of cables which has recently been improved.
 - 2.10 There is monitoring in place for the datacentre rooms. The Health Board uses a mixture of the building management system, Solar Winds and NetBotz rack-based software to monitor its infrastructure. These provide alerts and there is a dashboard for site monitoring. We also note the new room within PCH uses smart PDUs which monitor the power supplies.
 - 2.11 There is extensive use of virtualisation software in order to provide resilience within each site. The Health Board is moving away from the previous Hyper-V environment and onto VMware on a hyperconverged environment using Dell VxRail. This is a combination of servers and storage within a distributed infrastructure platform with intelligent software that manages the whole environment and provides a greater degree of resilience.
 - 2.12 The VxRail environment is complex and enables self-monitoring to track the 'health' of the environment to detect and resolve issues before they impact on
-

service delivery. Fault domains have been defined within the environment with a fault tolerance of 1, which provides resilience by ensuring that virtual machines (VMs) are provided across the domains so the loss of one will not stop services.

- 2.13 The VMware version in use is version 7, and key resilience enabling functionality is active such as Vmotion and VSphere High Availability, which enable virtual machines to be kept running in the event of disruptions. VSphere Fault Tolerance is also active, with primary and secondary fault domains defined.
- 2.14 We do note that the position within RGH is not as advanced as the implementation of VMware, and VxRail is still ongoing. In addition, PoW is not an active site, but management's intent is to use this as a disaster recovery site which can rapidly activate a VxRail cluster to provide services.
- 2.15 Currently Vcenter Site Recovery Manager (SRM) is not in use which automates disaster recovery, although we note that Dell RecoverPoint is in use which replicates virtual machines (VMs) over the network to PoW. The use of SRM could speed up the time taken to recover services. **Matter Arising 1**
- 2.16 Clustering is in use with the PCH production environment provided using five nodes in each room, (SQL using four nodes in each room), these are linked to paired switches in each room, providing on site resilience. We confirmed the capacity to ensure that all services can be run from either room within the PCH cluster, although we note that there is little additional capacity currently available, which may restrict the implementation of new services unless more is provided.
- 2.17 In the event of a loss of PCH, services can be provided from RGH (or PoW once established). The failover process is not automatic and so a manual process would need to be invoked, we discuss the procedures for which under Objective 3. However, we note that RGH does not have the capacity to run all digital services, and neither will PoW. As such, the loss of the primary site will adversely impact on the delivery of digital services. **Matter Arising 2**
- 2.18 Digital services are provided in general by two teams in the directorate: the Clinical Systems team; and the Infrastructure team. The teams work closely together, and when new applications are being developed and installed the Clinical Systems team inform infrastructure of the criticality, user base and technical requirements, and the infrastructure team then design and provide the appropriate server infrastructure.
- 2.19 Our testing of the design of applications in terms of resilience identified that resilience is designed with the following items included to varying extents:
- Geographic resilience;
 - Use of load balancing and multiple servers;
 - Virtualisation; and
 - Clustering.

- 2.20 We note that there is greater resilience built in for those services defined as critical (both clinical and administrative), which confirms that the Health Board is focusing resources on the most valuable services.

Conclusion:

- 2.21 The core infrastructure is provided using a resilient architecture across two main geographically distant datacenters, with extensive use of virtualisation. Improvements continue to be made with a move onto a modern hyperconverged architecture which better enables resilience, although we note that the current position does not provide full capacity at secondary sites. The physical equipment is protected with dual power and redundant cooling. Resilience is designed into applications, in particular for those deemed critical to the organisation. Accordingly, we have provided **Reasonable Assurance** for this objective.

Objective 2: Resilience is subject to testing at both infrastructure and application level to ensure that processes are operating as anticipated.

- 2.22 There is no structured process for testing the resilience of the infrastructure in order to ensure it functions as anticipated.
- 2.23 There is testing of some of the components as part of normal operations, with restores of virtual machines being an example. We also note that there is monthly testing of generators which interrupt the power supply from mains to UPS.
- 2.24 There is some testing of application failover as normal operation and as part of maintenance of applications and of UPS, where services are failed over to one room to enable patching, then failed back. We also note that the document management system (CITO) resilience has been tested, as has the provision of Citrix services.
- 2.25 We note that the move onto the VxRail environment is ongoing, and there has been an element of testing of the resilience elements as part of that process. As we note above, the intent is to use PoW as a DR site, although this has not been fully provisioned as yet with the hardware capacity in place and the prioritised replication of VMs being scheduled into the digital workplan.
- 2.26 However, there is no structured process for testing the resilience of the infrastructure or applications in order to ensure it functions as anticipated in the event of a rack, room or site failure, and there has been no full testing of the resilience of the digital provision as a whole which would ensure that all services could be brought back, or re-provisioned from an alternative site within the timeframes defined in the service catalogue. **Matter Arising 3**

Conclusion:

- 2.27 There is testing of the resilience of component parts of the infrastructure such as the UPS. There is testing of aspects of resilience such as individual failover, and there has been some testing as part of the implementation of VxRail. However, there is no full testing of resilience and no formal plan for resilience testing. Without a full test, the Health Board cannot be fully assured that its disaster recovery plans

will operate as anticipated. Accordingly we have provided **Reasonable Assurance** over this objective.

Objective 3: An effective and tested recovery plan which meets the business requirements should be in place.

- 2.28 There is a Server and Storage Services Continuity and Recovery document which contains key information over the architecture in place, the resilience arrangements for core infrastructure and servers, discusses failure scenarios and includes restore instructions in place that set out how to restore virtual servers and how to restore data from the backups. This document defines a set of resilience tiers for applications and includes information on the recovery time (RTO) for each tier.
- 2.29 However the documentation is out of date as it still references the previous Hyper-V environment and has not been updated to reflect the new VxRail environment. We note that this is a new architecture and there was a stated intent to update the DR documentation. **Matter Arising 4**
- 2.30 There are specific application DR documents for some services, with newer, critical services having more detailed information. Eg CITO and Citrix, although as we note above, these are out of date. However, not all individual applications, (non critical) have DR plans, with reliance placed on the server team to restore provision as per the core server DR document. While this may be appropriate, there is inconsistency in approach, and service leads were not always aware of their resilience tier and RTO / recovery point objective (RPO) **Matter Arising 5**
- 2.31 The architecture has changed, and this better enables DR planning with the ability to use PoW as a recovery site. However, the capacity at both PoW and RGH is not sufficient to run all services and so the Health Board will only be able to run prioritised, critical services in the event of the loss of the primary site. In addition, the failover and restore process requires manual intervention and given the number of services this may take a considerable amount of time.
- 2.32 There is a service catalogue in place which defines all services provided, and this includes an indication of criticality. However, there is no full categorisation of services and no prioritisation over what should be restored to alternative sites, and in which order. **Matter Arising 6**
- 2.33 This is also true for Citrix, as although there is a DR plan in place which sets out the arrangements for failing over and restoring services, there is no restore order and no identification of RTO / RPO. **Matters Arising 6**

Conclusion:

- 2.34 Although there are restore instructions in place and there are disaster recovery documents in place, these are out of date due to the implementation of a new architecture, and there is no full set of instructions for recovery from varying levels of incident. There is no up to date prioritised list of services that sets out a restore order, and not all applications have DR plans. We note that the DR site provision is being improved and there is an intent to review the DR plan. Accordingly, we have provided **Limited Assurance** over this objective.

Objective 4: Back-ups are taken appropriately, are tested and protected from unauthorised access and change to enable resilience.

- 2.35 We note that the processes in place for backup up and recovery of data have recently been covered within our 2022/23 Cyber Security internal audit report, and we have reported a positive outcome within that review.
- 2.36 There is a process for ensuring backups of Health Board data are taken, which uses the Commvault facility, with backups taken to disk and then to tape. Backups are stored securely and are encrypted, and there is a process of monitoring the backup process and testing backups by restore to confirm their validity.
- 2.37 We further note that there has been recent investment to improve the security and resilience of the backups. The investment was for the implementation of Cyber Vault, which provides greater storage security and an air gap in order to reduce the risk associated with ransomware.

Conclusion:

- 2.38 There is an appropriate process for backup of data, and securely storing to ensure that this is available at the point of need. The validity of backed up data is also tested to ensure that it is usable and we note improvements to security of backups are underway. Accordingly we have provided **Substantial Assurance** over this objective.

Objective 5: There is a continual process of review and assessment, including post-incident reviews to identify the root causes of disruptions.

- 2.39 As part of our 2023/24 review of IT infrastructure we note that there was monitoring of the core infrastructure (network, servers, firewalls) which provides alerts in the event of an issue with any component, with the main monitoring tool in use being SolarWinds. Our work confirmed that there are resilience related alerts set up within the dashboard available and that there has been some adjustment of alert thresholds in order to obtain more meaningful alert information.
- 2.40 In addition to the SolarWinds monitoring there is rack based monitoring, for example, NetBotz in the old PCH room with sensors that monitor temperature, humidity, and provide relevant alerts.
- 2.41 For the new PCH room there is better integration with the building management system, so there are alerts provided and a daily check on the room status. The room also features smart PDUs which enable active monitoring of power supplies.
- 2.42 Any failures within the infrastructure are dealt with using a service management approach, with incidents recorded and subject to investigation and resolution. The Infrastructure team have developed a major incident tracker which enables them to monitor incidents and ensure that actions to investigate and resolve are maintained.
- 2.43 Our work confirmed that when incidents occur, they are subject to appropriate investigation to establish the root cause of the failure. As part of the investigation, potential lessons are considered and these feedback into the management

processes to improve resilience in the future, and we note configuration changes that have been enacted following incidents.

Conclusion:

- 2.44 There is a monitoring process in place which provides alerts where issues are impacting on resilience and rectifying any issues. There is a service management process in place which appropriately deals with incidents to enable improvements to be made. Accordingly, we have provided **Substantial Assurance** over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Use of SRM (Operation)			Impact
Currently, Vcenter Site Recovery Manager is not in use which automates disaster recovery, although we note that Dell RecoverPoint is in use which replicates VMs over the network to PoW. The use of SRM could speed up the time taken to recover services.			Potential risk of: Delays in restoring services
Recommendations			Priority
1.	Consideration should be given to enabling SRM in order to better facilitate DR to alternate sites.	Low	
Agreed Management Action		Target Date	Responsible Officer
1.1	A review into the use of SRM will be carried out. Although an automated DR would be optimal, there are a number of scenarios where it would be preferred to have manual intervention into this type of response. This is in part due to some of the other work that would be required to ensure systems were accessible at the DR site such as network addressing. The UHB is working with CISCO to design and architect a modern network that supports DR more seamlessly.	30/09/2024	Lead Infrastructure and Security Architect

Matter Arising 2: Full Resilience (Operational)			Impact
RGH does not have the capacity to run all digital services, and neither will PoW. As such, the loss of the primary site will adversely impact on the delivery of digital services.			Potential risk of: Delays in restoring services
Recommendations			Priority
2.1	The Health Board should consider increasing alternate site capacity to enable full service delivery.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	An assessment has identified that POW has the capacity to enable full service delivery, as such replication of Virtual machines and services is being targeted to the PoW Datacentre.	Completed	Lead Infrastructure and Security Architect / IT Clinical Systems Manager

Matter Arising 3: Resilience Testing (Operation)		Impact	
There is no structured process for testing the resilience of the infrastructure or applications in order to ensure it functions as anticipated and the instructions work. In addition, there has been no full testing of the resilience of the digital provision as a whole which would ensure that all services could be brought back, or re-provisioned from an alternative site within the timeframes defined in the service catalogue.		Potential risk of: Delays in restoring services	
Recommendations		Priority	
3.1	Once the DR site has been provisioned the resilience position should be tested to ensure it operates as anticipated. Going forward resilience should be subject to regular testing, failing over between rooms and across sites to ensure it still operates.	Medium	
Agreed Management Action		Target Date	Responsible Officer
3.1	A schedule for end-to-end failover testing will be produced and implemented. This should include a full prioritised recovery of systems and validation by system managers/end users. An ongoing log will be maintained.	31/12/2024	Lead Infrastructure and Security Architect / Head of Server Management

Matter Arising 4: Disaster Recovery Plan (Operational)		Impact	
The DR documentation in place is out of date as it still references the previous Hyper-V environment and has not been updated to reflect the new VxRail environment. We note that this is a new architecture and there was a stated intent to update the DR documentation.		Potential risk of: Delays in restoring services	
Recommendations		Priority	
4.1	The DR plan should be updated to reflect the new environment. The plan should consider the main types of failure such as IT, power, communications and cover the network infrastructure. - The DR plan should include processes to follow in order to restore services in the event of varying degrees of failure such as: - Failure of site> provision of failover instructions, restore priorities; - Failure of rack >provision of failover and restore instructions; - Failover of VM > restore and restore from backup; and - Failure of system – VM restore / backup restore.	Medium	
Agreed Management Action		Target Date	Responsible Officer
4.1	The UHB will establish a prioritised plan, incorporating step by step procedures for the restoration of services following a major incident, under 4 separate scenarios, incorporating the fault domain failures as relevant (site, rack, VM, system): - Cyber impacting affecting CTM network and services - Environment impact affecting CTM network and services (e.g. utility loss, flood or fire)	30/12/2024	Head of Server Management

	- Loss of DHCW services - Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet)		
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Matter Arising 5: Application DR Plans (Operational)		Impact	
Not all individual applications have DR plans, with reliance being placed on the server team to restore provision as per the core server DR document. While this may be appropriate, there is inconsistency in approach, and service leads were not always aware of their resilience tier and RTO / RPO.		Potential risk of: Delays in restoring services	
Recommendations		Priority	
5.1	An assessment of the need for individual service DR plans should be undertaken. Following that detailed DR documentation should be in place, either within the Server DR document, or within individual DR documents for each service which sets out the architecture, and processes to follow in order to restore the service. The DR documentation should explicitly include information on the resilience tier and RTO/RPO and this should be communicated to service leads.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5.1	The criticality of systems will be prioritised based on criticality. The exercise to document DR plans for all critical systems as defined by NIS regulations will continue with progress overseen by the Cyber Security Assurance Board. The DR documentation will include information on the resilience tier and RTO/RPO and will be communicated to system managers.	30/12/2024	IT Clinical Systems Manager

Matter Arising 6: Restore / Resilience Priority (Operational)		Impact	
The DR site provision cannot host all services and moving to alternate site provision involves manual intervention that may take time given the number of services involved. There is a service catalogue in place which defines all services provided, and this includes an indication of criticality. However, there is no full categorisation of services and no prioritisation over what should be restored to alternative sites, and in which order.		Potential risk of: Delays in restoring services	
Recommendations		Priority	
6.1	The services to be restored to alternate sites should be formally defined and a prioritised order for recovery set out. This should be based on a formal assessment of service criticality and risk.	High	
Agreed Management Action		Target Date	Responsible Officer
6.1	1) The UHB will establish a prioritised plan, incorporating step by step procedures for the restoration of services following a major incident, under 4 separate scenarios: - Cyber impacting affecting CTM network and services - Environment impact affecting CTM network and services (e.g. Utility, flood or fire) - Loss of DHCW services - Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet)	30/12/2024	Lead Infrastructure and Security Architect / IT Clinical Systems Manager

The plan will be in line with the organisation’s overall major incident response plan but will consider informatics resources e.g. the capacity of data centres, dependency and availability of underlying infrastructure and services (e.g. NADEX) This will be a substantial plan and to actually implement the plan is anticipated to have a significant resource requirement. The prioritisation will be in line with the classifications provided by the Civil Contingencies Act around service criticality and risk. 2) The mapping of elemental infrastructure and systems (i.e. the critical rebuild materials) to the most critical services will be carried out to determine what will need to be restored is the initial element of this work (e.g. Network, IP addressing, NADEX) 3) Contract re-negotiations to make these critical rebuild materials and the critical applications themselves available for on prem rescue and recovery will then be required, prior to the business case process being followed for this functionality to be procured. (i.e. it will cost to launch and run LIMs from the a local on prem viable copy of the application & to ensure that this copy is supported and up to date.)		
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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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Audit and Risk Committee Update – Cwm Taf Morgannwg University Health Board

Date issued: August 2024

Document reference: 3313A2023

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About this document

- 1 This document provides the Audit and Risk Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.
- 2 We also provide additional information on:
 - Other relevant examinations and studies published by the Audit General.
 - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2023-24 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2023-24 Annual Report and Accounts.	The Auditor General certified the Annual Report and Accounts on 12 July; and they were laid by the Senedd that day. We are due to issue the draft Audit of Accounts Addendum Report, which we anticipate agreeing with officers in time	August 2024

			for the August meeting of the Audit and Risk Committee.	
Audit of the 2023-24 Charitable Funds Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2023-24 Annual Report and Accounts.	We have recently issued the draft Audit Plan, for officers' consideration.	Certification is scheduled for late January 2025.

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Review of Unscheduled Care	Chief Operating Officer	This work examines different aspects of the unscheduled care system and includes analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working.	Part 1 – Regional report drafting	October 2024
		The work includes 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 (Part 1).	Part 2 – Fieldwork Underway	To be confirmed
		We are also reviewing progress being made in managing unscheduled care demand by helping patients access		

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		services which are most appropriate for their unscheduled care needs (Part 2).		
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 follows-up progress against these recommendations.	Report Drafting	October 2024
Structured Assessment 2023 – Deep Dive – Cost Savings	Executive Director of Finance	This work examines the approach the Health Board is taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Report Drafting	October 2024
Structured Assessment 2024 – Deep Dive – Digital	Director of Digital	This work will examine digital arrangements, with a particular focus on how the Health Board is investing in digital technologies, solutions, and capabilities to support the workforce, transform patient	Scoping	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		care, meet demand, and improve productivity and efficiency.		
Review of the Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries - Follow up	Director of Nursing, Midwifery and Patient Care & Chief Operating Officer	This work focussed on reviewing the Health Board's progress in implementing the four recommendations made in our 2022 review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit.	Report finalised and included in today's committee papers.	August 2024
Quality Governance Arrangements Joint Review Follow-up - Progress update	Chief Executive	In our joint report published in August 2023, we signalled our intention to ask the Health Board for a written update on its progress in addressing the areas the joint review follow-up team felt that further work was necessary. These areas were set out in the report. We assessed the Health Board's progress jointly with Healthcare Inspectorate Wales with the aim of determining whether the outstanding recommendations can be closed.	Letter included in today's committee papers.	August 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
All-Wales thematic review of planned care	Chief Operating Officer	This work follows on from the national report on <u>tackling the planned care backlog</u> and considers: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork underway	To be confirmed
Structured Assessment – core	Director of Corporate Services / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, • cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements.	Set-up meeting held in May 2024	December 2024

Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
<u>Community Pharmacy Data Matching Pilot</u>	May 2024
<u>Supporting Ukrainians in Wales</u>	March 2024
<u>From Firefighting to Future-proofing – the Challenge for Welsh Public Services</u>	February 2024
<u>Board effectiveness follow-up – Betsi Cadwaladr University Health Board</u>	February 2024

Additional information

- 7 Audit Wales has not published any corporate documents since the last committee update.
- 8 There are no relevant Audit Wales consultations currently underway.



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Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board

Audit year: 2023

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Introduction

- 1 In September 2021, the Health Board decided to temporarily close the Minor Injuries Unit (the MIU) at Ysbyty Cwm Cynon (YCC) due to concerns relating to the fragility of the service and competency-based training compliance. The Health Board subsequently reopened the MIU, albeit on a phased basis, in May 2022.
- 2 In November 2021, we decided to undertake a high-level review to examine the issues surrounding the temporary closure of the MIU at YCC. We found that the closure of the MIU could have been avoided if action had been taken sooner to strengthen managerial oversight of the unit as well as to address the concerns raised in 2018-19 around staff training and qualifications. We also found that the closure of the MIU increased footfall to an already pressured Emergency Department, and that no assessment of the impact on patients had been undertaken. Whilst the Health Board's arrangements to communicate the temporary closure to stakeholders and to redeploy staff were effective, we found gaps in reporting to the Quality and Safety Committee, particularly around the potential harm to patients.
- 3 We made four recommendations for improvement, focussed on:
 - Reviewing managerial oversight arrangements of remotely operating services.
 - Improving oversight of competency-based training arrangements at the MIU and across the wider organisation.
 - Improving performance appraisal compliance rates.
 - Enhancing Quality and Safety Committee oversight and ensuring lessons learnt.

Objectives and scope our work

- 4 The objective of our follow-up review has been to examine whether the Health Board has addressed the recommendations arising from our 2021 review.
- 5 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

- 6 Overall, we found that **the Health Board has made good progress in addressing our recommendations, particularly in relation to strengthening managerial oversight of remotely operating services, improving competency-based training arrangements, and increasing performance appraisal rates. However, it still has further work to do around learning and applying the lessons arising from the temporary closure of the Minor Injuries Unit.**
- 7 The findings that support our overall conclusion are summarised below per recommendation:

Recommendation 1 - Reviewing managerial oversight arrangements of remotely operating services

- 8 We considered whether the Health Board has reviewed the managerial oversight arrangements of services which are staffed by the Health Board but operate remotely to ensure they are sufficiently robust and effective. We also considered whether the findings of the review have been reported to the Quality and Safety Committee to provide the required assurances.
- 9 We found that the Health Board has **strengthened its arrangements for providing managerial oversight of remotely operating services, including the Minor Injury Units in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda.**
- 10 Since our initial review, the Health Board has introduced a new operating model, consisting of Care Groups¹, through an organisational change process. As part of this process, all services delivered remotely outside of the Health Board's three acute sites (Prince Charles Hospital, Princess of Wales Hospital, and Royal Glamorgan Hospital) were reviewed and incorporated into the relevant Care Group structure.
- 11 The YCC MIU, along with the Ysbyty Cwm Rhondda MIU, are now part of the Unscheduled Care Group. The Health Board has agreed a clear scope of practice and standard operating procedure for its MIUs, which set out managerial oversight arrangements. We have seen evidence of the Care Group maintaining appropriate oversight of MIU activity and issues, with regular reporting from the MIUs to the Care Group's Quality and Safety Committee.
- 12 As the review of the remotely operating services was part of the organisational change process, this was reported directly to the Board rather than the Quality and Safety Committee. However, since the implementation of the new operating model, we have observed the Quality and Safety Committee providing good oversight of the quality and safety of the services provided by the Care Groups.
- 13 **We therefore consider Recommendation 1 as implemented.**

Recommendation 2 - Improving oversight of competency-based training arrangements at the MIU and across the wider organisation

- 14 We considered whether the Health Board has reviewed its competency-based training arrangements (at the MIU and across the wider organisation) to ensure:
- effective policies and procedures are in place to support staff to complete all relevant competency-based training in a timely manner;

¹ 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.

- competencies requiring assessment are assessed by qualified assessors in a timely manner;
- evidence of competency-based training completed by staff is recorded appropriately; and
- competency-based training completion rates are monitored and reviewed on a regular basis by the relevant management teams.

We also considered whether the findings of the review were reported to the Quality and Safety Committee to provide the required assurances.

- 15 We found that the **Health Board has taken positive steps to improve its arrangements for competency-based training, with specific arrangements now in place to support Emergency Nurse Practitioners to complete the relevant competency-based training.**
- 16 Whilst the Health Board does not have a specific policy in place relating to competency-based training, it is committed to ensuring that competency-based training is up to date for all relevant staff. Role specific competency-based training is explored as part of an individual's annual Performance Appraisal and Development Review (PADR). If a gap is identified that could potentially impact service delivery, the senior nurse for that area would highlight this in the Care Group workforce meeting and appropriate targeted intervention would be put in place.
- 17 The Health Board has appointed a full-time Senior Nurse for Professional Education, who is also an Agored Cymru² approved assessor. The Senior Nurse for Professional Education is responsible for the governance of the education and training of Emergency Department nurses. Each Emergency Nurse Practitioner³ is aligned to a medical clinical supervisor alongside the Senior Nurse for Professional Education. This is a positive development, as these assessors are in short supply across Wales. The Senior Nurse for Professional Education is currently supporting the YCC MIU and Emergency Department at Prince Charles Hospital. The Health Board has put a plan in place for the Senior Nurse for Professional Education to support the Practice Development Nurses across other Emergency Departments and the Ysbyty Cwm Rhondda MIU over the next few months.
- 18 Professionally trained staff, such as doctors or nurses, are required to undertake and evidence relevant continuing professional development as part of their on-going registration with their respective professional bodies. However, as with other

² Agored Cymru is an education provider that creates nationally recognised, quality assured qualifications and units across a diverse range of subjects in Wales. It delivers the Level 7 Diploma in the Autonomous Management of Minor Injuries, which all Emergency Nurse Practitioners are required to complete.

³ Emergency Nurse Practitioners are registered nurses who have completed further training in the management of minor injuries and who practice without consultant supervision to see, treat, and discharge patients.

Health Boards, there is no computer system in place for them to record this. As a result, the Health Board continues to rely on manual records.

- 19 Within the Unscheduled Care Group, mandatory training compliance is discussed at a bi-monthly Care Group meeting led by the Nurse Directors for unscheduled care and planned care.
- 20 Whilst all of this is positive, there has been no formal reporting on these matters to the Quality and Safety Committee or the People and Culture Committee. We would encourage the Health Board, therefore, to provide an update on these matters to the relevant committee at the earliest possible opportunity to ensure it receives the necessary assurance.
- 21 **We therefore consider Recommendation 2 as implemented.**

Recommendation 3 - Improving performance appraisal compliance rates

- 22 We considered whether the Health Board has agreed a range of appropriate actions to improve compliance rates across the organisation.
- 23 We found that **most staff within the MIU have up-to-date performance appraisals. However, the Health Board's overall PADR compliance rate, whilst improving, remains below the target level of 85%.**
- 24 All but two staff⁴ within the MIU have an up-to-date performance appraisal, which is a significant improvement since our initial review.
- 25 The Health Board has revised its approach to PADRs, recognising their importance on staff development, performance, and well-being. The new approach – known as the 'Your Conversation' process – also places an emphasis on the importance of values and behaviours. As a result, the Health Board has seen an increase in PADR compliance, achieving a 64.4% completion rate in May 2024 compared to 59.4% in June 2023. However, the Health Board, like other Health Boards in Wales, continues to experience challenges in achieving the PADR compliance target of 85% across all staff groups.
- 26 **We therefore consider Recommendation 3 as implemented.**

Recommendation 4 - Enhancing Quality and Safety Committee oversight and ensuring lessons learnt

- 27 We considered whether the Health Board has provided an update report to the Quality and Safety Committee outlining the lessons learned, and confirmation of any outcomes from its work on assessing potential patient harm.
- 28 We found that **whilst no patients came to harm, the Health Board is yet to capture and apply the learning from the temporary closure of the MIU.**

⁴ One is currently on maternity leave, and one is on a long-term absence.

- 29 The Health Board has confirmed there were no reported incidents of patients coming to harm following the temporary closure of the MIU. However, it recognises that further work is needed to capture and apply the learning from the temporary closure. Disappointingly, the Health Board did not undertake a listening and learning exercise at the time of the temporary closure, and three years have now passed. However, the Health Board plans to carry out a listening and learning exercise within the next six months to bring staff and the local community together to explore opportunities to learn from the temporary closure. The event will be supported by Llais Cymru⁵, and the outcomes will be reported to the Quality and Safety Committee.
- 30 **We therefore consider Recommendation 4 as ongoing.**

⁵ Llais Cymru is an independent statutory organisation which represents the interests of patients and the public in the National Health Service.

Appendix 1

Audit methods

Exhibit 2 set out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 2: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Minutes, agendas, terms of reference and papers from Board and relevant committees and groups, including the Quality and Safety Committee and the People and Culture Committee. • A self-assessment document completed by the Health Board setting out progress against the previous recommendations; • Reports on operating model implementation; • Audit recommendations tracker; and • Job descriptions for relevant staff
Interviews	We interviewed the following Senior Officers: • Advanced and Consultant Practice Development Manager HEIW; and • Director of Corporate Governance.



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Jonathan Morgan, Chair
and Paul Mears, Chief Executive
Cwm Taf Morgannwg University Health Board

Reference: PA340/DT/hcj
Date issued: 26 July 2024

Dear Jonathan and Paul

Quality Governance Arrangements in Cwm Taf Morgannwg University Health Board: Joint Review Follow Up

We have now concluded our review of the Health Board's progress in addressing the outstanding areas we highlighted in our August 2023 [report](#). We are grateful to the Health Board for its comprehensive self-assessment and for responding promptly to our request for additional information. In determining the progress that has been made, we have drawn on the self-assessment and accompanying evidence as well as knowledge gleaned from other relevant audits and inspections undertaken since the review.

Overall, we are satisfied that the Health Board has continued to make good progress in addressing the outstanding areas highlighted in our 2023 report.

Table 1 overleaf contains a summary of our assessment of the Health Board's progress in addressing the four partially implemented recommendations. We provide further detail in **Appendix 1**.

Table 1 Summary of assessment

Rec	Description	Status
R3	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	Partially Implemented
R4	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	Implemented
R6	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	Implemented
R14	Tackle the LFERs backlog and put improved processes in place to ensure LFERs are completed and submitted on a timelier basis in future	Implemented

Based on the above, we are content to for the Health Board to mark Recommendations 4, 6, and 14 as closed.

In terms of Recommendation 3, we acknowledge the efforts made by the Health Board in substantively recruiting to over 80 percent of its Clinical Director posts¹. However, four Clinical Director posts remain vacant, and an interim appointment has been made to the Clinical Director post for Emergency Medicine for a period of six months, with an aim to then appoint substantially. Whilst we can see evidence of plans to complete the recruitment process in the next three months, we do not think the Health Board can close this recommendation until all remaining vacancies have been filled, particularly given the importance of the clinical areas they cover.

We also considered the areas where we identified further work was necessary. Our assessment of progress in these areas is set out in **Appendix 1**. Our overall view is that the Health Board has made good progress in most of the areas identified. However, further work is required to support continued improvement in the following areas:

¹ Of the 28 posts, 23 were appointed at the time of our review with posts remaining vacant for Clinical Director posts in pathology, radiology, respiratory medicine, diabetes, and endocrine services.

- **The Annual Quality Work Plan** - At the time of our work, the workplan was incomplete and the arrangements for the ongoing oversight of the plan were unclear. As a result, the Health Board should ensure it finalises the workplan as well as put appropriate arrangements in place to monitor the work plan's delivery to obtain assurance that it is driving the intended improvements in quality.
- **Clinical Audit** - We recognise that the management and oversight of clinical audit processes and actions have improved. However, we are aware there are concerns about the capacity of medical and nursing staff to undertake clinical audit. As a result, the Health Board should ensure it continues to monitor this and allocate sufficient resources to deliver the Clinical Audit Plan in full.
- **Culture and Behaviours** - We recognise that there has been a continued focus on challenging and addressing behaviour that is inconsistent with the organisation's values and behaviours. We also note the work on developing the Health Board's Culture Plan which should help strengthen these arrangements further. Noting that embedding cultural change can be challenging and take time, the Health Board should ensure its Culture Plan contains clear aims and priorities along with indicators of success that can help demonstrate on-going improvements in culture and behaviours across the organisation.

Given our overall view that the Health Board has made good progress in addressing the outstanding recommendations and areas of further work we identified, we do not propose to undertake any further formal joint follow up work in these areas. Instead, we will continue to monitor the Health Board's progress in addressing these matters through our routine audit and inspection work.

Finally, we would like to formally record our thanks to the Health Board's staff who have given up their time to support our follow up work and respond to our queries.

Yours sincerely



Dave Thomas
Audit Director,
Audit Wales



Rhys Jones
Director of Assurance,
Healthcare Inspectorate Wales

Appendix 1

Table 2 – Progress against partially implemented recommendations

Rec No	Recommendation	Conclusion
R3	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.	The Health Board has successfully recruited to over 80% of the Clinical Director roles as of March 2024. Four posts remain vacant at present for Pathology, Radiology, Respiratory, and Diabetes and Endocrine, with plans in place to complete recruitment within the next three months. However, in the interim, the relevant Care Group Medical Directors are managing these posts to ensure effective oversight. Emergency Medicine has an interim appointment for a period of six months, with an aim to appoint substantially at the end of that period. Whilst we are assured with the plans in place to complete the recruitment process, we are unable to close the recommendation until all remaining vacancies have been filled, particularly given the importance of the clinical areas they cover. We therefore consider this recommendation to be partially implemented.
R4	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.	The Health Board has continued to make progress in this area, with terms of reference in place for the operational quality and safety groups. However, some have not been reviewed or updated for a while. The Health Board has provided assurance that these will be updated within the next three months, and then receive an annual review. The Health Board has also provided assurance that

Rec No	Recommendation	Conclusion
		adequate support is provided to ensure the effective administration of the quality and patient safety groups. We therefore consider this recommendation to be fully implemented.
R6	The Health Board needs to make better use of real-time patient feedback to make immediate changes and improvements to the overall patient experience, where appropriate and ensure that patient experience features more prominently in routine performance and quality reports to the Board and relevant committees.	The Health Board has continued to make progress in this area and has extended the Patient Advice and Liaison Service (PALS). Patient experience also features more prominently in the routine performance and quality reports to the Board. We therefore consider this recommendation to be fully implemented.
R14	Tackle the LFERs ² backlog and put improved processes in place to ensure LFERs are completed and submitted on a timelier basis in future.	The Health Board has made significant progress in this area. It has successfully cleared its overdue LFERs. The Health Board is aware that it still has some further work to do to ensure that all future LFERs are submitted in a timely manner; however, this will be monitored on an ongoing basis by the Welsh Risk Pool. We therefore consider this recommendation to be fully implemented.

² Learning From Events Reports

Table 3 - Progress against other matters

Matter Raised	Conclusion
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.	The Health Board took steps to ensure effective consultation and engagement through a variety of methods, including informal workshops, information events, space on the Health Board's intranet page with dedicated information on the organisational change process, publishing frequently asked questions, and providing wellbeing support. Phase 2 of the operating model went live on the 1st of April 2024. We therefore feel sufficiently assured that the Health Board has addressed this matter in full.
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.	The Health Board has developed the annual quality workplan in partnership with Care Groups and other stakeholders. The workplan has clear links to the Health Board's Quality Strategy. However, at the time of our work, the workplan was incomplete. The workplan had only been received once at the Quality and Safety Committee in January 2024, and the future oversight arrangements were unclear. As a result, the Health Board should ensure it finalises the workplan as well as put appropriate arrangements in place to monitor the work plan's delivery to obtain assurance that it is driving the intended improvements in quality. We therefore do not feel sufficiently assured that the Health Board has addressed this matter in full. As a result, the Health Board should ensure it finalises the workplan and puts arrangements in place for monitoring its delivery to ensure it is improving quality as intended.
Establish clear performance monitoring and management arrangements within the new Care Group structure.	Performance monitoring and management arrangements for Care Groups have been strengthened and reflect the new care group structure, with clear leadership structures established. There are regular performance meetings which have senior and operational attendance and focus on performance metrics relating to on quality, performance, workforce, and finance. We therefore feel sufficiently assured that the Health Board has addressed this matter in full.

Matter Raised	Conclusion
Ensure clinical audits are appropriately staffed and supported to target areas of concern and to complete revalidation to assess whether improvements have been made.	The management of clinical audit processes is improving and includes the oversight and management of actions that follow the audit results. The Health Board's Audit Management and Tracking (AMaT) system is also embedded across the organisation, and it provides real-time oversight from 'ward to board' of the progress with implementing actions for improvement. The Health Board indicates it is staffed to deliver clinical audit; however, we have not been fully assured that the delegated staff have time allocated to them to fulfil this duty and the capacity of medical and nursing staff to achieve compliance with Tier 1 national audits has been flagged as a concern to the Quality and Safety Committee in March 2024. The new approach to undertake Tier 2 organisation priority audits, following incidents and patient safety alerts has improved, and is completed monthly instead of annually. We therefore do not feel sufficiently assured that the Health Board has addressed this matter in full.
Continue to improve the content of Care Group risk registers, particularly around the identification of mitigating actions.	The Health Board has continued to improve the content of the Care Group risk registers. Since our last review, all risk registers have been cleansed following the transition from Integrated Locality Groups to Care Groups. We have seen evidence that the new clinical service groups have arrangements in place to review risks, and these arrangements are operating well. We therefore feel sufficiently assured that the Health Board has addressed this matter in full.
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.	Health Board employees can now report incidents through a link on the organisation's intranet and work is ongoing to ensure that all responsible managers have the required system access. An offline version of the electronic incident form is available for temporary staff, such as agency staff. Incident reporting forms are also available via NHS Wales Shared Services Partnership (Primary Care Wales Incident Reporting). The rollout of training continues for staff as applicable. We therefore feel

Matter Raised	Conclusion
	sufficiently assured that the Health Board has addressed this matter in full.
Fully integrate the Princess of Wales hospital into the organisation's operational arrangements.	The Princess of Wales Hospital site is now fully integrated in the new Care Group structure. Senior leadership roles are pan-health board, and their roles and remits are speciality specific and not site specific as previously. We therefore feel sufficiently assured that the Health Board has addressed this matter in full.
Continue to challenge and address behaviour that is inconsistent with the organisation's Values and Behaviours Framework.	The Health Board has continued to demonstrate a drive and focus to challenge behaviours which are inconsistent with its values. There has been significant investment in leadership development as well as the 'Just and Learning' approach which seeks to promote openness and transparency. The 'Just and Learning' approach will support the implementation of speaking up safely, the listening and learning framework, and strategic equality plan. At the time of our work, the Health Board was developing its Culture Plan which should help strengthen these arrangements further. Noting that embedding cultural change can be challenging and take time, the Health Board should ensure its Culture Plan contains clear aims and priorities along with indicators of success that can help demonstrate on-going improvements in culture and behaviours across the organisation. We therefore do not feel sufficiently assured that the Health Board has addressed this matter in full.