CTM Audit & Risk Committee

Thu 17 October 2024, 14:00 - 16:00

Virtual Via Teams

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

Agenda

14:00 - 14:05
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*

14:05 - 14:15
10 min

2. CONSENT AGENDA

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 15th August 2024

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

2.1.1 Unconfirmed Minutes 15.8.24 CTM ARC 17 October 2024.pdf (11 pages)

2.1.2. Unconfirmed In Committee Minutes of the Meeting held on 15th August 2024

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

2.1.2 Unconfirmed Minutes 15.8.24 ARC In Committee ARC 17 October 2024.pdf (3 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 17 October 2024.pdf (4 pages)
2.2.1a Appendix 1 - Annual Cycle of Business ARC 17 October 2024.pdf (4 pages)

2.2.2. Committee Forward Work Plan

Information *Patsy Roseblade, Chair*

2.2.2 Forward Work Plan Audit & Risk Committee 17 October 2024.pdf (5 pages)

14:15 - 14:25
10 min

3. MAIN AGENDA

3.1. Action Log

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

- 3.1 Action Log ARC 17 October 2024.pdf (9 pages)

3.2. Matters Arising Not Contained within the Action Log

Discussion *Patsy Roseblade, Chair*

14:25 - 14:50
25 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

Discussion *Matthew Evans, Local Counter Fraud Officer*

- 4.1 Local Counter Fraud Update Report ARC 17 October 2024.pdf (3 pages)
- 4.1a Appendix 1 Local Counter Fraud Update Report ARC 17 October 2024.pdf (4 pages)
- 4.1b Appendix 2 - Counter Fraud Investigations Update ARC 17 October 2024.pdf (13 pages)

4.2. Procurements and Scheme of Delegation Report

Discussion *Sally May, Director of Finance*

- 4.2 Procurement & SoD ARC17 October 2024.pdf (10 pages)
- 4.2a Appendix 1 NWSSP No PO No Pay Policy.pdf (10 pages)
- 4.2b Appendix 2 - Draft FCP 2024 v8 NE.pdf (12 pages)
- 4.2c Appendix 3 - Pay expenditure SOD - Tracked changes.pdf (4 pages)
- 4.2d Appendix 4 - Pay expenditure SOD.pdf (3 pages)

4.3. Post Payment Verification Mid Year Update

Discussion *Amanda Legge, Post Payment Verification Manager*

- 4.3 PPV Mid Year Report 2024-2025 ARC 17 October 2024.pdf (5 pages)
- 4.3a Appendix 1 CTMHB Mid-Year 2024-2025 ARC 17 October 2024.pdf (4 pages)

14:50 - 15:50
60 min

5. IMPROVING CARE

5.1. Organisational Risk Register

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

- 5.1a Organisational Risk Register - Cover report - Sept 2024.pdf (7 pages)
- 5.1b Appendix 1 - Org RR September 24.pdf (14 pages)

5.2. Audit Recommendations Tracker

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

- 5.2 Audit Recommendations Tracker Cover Paper ARC 17 October 2024.pdf (8 pages)
- 5.2a Appendix 1 AMaT Audit Recommendations Tracker ARC 17.10.2024.pdf (15 pages)
- 5.2b Appendix 2 - Audit Tracker ARC 17 October 2024.pdf (9 pages)
- 5.2c Appendix 3 - Audit Tracker Development Work Prrogramme Update ARC 17 October 2024.pdf (5 pages)
- 5.2d Appendix 4 -HIW Tracker ARC 17 October 2024.pdf (36 pages)

5.3. Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24

Discussion *Greg Padmore-Dix, Director of Nursing & Midwifery/Deputy CEO*

5.4. Consultant Job Planning

Discussion *Dom Hurford, Medical Director*

5.4 Consultant Job Plannning ARC 17th October 2024.pdf (7 pages)

5.5. Medical Rostering

Discussion *Dom Hurford, Medical Director*

5.5 Medical Rostering Progress Report ARC 17 October 2024.pdf (5 pages)

5.6. Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

5.6 Internal Audit Progress Report ARC 17 October 2024.pdf (11 pages)

5.6.1. Internal Audit Review - Medical Variable Pay

Discussion *Paul Dalton, Head of Internal Audit*

5.6.1 IA Review - Medical Variable Pay Follow Up Final Report ARC 17 October 2024.pdf (20 pages)

5.6.2. Internal Audit Review - Reasonable Offer - Follow Up

Discussion *Internal Audit*

5.6.2 Ia Review - Reasonable Offer Follow Up ARC 17 October 2024.pdf (15 pages)

5.6.3. Internal Audit Review - Patient Pathway - Follow Up

Discussion *Internal Audit*

5.6.3 IA Review - Patient Pathway Final Follow Up Report ARC 17 October 2024.pdf (18 pages)

5.6.4. Internal Audit Review - Embedding Quality Framework

Discussion *Internal Audit*

5.6.4 IA Review - Embedding the Quality Framework ARc 17 October 2024.pdf (18 pages)

5.6.5. Internal Audit Review - Information Provision – Intelligence Led Organisation

Discussion *Internal Audit*

5.6.5 IA Review - Intelligence Led Organisation 17 October 2024.pdf (22 pages)

5.6.6. Internal Audit Review - Facilities Governance Arrangements – Follow Up

Discussion *Internal Audit*

5.6.6 IA Review - Facilities Governance Follow Up Final Report ARC 17 October 2024.pdf (19 pages)

5.7. Audit Wales - Audit & Risk Committee Update

Discussion *Mark Jones, Audit Wales*

5.7 Audit Wales Audit Update ARC 17 October 2024.pdf (12 pages)

15:50 - 15:55
5 min

6. CLOSE OF BUSINESS

6.1. Any Other Urgent Business

Patsy Roseblade, Chair

6.2. Committee Highlight Report to Board

Discussion *Patsy Roseblade, Chair*

15:55 - 15:55
0 min

7. PRIVATE/IN COMMITTEE SESSION

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

Financial Control Procedure – Medical Variable Pay

15:55 - 16:00
5 min

8. DATE AND TIME OF NEXT MEETING

Information *Patsy Roseblade, Chair*

17th December 2024 at 12:00 pm

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item	2.1.1

Unapproved / Minutes of the Audit & Risk Committee

Date and Time of Meeting	Thursday 15 August 2024 at 10:30 am
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member (Chair)
	Kath Palmer	Health Board Vice Chair/Independent Member
	Ian Wells	Independent Member
In Attendance	Sally May	Executive Director of Finance & Procurement
	Gethin Hughes	Chief Operating Officer (in-part)
	Paul Dalton	NWSSP - Internal Audit & Assurance
	Emma Samways	NWSSP - Internal Audit & Assurance
	Huw Richards	NWSSP - Internal Audit & Assurance
	Darren Griffiths	Audit Wales
	Steve Stark	Audit Wales
	Matthew Evans	Local Counter Fraud Officer (in-part)
	Beverley Jones	Local Counter Fraud Specialist (in-part)
	Cally Hamblyn	Assistant Director of Governance & Risk
Meeting Observers	Kelly Eddington	Quality Assurance & Compliance Officer

Agenda Item	**Meeting Business**
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording

	would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.
1.2	**Apologies for Absence**
	Apologies were received from: • Gareth Watts, Director of Corporate Governance (Cally Hamblyn deputising) • Nathan Couch, Audit Wales • Mark Jones Audit Wales • Geraint Hopkins, Independent Member • Owen James, Head of Corporate Finance
1.3	**Declarations of Interest**
	No declarations were identified.
2.	**CONSENT AGENDA BUSINESS**
2.1	**Items for Approval**
2.1.1 Resolution	**Unconfirmed Minutes of the meeting held on 20 June 2024** The minutes were **APPROVED** as an accurate record.
2.1.2 Resolution	**Unconfirmed Minutes of the In Committee meeting held on 20 June 2024** The In Committee minutes were **APPROVED** as an accurate record.
2.1.3 Resolution	**Unconfirmed Minutes of the EXTRA ORDINARY Meeting held on 20 June 2024** The minutes were **APPROVED** as an accurate record.
2.1.4 Resolution	**Committee Annual Report** The Annual Report was **APPROVED**
	ITEMS FOR NOTING
2.2.1 Resolution	**Audit & Risk Committee Annual Cycle of Business 2024-25** The Annual cycle of Business was **NOTED**.
2.2.2 Resolution	**Audit & Risk Committee Forward Work Programme** The forward work programme was **NOTED**

2.2.3 Resolution	**Declarations of Interest and Gifts and Hospitality Report** The report was **NOTED**
3.	**MAIN AGENDA**
3.1	**GOVERNANCE**
3.1 Resolution Action	**Audit & Risk Committee Action Log** C. Hamblyn presented the Action Log and provided an update on the following: • Action 3.1 – JAG Accreditation - this item was on the agenda for today's meeting so this could now be closed. • Action 5.2 – Audit Recommendations Tracker - in progress and a review was underway led by the Director of Corporate Governance. • Action 5.5 – Internal Audit Review – Technical Resilience - this item was on the agenda for the meeting today so can now be closed. The Chair referred to a previous action with regard to a Committee Referral to the People & Culture Committee relating to Counter Fraud and asked for an update on the outcome. C. Hamblyn advised that they would review this outside of the meeting and provide an update. The Committee **DISCUSSED** and **NOTED** the action log. To review the outcome of the Committee Referral to People & Culture Committee and provide an update.
3.2 Resolution	**Matters Arising not contained within the Action Log** There were no matters raised.
4.	**SUSTAINING OUR FUTURE**
4.1	**Local Counter Fraud Report** M. Evans and B. Jones presented the report that provided detail on tasks and actions undertaken with the four strategic counter fraud work areas. I Wells referred to the case with regard to the Neonatal Ward at Princess of Wales Hospital and queried what mitigations could be put in place to prevent this happening at the recruitment stage to provide assurance that there were appropriate checks in place to reduce the risk of this happening again. S. May recognised the concern raised and confirmed that the Counter Fraud Team would be identifying lessons learned. It was suggested that the People & Culture Committee could look at this issue in more detail and provide further assurances on the robustness of existing processes. S. May thanked the team for the huge amount of work undertaken on this case. The Chair requested that the thanks be extended to the team including the manager who was instrumental in identifying the fraudulent activity.

	The Chair in response to I. Wells point, queried whether random spot checks were undertaken. M. Evans advised that they were reviewing the risks associated with employment controls and would look to undertake sample testing as part of that activity, he confirmed that he would engage with the people services and recruitment in relation to this suggestion. The Chair commented that this had been a significant piece of work and there was a need to ensure that communications were maximised to ensure the deterrent potential. B. Jones advised that there had been a BBC reporter in the court every day of the trial leading to significant media coverage. P. Dalton advised that part of the recruitment process was undertaken by NHS Wales Shared Services Partnership and suggested that some of the learning for that element of the process should be led through their recruitment function. M. Evans confirmed that the People Services Team have been in communication with the function as appropriate. K. Palmer drew attention to the previous Committee referral to People & Culture Committee regarding the recruitment of agency staff and requested an update. The Chair advised that this had already been raised under the Action Log item and that a response was awaited. K. Palmer referred to the open fraud cases and timescales and in particular the contractor prescription fraud case that was dated back to October 2023 and requested an update. M. Evans advised that they were struggling to obtain sufficient evidence to move on to a criminal case. He added that they were just finalising the matter and would be discussing further with the Primary Care Team.
Resolution Action	The report was **NOTED**. To discuss carrying out random spot checks with the people and recruitment services team.
4.2	**Procurements and Scheme of Delegation Report** S. May presented the report and highlighted the position on procurement matters for the period 1st – 30th June 2024. The Chair referred to the retrospective orders and non-receipting areas section of the report and queried why the industrial gases and equipment orders were retrospective. S. May advised that there was further investigative work ongoing on that area that within the team. The Chair referred to the financial controls procedure and in particular FCP12 and queried what would happen when the VAT was not recoverable. S. May confirmed that if it was not recoverable then the value would be as you would expect. She advised that the forms for requisitioning contain a section where it confirms if it is exclusive or inclusive of VAT.

Resolution	The Committee; **APPROVED** the updated following FCPs: • FP4 Cash & Banking • FP5 Cash Management • FP7 Income & Debtors • FP13 Requisitioning Goods and Services • **NOTED** the position on procurement matters for the period 01.06.2024 to 30.06.2024; • **NOTED** the update regarding Purchase to Pay and achievement of PSPP target for the first quarter of 2024/25.
4.3	**Losses and Special Payments Report** S. May presented the report that provided the Committee with an update 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 the Standing Financial Instructions. S. May suggested to the Committee that for future meetings they would present a summarised report with all other supporting documentation uploaded on Admin Control for the Committee to review. K. Palmer referred to late submission of deferred learning from events reports outlined in section 3 of the report and sought assurances as to the measures being taken to improve submission times so that penalties were not incurred. S. May and C Hamblyn provided further context to the complexity of cases that are sometimes presented a challenge with timescales, however, assured the Committee that these discussions and scrutiny are undertaken at the Quality & Safety Committee and the weekly 'Executive Director led Patient Safety Meeting".
Resolution	The Committee; • **NOTED** the losses and special payments made for the period 1 April 2024 to 30 June 2024. • **NOTED** the penalties that have been imposed for submission of late information to the Welsh Risk Pool.
4.4	**Breaches to the Standing Orders** C. Hamblyn presented the report that provides an update on the current breaches to the Standing Orders.4.
Resolution	The Committee **APPROVED** the Breach to Standing Orders being reported
5.	**IMPROVING CARE**
5.1	**Organisational Risk Register** C. Hamblyn presented the Report report and highlighted key updates to members.

	S. May referred to the risk 5820 – Reduced Health Protection Funding allocation for 2024-25 that had a risk score of 12. C. Hamlyn advised that, whilst the risk was not scored at 15 and above, the Executive Lead considered this risk to be of a contentious nature and that it should be escalated to the Board via the organisational risk register. S. May noted that the issue had already been realised as the funding allocation had been confirmed and subsequent dialogue with WG colleagues had rejected any change to this allocation. She suggested therefore that this was an issue rather than a risk and that the risk descriptor should be reviewed. C. Hamblyn, in response, advised that she would raise the point made to the Executive Lead following the meeting. K. Palmer advised that this had also been discussed in the Population Health & Partnerships Committee where there had been an action for the Director of Public Health to review the risk and revert back to the Committee with an update. I Wells referred to risk 5462 on the Weight Management Service and sought an update on the timescales for when the Business Case was going to be brought forward. C. Hamblyn confirmed that she had discussed this with the Diagnostics, Therapies, Pharmacy and Sciences Care Group and that they would be reviewing this detail in readiness for the September 2024 iteration. In response, S. May reminded the Committee that there was no funding set aside for this Business Case within this year's IMTP and budget. K. Palmer referred to Datix Risk ID 4906 - Failure to provide evidence of learning from events where the risk score had reduced from 16 to 12 and queried whether that score should be decreased in light of the penalties for late submissions captured in the Losses and Special Payments report at item at 4.3 on the agenda. C. Hamblyn confirmed that she would feed this back to the Patient Care and Safety team to revisit along with the query from the Chair as to the trajectory to achieving zero penalties. The Chair drew attention to risk 5755 on page one with regard to infrastructure failures which had a consequence of 5 in the current score and a consequence of 3 for the target score and sought the rationale for this decrease. C. Hamblyn advised that she has raised this with the relevant Care Group and will circulate the update outside the meeting. The Chair referred to risk 1133 – Sustainability of the Emergency Department at the Royal Glamorgan Hospital, and requested that the mitigating action be reviewed to ensure it was clear in terms of the rationale for reinstating the risk which had previously been de-escalated from the Organisational Risk Register. C. Hamblyn advised that she would share this feedback with the Care Group and request that they revisit this section in their next risk review.
Resolution:	The Committee **NOTED** the report.

Action:	To review, discuss and feedback comments to the Executive Leads and Care Groups on the risks 5820, 5462, 4906, 5755 and 1133 and provide updates outside the Committee or via the next iteration of the Organisational Risk Register as appropriate
5.2	**Audit Recommendations Tracker** C. Hamblyn presented the report to the Committee which outlined the 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 recognised the progress being made and the improvements the team were making in terms of the process. She advised that she would like to understand the process of escalation in terms of overdue actions and sought assurance as to the role the Executive Team take in focussing in on the areas that required attention. S. May advised that a Corporate Governance Dashboard was presented at the Executive Leadership Group on a weekly basis where this tracker was sighted. C. Hamblyn advised that the Director of Corporate Governance is leading on an approach to improve not only the audit action updates but also the compliance with management response returns. P. Dalton advised that some of the recommendations on the Tracker could have been agreed prior to the new Operating Model being implemented and recognised that this could have impacted the relevance of the recommendation and he suggested that he link in with the Corporate Governance Team if required to review any recommendations where this could be the case. The Chair reiterated the points of other members and requested further detail is captured in the report in terms of providing further detail in the dashboard as to the areas which have been overdue and higher risk. C. Hamblyn, in response, supported this request and agreed that whilst they were waiting for the automated system to be fully established they would look to improve the report for future meetings. The Chair queried the wording of the recommendation in that they were asking the Committee to approve the closures. C. Hamblyn advised that the wording should have been that the Committee were assured in terms of closing the recommendations.
Resolution	The Committee **NOTED** the Report and **AGREED** the assurances provided.
Action	To advise on the comments and feedback provided to the Committee to the Director of Corporate Governance.
5.3	**Joint Advisory Group (JAG) on GI Endoscopy** G. Hughes provided a presentation on the progress with the JAG on GI Endoscopy.

	K. Palmer referred to the decontaminated unit at the Princess of Wales Hospital and queried the impact on patients and services. G. Hughes confirmed that it did not have an impact. He advised that it was important that they had external pathways for best practice and that in terms of the decontaminated unit it was not unsafe, however, they wanted to move to a more permanent solution for this, however it would cost a significant amount of funding for a mobile unit and was not an appropriate use of resources. I Wells commented that it was helpful to receive the update. He referred to the Princess of Wales Hospital (POWH) and agreed that the funding for the mobile unit was not appropriate but queried whether there were any plans for a permanent facility. G. Hughes confirmed that there was an allocation within this year's capital plan to develop plans to incorporate the facility into the old pathology unit on the ground floor of POWH and it was intended that this would be included in future years of the all Wales Capital Programme. S. May confirmed that they were in the process of re-designing a new scheme that would be less expensive than the original one and that this was recognised as a priority within the 10 year prioritisation submission for the all Wales Capital Programme. She advised that this submission was currently going through a detailed review process with Welsh Government and they were awaiting feedback. The Chair requested a further update in six months' time.
Resolution:	The Presentation was **NOTED.**
Action:	To provide a further update to the Committee in six months.
	INTERNAL AUDIT
5.4	**Internal Audit Progress Report** P. Dalton presented the progress report that provided the Audit & Risk Committee with the current position of the work undertaken by Internal Audit. P. Dalton advised that there would be a number of reports coming through to the October meeting of the Committee and he would be working with the Governance Team on these. The Chair referred to the outstanding draft reports some of which were from May and requested that the Executive Team provide some momentum on them to improve the timescales for turnaround times. P. Dalton advised that there had been some transition between years with the 2024-25 programme of work being presented to the last meeting. He advised that this would be updated for the October meeting.
Resolution:	The report was **NOTED**
5.4.1	**Internal Audit Review - PCH Key Project Objectives** H. Richards presented the report which has been given a Reasonable Assurance rating.

	K. Palmer congratulated the team on a very positive review. The Chair referred to the earlier discussion on the high risks and the current forecast overspend subject to the VAT contingency within the plan and should the risks materialise they would be looking at a significant higher overspend and queried what the percentage level of that risk was. S. May advised that they intend to submit a detailed report on Capital schemes, including PCH, to the Planning, Performance & Finance Committee and suggested that the report could be shared with the Audit & Risk Committee once received. She added that the main challenge of the scheme was with regard to asbestos at Prince Charles Hospital (PCH) and the initial costs for phase 3 of the work will be exceeded. S. May assured the Committee that this was a regular feature at the Capital Board meetings and also discussed in detail at the PCH Ground and First Floor Project Board meetings. It was noted that a specialist estates lead from NWSSP sits on the Project Board.
Resolution:	The Committee **NOTED** the report.
5.4.2	**IA Review – PCH Redevelopment Programme Integrated Audit Plan 2024-25** H. Richards presented the report that set out the risk based audit plan for 2024-25. The Chair welcomed sight of the plan.
Action:	The Committee **NOTED** the report.
5.4.3	**IA Review – Technical Resilience Updated Management Actions** E. Samways presented the report that had received a Reasonable Assurance rating. I Wells commented that he did raise this at the last meeting of the Committee as he did not consider that the management response was as robust as it could be, however, confirmed that he is now assured of the plans in place and the actions assigned.
Resolution:	The Report was **NOTED.**
5.5	**Audit Wales - Audit & Risk Committee Update** S. Stark and D. Griffiths presented the report that updated Members on Audit Wales current and planned accounts and performance audit work. S. Stark advised Members that the draft Addendum Report was being finalised and would be presented to the Committee at their October meeting.
Resolution:	The Report was **NOTED.**
5.5.1	**Audit Wales Report – Minor Injuries Unit Follow Up**

	D. Griffiths presented the report that outlined the high level review to examine issues surrounding the temporary closure of the Minor Injuries Unit at Ysbyty Cwm Cynon. The Committee were advised that 3 out of the 4 recommendations had now been recommended to be closed on the audit tracker. The remaining recommendation with regard to the learning had plans in place.
Resolution:	The Report was **NOTED.**
5.5.2	**Audit Wales Report – Joint Review with HIW** D. Griffiths presented the report that outlined the conclusion of the review of the Health Board's progress in addressing the outstanding areas that had been highlighted in the previous report of August 2023. The report provided assurance that the Health Board had continued to make good progress in addressing the outstanding areas highlighted in the August 2023 report. D. Griffiths extended his thanks to G. Watts and C. Hamblyn for their assistance and support in this work.
Resolution:	The report was **NOTED.**
6.	**CLOSE OF BUSINESS**
6.1	**Any Other Urgent Business** The Chair referred to the earlier discussion on the Committee Referral to the People & Culture Committee with regard to agency staff and advised that she had now been provided with the outcome of the referral. The Chair advised that the response from the People & Culture Committee had provided reassurance rather than assurance and suggested that this should be further considered at the next meeting of the People & Culture Committee and that the Local Counter Fraud Specialist should be included in the discussion. The Chair also suggested that the scope should be extended to medical staff as well as nursing staff. The Chair requested that the outcome following the re-referral should be brought back to the Audit & Risk Committee. Members of the Committee sought assurance as to the recruitment process and if/how the Health Board could undertake checks to identify any other individuals in the system that were undertaking fraudulent activity in similar ways to the individual referred to in the counter fraud case discussed earlier in the meeting, in order to understand the scale of risk and the mitigations C. Hamblyn confirmed that she would action this outside of the meeting and link in with the Executive Lead and Chair of the People & Culture Committee.
6.2	**How Did we Do in this meeting**

	The Committee Chair advised that if Committee Members had any comments to raise as to how the meeting went today, then they could share these with herself and the Head of Corporate Governance outside the meeting.
6.3	**Committee Highlight Report**
Resolution:	The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.
7.	**CLOSE OF MEETING**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item	2.1.2

Unapproved / Approved Minutes of the Audit & Risk (CLOSED) In Committee

Date and Time of Meeting	Thursday 15th August 2024 at 12:30 pm
Venue	Virtual via MS Teams

Members Present	Patsy Roseblade	Independent Member (Committee Chair)
	Kath Palmer	Independent Member
	Ian Wells	Independent Member
In Attendance	Sally May	Executive Director of Finance
	Paul Dalton	NWSSP- Internal Audit & Assurance
	Emma Samways	NWSSP- Internal Audit & Assurance
	Steve Stark	Audit Wales
	Darren Griffiths	Audit Wales
	Cally Hamblyn	Assistant Director of Governance & Risk
	Kathrine Davies	Corporate Governance Manager (Secretariat)
Meeting Observers	None	

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions** P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.

1.2	**Apologies for Absence**
	• Gareth Watts – Director of Corporate Governance/Board Secretary (Cally Hamblyn in attendance) • Nathan Couch – Audit Wales • Mark Jones – Audit Wales • Geraint Hopkins, Independent Member
1.3	**Declarations of Interest**
	There were none to declare.
2.	**MAIN AGENDA**
2.1	**Organisational Risk Register (Business Sensitive Risks)** C. Hamblyn presented the report report for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed. C. Hamblyn advised that as these risks related to the Digital and Data portfolio they had been discussed in detail and reviewed by the Digital and Data Committee. She added that she had recently met with the Digital Team who advised that they are planning to undertake a wider review of their risks. The Chair queried where the risks would be discussed following the new Committee Structure coming into place. C. Hamblyn advised that the organisational risk register would be discussed and reviewed by the Operational Delivery Committee. In terms of the Board Assurance Framework, which articulates the strategic risks, these would be received at the Strategic Development Committee. The Chair reiterated her request that where the consequence score is changed when assessing the target score that a rationale is added to support the assessment. C. Hamblyn advised that this is fed back to risk leads and captured on the Risk Management Awareness training sessions.
Resolution:	The Organisational Risk Register was **DISCUSSED** and **NOTED**.
2.2	**Audit Recommendations Tracker** C. Hamblyn 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. The Chair queried why the report was being received in the private session given that the annual accounts had now been held in public along with the Auditors Report. C. Hamblyn advised that this has previously been discussed with Audit Wales colleagues who considered it best placed to be received in the 'Closed' session, however, in light of the position on the accounts now being publically available this will be revisited with Audit Wales colleagues.

	S. Stark advised that he would discuss with M. Jones following the meeting.
Resolution:	The report was **NOTED** and the assurances provided were **AGREED**.
Action:	To query with Audit Wales whether the report should now be received in the public session of the Committee.
3.	**ANY OTHER BUSINESS**
	There was no urgent business to report on this occasion.
4.	**DATE AND TIME OF NEXT MEETING:**
	17th October 2024 at 12:00 pm

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

Agenda Item
2.2.1

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
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

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	

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

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable for this report
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): 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.

6. Next Steps

6.1 There are no next steps required.

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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.

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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		⚑		⚑		⚑		⚑		⚑		⚑
Audit & Risk Committee Annual Cycle of Business	Director of Corporate Governance	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Committee Forward Work Programme	Director of Corporate Governance	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Audit & Risk Committee Annual Report	Director of Corporate Governance	Annually								⚑				
Audit & Risk Committee Annual Self-Assessment	Director of Corporate Governance	Annually				⚑								
Audit & Risk Committee Terms of Reference	Director of Corporate Governance	Annually								⚑				
Declarations of Interest and Gifts & Hospitality Report	Director of Corporate Governance	Quarterly				⚑				⚑				⚑
National Clinical Audit Annual Plan	Medical Director	Annually						⚑						
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Annual Financial Accounts	Director of Finance	Annually						⚑ Draft	⚑ Final					
Accountability Report (Including the Governance Statement)	Director of Corporate Governance	Annually						⚑ Draft	⚑ Final					
Annual Review of the Risk Management Strategy / Board Assurance Framework	Director of Corporate Governance	Annually				⚑								
Sustaining our Future														
Losses & Special Payments Report	Director of Finance	Quarterly		⚑				⚑		⚑				⚑
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		⚑		⚑		⚑		⚑		⚑		⚑

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

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		⚑		⚑		⚑		⚑		⚑		⚑
Counter Fraud Annual Report	Head of Local Counter Fraud	Annually				⚑								
Counter Fraud Annual Self Review	Head of Local Counter Fraud	Annually				⚑								
Counter Fraud Draft Work plan	Head of Local Counter Fraud	Annually				⚑								
Post Payment Verification Annual Report	Post Payment Verification Manager	Annually				⚑								
Post Payment Verification Mid-Year Update	Post Payment Verification Manager	Annually										⚑		
Improving Care														
Audit Recommendations Tracker	Director of Corporate Governance	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Organisational Risk Register	Director of Corporate Governance	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Consultant Job Planning	Medical Director	Bi-Annually				⚑						⚑		
Medical Rostering	Medical Director	Bi-Annually				⚑						⚑		
Internal Audit Progress Report	Head of Internal Audit	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually				⚑								
Internal Audit Reviews	Head of Internal Audit	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually						⚑						
Audit & Risk Committee Update	Audit Wales	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Audit Wales Review Reports (as relevant)	Audit Wales	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
Audit Wales Annual Audit Report	Audit Wales	Annually				⚑								
Audit Wales Audit Plan	Audit Wales	Annually				⚑								

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		⚑								⚑		

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

Agenda Item 2.2.2

AUDIT & RISK COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
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.**
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

Annual Item (deferred from August 24 meeting)	Audit Wales	Audit of Financial Statements Addendum Report	Audit Wales	17 October 2024
Deferred from October 2024 Meeting	IA Item	Capital Systems	Internal Audit	17 December 2024
Deferred from August & October 2024 Meeting	IA Item	Internal Audit Review – PCH Supply Chain Partner	Internal Audit	17 December 2024
Deferred from October 2024 Meeting	IA Item	Energy Management	Internal Audit	17 December 2024
Deferred from October 2024 Meeting	IA Item	Financial Savings Follow Up	Internal Audit	17 December 2024

COMPLETED ITEMS

Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	15 August 2024 **- Completed**
Requested via email	Audit Wales Item	MIU follow Up Report	Audit Wales	15 August 2024 – **Completed**
Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – PCH Key Project Objectives	Internal Audit	15 August 2024 – **Completed**
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**
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**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.1

ACTION LOG – AUDIT & RISK COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
3.1 & 6.1	August 2024	**Action Log/Any Other Urgent Business** Further re-assurance to be sought from the previous Committee Referral to the People & Culture Committee with regard to the Local Counter Fraud Report - Recruitment of Agency Staff.	Director of Corporate Governance/ Board Secretary	November 2024	**In Progress** Process to provide assurance is underway working with counter fraud and NWSSP colleagues with a report being received by the People & Culture Committee at their meeting to be held on 6th November 2024. The outcome of which will be fed back to the Audit & Risk Committee.
4.1	August 2024	**Local Counter Fraud Report** To discuss whether random spot checks at the recruitment process could be undertaken with the people and recruitment team.	Local Counter Fraud Officer	October 2024	**In Progress** Relates to above. A meeting between NWSSP Recruitment Services and the Counter Fraud Team has been set for 14 October. A quality assurance process is in place within Recruitment which is applied to individual files, this process will be reviewed during the meeting. Undertaking spot

					checks or a sample review will also be discussed for viability
5.1	August 2024	**Organisational Risk Register** To review, discuss and feedback comments to the Executive Leads and Care Groups on the risks 5820, 5462, 4906, 5755 and 1133 and provide updates outside the Committee or via the next iteration of the Organisational Risk Register as appropriate	Assistant Director of Governance & Risk	October 2024	**Completed** Captured in the Organisational Risk Register paper at item 5.1. • Risk 5820 has been updated in terms of the articulation of the risk (See row 38). • Risk 5462 – update in risk register notes that the A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3. (See row 10) • Risk 4906 – risk updated to reflect rationale for closure (See row 2 in de-escalated risks). It should be noted that this has been further updated since publication following discussion at the September QSC. • Risk 5755 – rationale for consequence change shared outside the Committee via email on the 1.10.2024. Risk 1133 – additional rational for de-escalation added. (See row 4 in d-escalated risks)
5.2	August 2024	**Audit Recommendations Tracker** To advise on the comments and feedback provided to the	Assistant Director of Governance & Risk	October 2024	**Completed** The report has been updated for the October meeting to incorporate further detail in terms of a performance

		Committee to the Director of Corporate Governance.			dashboard which hopes to address the queries and requests received at the meeting in August 2024.
5.3	August 2024	**JAG Accreditation Progress Report** To receive a further update in six months' time.	Chief Operating Officer	February 2025	**In progress** Added to Forward Work Plan
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 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	**Completed** Management Actions updated and received at the August 2024 meeting.

Completed Actions

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 *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 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.
3.1	June 2024	**Action Log**	Chief Operating Officer	August 2024	**Completed** Updated received at the August 2024 meeting.

		Query on when the Committee would receive an update on JAG Accreditation report or			
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
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	Assistant Director of	June 2024	**Completed** • Risk ID 5276 – an update on the

		Ophthalmology and 5417 Community Dental outside of the meeting.	Governance & Risk		mitigating action for the Laboratory Information System has been captured in the May 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 closed recommendation outside of the meeting.	Director of Corporate Governance/ Board Secretary	June 2024	**Completed** There was only one recommendation which remained open from this 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: *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.* 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 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	18th 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 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	15th April 2024	**Completed** Referral received and discussed at the People & Culture Committee held on 15 April 2024

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Agenda Item
4.1

Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
Statws Cyhoeddi / Publication Status	Open/ Public Choose an item.
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

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1. Situation /Background

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

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

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

4. Assessment

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

(Duty of Quality Statutory Guidance (gov.wales))		
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
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): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

6. Next Steps

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

Agenda Item 4.1a

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 17 October 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	30
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	30
Prevent and Deter Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	148	67
Hold to Account Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	310	181
TOTAL	606	308

4. STRATEGIC GOVERNANCE

An All Wales Counter Fraud Workshop was hosted by NHS Finance Academy. Guest speakers from DWP Benefits Fraud and NHS Counter Fraud Authority attended to provide detail around their approach to counter fraud activity. Counter Fraud Specialists then discussed Counter Fraud approach in NHS Wales and potential future structure. A further workshop is being planned to discuss approach with a wider range of attendees to include Directors of Finance, Audit Committee Chairs, Welsh Government and Counter Fraud representatives. To inform this approach Counter Fraud Colleagues have met and devised a strategy document including a potential structure to put forward as an option.

5. INFORM AND INVOLVE

A review of the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited is to be undertaken and will follow awareness opportunities arising from sentencing in recent prosecution. The Communications Team will be engaged and advice sought on current and future approach.
Alongside this the Counter Fraud Team's intranet offering will be reviewed and if necessary refreshed in line with any change in communications and awareness strategy.

6. PREVENT AND DETER

As follow up to successful prosecution relating to recruitment fraud the Counter Fraud Team have met with People Services to discuss learning and risk arising from that matter. Subsequently a meeting between Counter Fraud and NWSSP Recruitment has been set for 14th October and a draft Fraud Risk Assessment will then be shared with People Services for finalisation and recording on DATIX.

Work has concluded on the NHS Counter Fraud Authority led national proactive exercise around procurement with a focus on due diligence and contract management. Submissions to the NHS Counter Fraud Authority have been made and a findings report is anticipated around end of Q4.

7. HOLD TO ACCOUNT

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

The Counter Fraud Team are at near capacity for Hold to Account work given the amount of resource committed to action in current caseload.

Contingency is available to ensure continuation of investigative service by way of CFS Wales support to take on investigations on the Health Board's behalf.
Additional contingency would be to pause counter fraud proactive work to focus on reactive investigations. Deploying resource in this way may have an impact on deliverables in the Counter Fraud Work Plan however.

There is no cause for adjustment as yet and investigations are progressing alongside proactive work.

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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
16	0	14

Case Rates

Referrals Received 2024/25	Cases Under Investigation for Over 12 Months
12	3

Sanctions/Outcomes

Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
1	1	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 was originally set for September 2024 but was rescheduled for 17 October 2024. 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 investigaiton 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 meeting has been held with senior Primary Care colleagues to discuss investigation and current barriers to progression. An agreement was reached to proceed with seeking an independent expert opinion. This will then feed into providing clarity to this area to strengthen response to claims disputes as well as future counter fraud actions. The Counter Fraud Team will maintain presence across these discussions and provide advice along with review of ongoing fraud risk on a proactive basis.

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 approached to gain account and potential documentary evidence. Analysis of information now being undertaken.
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/24/00221	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.

Open Cases			
Reference Number	Date Opened	Allegation	Status
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. An overpayment of salary arose due to a subsequent job plan reduction and pay remaining the same. There were questions around the start date of the job plan reduction. A date has been settled on by Managers in this case and overpayment calculated on that basis. Counter Fraud enquiry centred on gaining assurance of that start date which then provides evidence in relation to the allegation of non-completion of contracted hours.

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 was exploring the concerns and an audit is now being undertaken in this area. 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. Review of photographic evidence showed that 2 photographs had been forwarded one front view and one side view. Tattoo was present on one and obscured by viewpoint on the other. No evidence to support ongoing investigation, case closure to be sought.

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/24/01324 is the linked reference.

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 was arranged with the subject who was accompanied by an appropriate adult and a legal representative. A disclosure of an ongoing and serious mental health condition led to interview not being undertaken. An agreement was offered by the subject's legal representative around repayment with an acceptance of monies received which were not entitled to. Given this situation this case has been assessed as not being in the public interest to pursue and civil recovery is underway.
INV/24/02125	28/08/2024	Theft of Controlled Drugs	Intelligence report received following contact via the Fraud and Corruption Reporting Line. A named employee has been alleged have stolen boxes of co-codamol from an identified department store. Controlled Drug Investigation Guidelines are being followed and Pharmacy colleagues have been engaged who along with Ward Manager are undertaking an audit of order and usage records.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/02326	19/09/2024	Working Elsewhere Whilst Sick	Staff member is alleged to be working for a private business whilst on sick leave from their Health Board role. Matter discussed with People Services contact and subject's manager. It was established that the subject is in fact in a period of unauthorised absence from their role and not on sick leave. A disciplinary procedure is at an advanced stage and will continue to conclusion with outcome awaited.
INV/24/02428	30/09/2024	Overpayment of Salary	An existing staff member moved to a new post within the Health Board. Process was intended to be undertaken as an internal transfer but a new ESR record was established for new role that led to subject being paid for both assignments resulting in an overpayment from 07/01/24 to 31/07/2024 with gross value of £10,508.17 and Net £7,216.78.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
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 established that a claim is still ongoing and is being actioned by the Legal & Risk Team. No evidence of dishonesty has been established. Details shared with Legal & Risk with agreement to refer any concerns arising from the process to be raised with the Counter Fraud Team.
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. Police were leading in this case and following enquiries did not establish any evidence to support ongoing investigation. GP was engaged and details shared for ongoing management of prescribing.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
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 hey 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.
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 supported with enquiries within the NHS. South Wales Police concluded the matter as intelligence only.

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Agenda Item
4.2

Audit & Risk Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
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	Endorse for Board Approval

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

Acronyms / Glossary of Terms	
OJEU	Official Journal of the European Union
FCPs	Financial Control Procedures
SoD	Scheme of Delegation
PSPP	Public Sector Payment Policy
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) Invoices on Hold & No PO No Pay summary

This report provides details of any such transactions within the period 01.08.24 to 30.09.24

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 01.08.24 to 30.09.24.

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 01.08.24 to 30.09.24

Table A – Single Tender Actions 01.08.24 to 30.09.24

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
CTM-STA 1740	Revenue	Strategy and Planning	Managing your Wellbeing with ADHD	Valley Steps	£50,000	(c)	12/09/24
CTM-STA 1744	Capital	Radiology	MRI Coil Replacement	Siemens Healthineers	£26,974	(c)	21/08/24

Reasons for approval:

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

b) Compatibility issue

c) Genuine 1 provider

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

TABLE B – Single Tender Actions – Retrospective – there are no retrospective STAs to report for this period.

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

Reference	Title	Supplier	Value	Date Approval Received
CTM-MIN-56846	Histopathology Outsourcing	Cyted Lot 1 Source Bioscience Ltd Lot 2	£2,000,000	17/09/24

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

Health Boards must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. Below is a retrospective summary of contracts awarded between 01.08.24 to 30.09.24

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

e) Free of Charge Services

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

unintentionally commit itself to a single provider or longer term commitment. Below is a summary of free of charge services that have been provided between 01.08.24 to 30.09.24:

There are no free of charge services to report for this period.

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	Area	Value of RT Order	Comments
BLUE ARROW LTD	559148_Houskeeping YCC	£169,016	Agency Staffing
	533928_RGH CAT STORE		
	533315_POW DOMS TENDER		
ST DAVID RECRUITMENT SERVICES LTD	533890_RGH PATHOLOGY	£34,627	Agency Staffing
	533870_RGH SURG OFFI		
	555972 Surg Dir Off		
BDI RESOURCING LTD	533351_POW X-RAY	£33,850	Agency Staffing
	555127 PCH WM and CHD		

g) Consultancy Contracts

Below is a table detailing consultancy contracts that have been awarded between 01.08.24 to 30.10.24

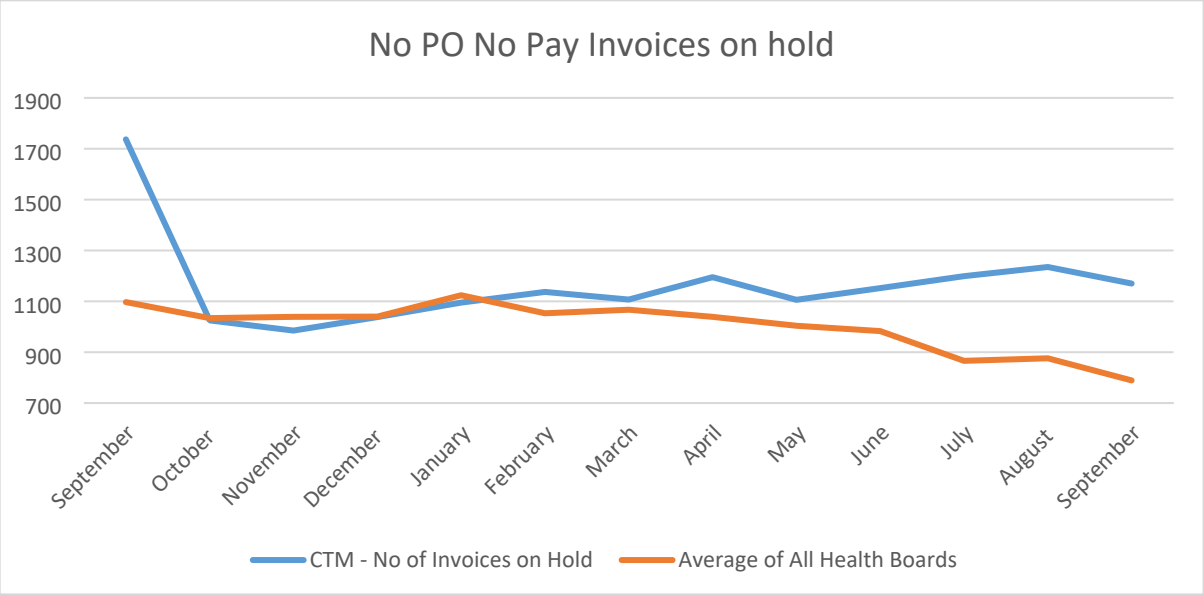
None for this period

h) Invoices on hold & No PO No Pay Summary

No PO No Pay

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 against the average across other Welsh Health Boards.



- CTM continue to have a higher number of invoices on hold due to NO PO compared to the average of all Welsh Health Boards.
- The trend of other health boards is an improving position since January, whereas the trend for CTM is remaining relatively steady.
- Recent communication has been included on staff news and circulated to all Oracle users on the recently updated All Wales No PO No Pay policy shown in Appendix 1. Highlighting the importance of raising POs in a timely manner.
- 516 (44%) of the invoices on No PO No Pay holds are relating to just 4 organisations. Procurement are prioritising focus on the category areas which are causing main issues.
- Without a PO an invoice cannot be assigned to a directorate or cost centre, therefore an assessment by directorate cannot be provided.

Other Invoices on Hold

Invoices can be put on hold in circumstances where a PO number has been provided, and this can be for various reasons, such as the good/service not being receipted; the value of the invoice being above the value of the PO; the quantity of the goods on the invoice being above the quantity on the PO etc.

At end of September 2024 there were 8,031 invoices on hold. Where the invoice quotes a PO the invoice can be associated to a directorate, below are number of invoices on hold by directorate:

Directorate	No of Invoice on Hold
Unknown	3511
Chief Operating Officer	1478
Planned Care	873
Diagnostics, Therapies & Specialities	565
Corporates	455
Unscheduled Care	399
Primary & Community Care	369
Children & Families	244
Mental Health & Learning Disabilities	110
Contracting & Commissioning	4
Non Delegated	1
Grand Total	**8031**

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to 31st August 2024.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 5 2024-25 achieving 95.1% (value 91.0%). This an improving position and it is projected the target will be met at 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
Jul-24	23,805	39,853,482	24,837	47,066,950	95.8	84.7
Aug-24	19,654	44,403,473	20,477	46,830,448	96.0	94.8
YTD	**105,489**	**195,531,665**	**110,875**	**214,899,409**	**95.1**	**91.9**

The NHS invoice position continues to be challenging and shows that 81.6% (number) and 96.0% (value) of invoices were paid within 30 days to Month 5 2024-25.

2.3 **Scheme of Delegation and Financial Control Procedures (FCPs)**

The previously titled Medical Variable Pay FCP has been reviewed, updated and is proposed to be replaced by the 'Medical Workforce controls and assurance procedure – Medical Variable Pay' FCP, shown in Appendix 2.

The Pay Expenditure section of the Scheme of Delegation requires amendment due to the approvals recommended within the Medical Variable Pay FCP. Appendix 3 and 4 show the tracked changes and clean version of the Pay Expenditure section of the Scheme of Delegation.

All changes to the Scheme of Delegation require approval at Board. Therefore the implementation of the updated Medical Variable Pay FCP is subject to approval, therefore

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

Escalate to board the approval of amendments to the Pay Expenditure Scheme of Delegation in line with the updated Medical Variable Pay FCP.

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 *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective	
	If more than one applies please list below:	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
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): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 The Audit & Risk Committee is asked to:

APPROVE the updated following FCPs:

MEDICAL WORKFORCE CONTROLS AND ASSURANCE PROCEDURE-MEDICAL VARIABLE PAY

ENDORSE TO BOARD FOR APPROVAL the update to the Pay Expenditure Scheme of Delegation in line with the update to the Medical Variable Pay FCP

NOTE the position on procurement matters for the period 01.08.2024 to 30.09.2024;

NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 5 of 2024/25;

6. Next Steps

If updated Scheme of Delegation approved by Board the updated Medical Variable Pay FCP will be implemented and communicated across the Health Board for adherence.

NHS Wales Shared Services Partnership

NHS Wales No PO No Pay (No Purchase Order No Payment) Policy

To be adopted by Each Health Board, Special Health Authority and Trust in NHS Wales

Contents:

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1 Introduction/Overview

The P2P - the Procure to Pay process – encompasses the end-to-end process from sourcing goods and services through to delivery and receipt of goods and payment to the supplier. A No PO No Pay policy is where invoices arriving in the system without an order number (unless on the approved exception list – see Appendix 1) are placed on hold and a weekly communication is emailed to the supplier who is instructed to seek an order number from the relevant department and manager that was supplied before payment is made. The aim is to drive up compliance with the Standing Financial Instructions as well as the standard order management process.

2 Policy Statement

The implementation of a national policy of 'No Purchase Order No Pay' is to be an essential and fundamental building block from which the efficiency and effectiveness of the P2P process can be developed.

3 Aims/Purpose

To ensure:

- That all goods and services are ordered appropriately and are supported by official Purchase Orders in line with LHB, Trust and Special Health Authority Standing Financial Instructions.
- Efficient processes are put in place so that goods are delivered when required.
- Costs are controlled by:
    - Ensuring all non-pay expenditure incurred by the organisation is valid and appropriately authorised in advance of the goods/services being received.
    - Minimising transactional costs associated with payment for goods.
    - Paying supplier invoices within deadlines set by Welsh Government.
    - Maximising financial incentives for early payment offered by suppliers.
    - Reducing the risk of late payment interest and fees being charged by suppliers.

4 Objectives

This policy seeks to ensure that NHS Wales only pays for goods, services and works which have been properly ordered and authorised in accordance with the NHS Wales Procurement rules and Standing Financial Instructions. It also ensures invoices received by the NWSSP Accounts Payable teams can be processed efficiently to minimise delay in payments to suppliers and contractors. Invoices received by the NWSSP Accounts Payable Team without a valid PO number will severely delay payment to the suppliers. Successful adoption of this policy will lead to the following benefits:

- Better control environment – the correct level of authorisation of purchase orders, in advance of expenditure being incurred.
- Catalogue compliance will be improved leading to less off catalogue purchasing and lead to revenue savings.
- More comprehensive procurement intelligence being captured through the system about what and where goods and services are purchased allowing for better sourcing decisions.
- Costs will be more accurately accrued by the system reducing management accounting and Accounts Payable (AP) team workload.
- Public Sector Payment Policy compliance will improve because processing times reduce.
- Early payment discounts can be maximised.
- Overall processing costs in NWSSP P2P will reduce, releasing resources for NHS Wales.
- Suppliers will be paid on time thus supporting the wider economy.
- Less late payment interest and fees will be charged.
- Supplies of goods / services will not be disrupted or stopped due to late payment of invoices.

5 Scope

This policy is relevant to the following groups of staff within NHS Wales Health Boards, Special Health Authorities, Trusts and NHS Wales Shared Services Partnership:

- ***Requistioners***
  Those staff that process requisitions for goods and services in departments and directorates within NHS Wales.

- ***Approvers/Budget Holders***
  Those staff that approve requisitions for goods and services in departments and directorates within NHS Wales.

- ***Staff that Receive Goods/Services***
  Those staff that indicate within the Oracle or other ordering systems that the goods/services ordered have been received.

- ***Procurement Staff***
  All NWSSP Procurement staff in the Procurement Directorate.

- ***Accounts Payable Staff***
  All NWSSP Accounts Payable staff involved in the invoice payment process.

- ***Finance Departments***
  All staff involved in financial management.

6 Roles and Responsibilities

6.1 All Staff with Responsibility for Ordering

It is the responsibility of all staff, designated under the local scheme of delegation, that order goods and services to ensure that a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.2 Requistioners

All staff that raise requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.3 Requisition Approvers/Budget Holders

All managers and budget holders designated to approve requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. It is their responsibility to ensure the person raising the order has sufficient information to be able to do so, and knowledge of when the goods / services are received to be able to update the system accordingly. If the goods/services being ordered are on the Exception list, then all managers and budget holders must ensure their staff are

aware of the correct payment authorisation process for those goods/services. These invoices will come in requiring Authorisation and be put on an Awaiting Authorisation hold. Any invoice not classed as an exception and does not quote a valid PO number will be subject to a non-compliance escalation procedure.

6.4 Staff who 'Receipt' Goods and Services

All staff that work in central stores, receipt and distribution points and local departments where goods are delivered, or services are received have responsibility for recording the goods/services as being received. They must ensure that the Purchase Order is marked as 'received' as soon as possible within the Oracle system within 2 working days following delivery of goods or provision of the service.

6.5 Procurement Services Staff

All staff working within NWSSP Procurement Services will engage with Health Board/Trust/SHA accountable Budget Holders to ensure that this policy is adopted and adhered to by all HB/Trust/SHA staff and that local operational procedures for supporting the No PO No Pay Policy are observed at all times. Procurement Services will ensure training and awareness of the Policy with Key HB/Trust/SHA stakeholders.

6.6 Accounts Payable Staff

All staff that process the payment of invoices within NWSSP Accounts payable must ensure that no invoice is paid (unless it is identified as an exception in Appendix 1) if a Purchase Order number is not quoted on the invoice. All invoices received with no Purchase Order number must be recorded within the Oracle system and the supplier notified in accordance with the communications shown in Section 8. The invoice will be placed on a No PO No Pay hold and marked as disputed.

6.7 Finance Staff

The Finance P2P Lead in each Organisation must promote this policy to finance staff, requisitioners, approvers, budget holders & receipters within their Organisations.

Finance staff must ensure there are processes in place to capture data on invoices received but unpaid, that have no Purchase Order, so that expenditure can be accrued if necessary.

7 Operation of the Policy

7.1 How does No PO No Pay Work?

No PO No Pay policy operates by requiring all invoices submitted by suppliers to contain an official PO number. In all but agreed exceptional circumstances the PO number will be:

- Generated from NHS Wales Oracle Ordering system or
- Generated from other local ordering systems e.g. pharmacy; and
- Given to the supplier or contractor BEFORE making any commitment to spend NHS Wales's monies.

There are a number of categories of expenditure that are excluded from the policy which are shown in Appendix 1.

Any invoice received by the Accounts Payable Team that is not on the exception list and does not quote a valid PO number will incur processing and approval delays which could result in severe delays to supplier payment. Exceptions will be reviewed and amended from time to time and users notified of the amendments accordingly.

7.2 What constitutes a Valid PO?

An exercise will be undertaken to remind suppliers of the NHS Wales No PO No Pay Policy and reinforce that they must not, under any circumstances, accept any verbal or written order from NHS staff unless a valid PO number is given or there is an agreed exception as set out in Appendix 1.

Any invoice received that does not quote a valid PO number will be placed on hold until a valid PO number is provided.

7.3 What is a Valid PO number?

Valid PO numbers are generated from NHS Wales ordering systems as follows:-

- Oracle Financial and Procurement System
  - Oracle is the standard financial system used by NHS LHBs/ Trusts/SHAs in Wales.
- Oracle via Basware

    - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- Oracle EBS via GHX
    - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- The Pharmacy system used for generating pharmaceutical orders.

7.4 Submission of invoice

The Purchase Order will confirm which address invoices need to be submitted for payment. Some invoices will be submitted through the electronic exchanges or via the OCR process.

7.5 Public Sector Payment Policy

Provided a supplier has quoted a valid Purchase Order number which has been obtained in advance of supply, NHS Wales commits to paying invoices in line with the Public Sector Payment Policy i.e. within 30 days from the later of the receipt of goods or services or receipt of a valid invoice [not the invoice date].

All NHS Wales organisations are required by Welsh Government to be at least 95% compliant with this policy. Compliance is reported quarterly to Welsh Government, and annually in the Organisation's annual financial accounts.

7.6 Notification to Supplier of No PO on Invoice

If a supplier sends an Invoice without a Purchase Order number quoted and it does not sit within the agreed exception list, Accounts Payable will email the supplier weekly to inform them that their invoice has been placed on hold and that the supplier must contact the Health Organisation and request a Purchase Order number to be given to them. The supplier will be reminded of outstanding invoices awaiting confirmation of a Purchase Order every time the No PO No Pay report is run.

8 Non-Compliance

Non-compliance with this policy results in non-compliance with the Organisation's Standing Financial Instructions. The method of dealing with non-compliance will be for each organisation to determine but may include:

- Retraining of member of staff
- Escalation to senior management
- Escalation to Audit Committee (or equivalent)
- Escalation to Board

- Removal of access rights to the Oracle system

9 Training

Training resources aimed at the key staff affected by this policy have been developed and iProcurement training can be provided upon request from the NWSSP e-Enablement team.

10 Implementation

The No PO No Pay policy was implemented across NHS Wales on the 1st September 2018. In accordance with clause 12 below, the latest formal review of the Policy has been undertaken in June 2024 and the proposed changes/amendments to it will be adopted by all NHS Wales Organisations

11 Audit

The application of this policy will be subject to internal audit review as part of the NWSSP Accounts Payable audits.

12 Review

This policy was implemented in September 2018, reviewed in September 2023 with further amendments in June 2024 and is due for further review in June 2027.

APPENDIX 1

All Wales Exceptions to the No PO No Pay Policy

The following items are exceptions and do not require a valid PO number. This includes a number of areas where local ordering systems are in place with appropriate authorisation control processes that do not require an Oracle PO to be raised.

	ALL WALES EXCEPTIONS
Barrister Fees	Yes
Blue Badges	Yes
Bunkered Fuel & Fuel Cards	Yes
Capital Construction contracts (where approval outside of Oracle)	SBU only
CHC - FNC	Yes
CHC/Nursing Home Payments	Yes
Collaborative Fees (GPs)	Yes
Dental (paper based ordering)	BCU only
Estates (Grammes/Studio 3 Feed)	BCU & WAST only
Eye Tests	Yes
Fleet vehicles (Chevin Feed)	WAST only
GP Loads (Drugs)	Yes
Grants	Yes
HMRC	Yes
Hospital Car service	Yes
Lease Car repairs	Yes
Local Government/Authorities including Business Rates	Yes
Losses & Compensation including Redress	Yes
NHS Organisations excluding NHS Supply Chain	Yes
Nurse agency	Yes
Orthotics	Yes
Patient reimbursements including patients travelling	Yes
Petty Cash	Yes
Pharmacy (including home deliveries ordered through pharmacy system)	Yes
Primary Care contracts OOHRs	Yes
Primary care Low vision - HESP forms	Yes
Public Finance initiative	Yes
Purchase/Procurement Card	Yes
Telephone Landline - Line Rental, Call Charges & Maintenance	Yes
Telephone - Mobile Phone Charges	Yes
Salary deductions	Yes
Salary Sacrifice Schemes	Yes
Same day couriers	Yes
Tax, NI & Superannuation	Yes
Taxi Patient transport	WAST & NWSSP only
TV & Music Licences	Yes
Utilities (Gas, Electricity, Water and Oil heating)	Yes
Work Permits/Certificate of Sponsorship	Yes

FCP: MEDICAL WORKFORCE CONTROLS AND ASSURANCE PROCEDURE

MEDICAL VARIABLE PAY

Initiated by:	Executive Medical Director Executive Director for People Executive Director of Finance Chief Operating Officer
Approved by:	Audit & Risk Committee
Date approved:	August 2024
Operational Date:	September 2024
Date for review:	September 2027
Version:	2
Distribution:	Executive Directors Deputy COOs Care Group Medical Directors Care Group Heads of People Care Group Operational Managers Care Group Heads of Finance Directorate Managers Medical Workforce SharePoint NWSSP Payroll Retinue

Freedom of Information Status: Open

ACRONYMS	
ADH	Additional Duty Hours
ANP	Advanced Nurse Practitioner
CCS	Crown Commercial Services
CG	Care Group
DE	Direct Engagement
DM	Directorate Managers
F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
MD	Medical Director
MVP	Medical Variable Pay
MWPP:PEG	Medical Workforce Productivity Programme: Performance and Escalation Group
NHS	National Health Service
NI	National Insurance
Non DE	Non-Direct Engagement
NROC	Non-resident on call
NWSSP	NHS Wales Shared Service Partnership
StL	Specialty Trainee (Lower)
StH	Specialty Trainee (Higher)
UHB	University Health Board
WLI	Waiting List Initiative
WTR	Working Time Regulations

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1.0 Scope and Principles

2.0 Additional Duty Hours

3.0 Agency

4.0 Agency Locum Control Deployment

5.0 Waiting List Initiatives

6.0 Monitoring Arrangements

7.0 Payroll Authorisation Records

8.0 Equality Impact Assesment

Appendix – Flow Charts

1.0 Scope & Principles

1.1 This document sets out the controls over the University Health Boards (UHB) Medical Variable Pay (MVP). This document replaces the MVP document dated February 2023.

1.2 This document has been produced as part of the ongoing work of MWPP.

1.3 This document clearly defines the use of ADHs and WLIs.

1.4 It states a consistent process for the monitoring, verification and payment of ADHs, WLIs and agency spend within CGs by setting out clear roles and responsibilities for approving, engaging, paying and monitoring. The People Directorate are responsible for the Retinue contract and providing oversight, reporting and monitoring of activity to CGs and MWPP: PEG and influencing alternative approaches to reduce bank and agency spend.

1.5 Where a rota gap is identified, the reason must be established by the Directorate Manager (DM) (or nominated deputy) and accurately recorded on Patchwork. If the gap is for long-term absence such as sickness/maternity leave, the first stage is to ensure that an advert is placed on the TRAC system for fixed term cover, in agreement with the Finance Business Partner and Head of People. It will be the responsibility of the DM or nominated deputy to ensure that the CTM Fixed Term Contract Policy is followed and only used in the correct situations. Also, to note the end of a FTC is a termination in law and the appropriate notice must be given. Advice should be sought from Medical Workforce / People Services Teams in these circumstances. Any extension of these arrangements will need to be escalated to the Medical Director/Head of Medical Workforce to ensure there are no workforce risks.

If the gap is for a vacancy, the Directorate Manager would need to discuss with their Finance Business Partner and Head of People to consider any other alternative workforce solutions before advertising the post on the TRAC system. These could be roles such as Specialist Grade Doctors, ANPs and Physicians Associates.

In the meantime, if the gap must be covered a bank worker should be sought via the Patchwork App and only sent out to agency as a last resort. The DM will be responsible for monitoring the process to ensure bank has been exhausted before sourcing agency cover.

1.6 The UHB must use the approved framework agreement "Crown Commercial Services (CCS) Framework RM6281 in order to procure all medical and dental agency workers. National Framework for the Provision of Clinical and Healthcare Staffing - CCS (crowncommercial.gov.uk)

1.7 The UHB currently contracts with a neutral vendor (Retinue) to provide bank and agency workers requested within the health board.

1.8 No agency locum bookings may be made outside the Retinue process.

2.0 Additional Duty Hours

2.1 ADH cover can be provided by both substantive Medical and Dental staff or by bank only workers. Both substantive staff and bank only workers are engaged to undertake ADHs on bank worker terms of engagement.

2.2 Medical and Dental staff also provide "backfill" for planned activity for example, out-patient clinics and theatre lists, and this will be remunerated at the ADH rate; if the doctor is accommodating this work in an uncontracted session.

2.3 If a doctor is covering on call during the daytime, and is already in work, then no additional payment is made. If the doctor is covering during the daytime or out of hours, when they are on leave or uncontracted to work, then this activity is remunerated as per the ADH rate card. If undertaking additional Direct Clinical Care (DCC) in what should be Supporting Professional Activities (SPA) time, a claim is for the time period to which the SPA has been displaced. Confirming that by working these additional shifts, the working pattern has not breached the rest break and rest period requirements of the Working Time Directive.

2.4 A standard rate card has been developed for all Medical and Dental ADH cover. These are the rates that are payable to the Doctor. The rates in the table below are resident rates. The non-resident rate on call (NROC) is remunerated at 50% of the rate below.

Grade	In Hours (per hour)	Out of Hours 9pm-7am, Weekends and Bank Holidays (per hour)
F1	£40	£50
F2	£45	£60
STL(CT/ST1-ST2/3)	£60	£70
STH (ST3/4- ST8)	£70	£80
Specialty Doctor	£70	£80
Consultant	£100*	£125

Non Residential On Call Rate (NROC) 50% of rate above

*In exceptional circumstances where the Consultant is requested and agrees to be immediately available, i.e., 'resident on call', this will be remunerated at three times the sessional payment at Point 6 of the Consultant salary scale, excluding commitment awards and Clinical Excellence awards. In such circumstances, there will be an agreed compensatory rest period the following day. For these purposes, a session will comprise four hours and apply between 5pm and 9am weekdays and across weekends.

2.5 The ADH rates includes annual leave but does not include employer's on-costs, such as NI and pension. Breaks (20 minutes after 6 hours) are automatically deducted by the Patchwork software. In the event a break

cannot be taken, manager to authorise so this time is paid as a break could not be taken. This will be monitored via reports from Retinue and any issues or themes will be escalated by the People Directorate to MWPP: PEG.

2.6 Where there is a requirement for **any** rates up to 10% outside the ADH rate card for additional duty hours, payments must be authorised in advance by the Care Group Medical Director and for any rates over 10% outside the ADH rate card must be authorised in advance by the Executive Medical Director. The (Deputy) Directorate Manager will create a rate escalation on the Patchwork system for EMD approval. In the absence of the EMD, authorisation in advance could be sought from the Deputy Medical Directors or for urgent Out of Hours requests to be approved by the Executive Director on call. There will be regular reporting and review of all rates in excess of the Rate Card per Care Group at PEG for any issues, themes and actions to be addressed.

2.7 ADH rates which are above the agreed rate card are reported monthly via the MWPP Performance and Escalation Group (PEG), chaired by the Deputy Medical Director. The Care Groups are accountable for any escalations of ADH rates above the agreed rate card and for ADH spend.

2.8 The ADH shift will be remunerated at the rota grade required on the roster and not the grade of the individual.

2.9 All ADH claims must be submitted via the Retinue Bank using the Patchwork app.

2.10 Where there is a pattern of regular and predictable ADHs then the Directorate Manager would review the underlying reason(s) for the additional demand and develop plans with the CG, Finance Business Partner and the Head of People for a more sustainable and affordable workforce solution.

3.0 Agency

3.1 The rate noted in the table is the total rate to be paid to the agency doctor. It *does **not*** include agency commission, travel costs and accommodation costs. The rate is exclusive of VAT & the managed service fee.

The NROC rate is 50% of the resident rate.

Breaks (20 minutes after 6 hours) are automatically deducted by the Retinue software. In the event a break cannot be taken, a worker can make a note to on the Patchwork App for the approving manager to authorise so this time is paid as a break could not be taken. This will be monitored via reports from Retinue and any issues or themes will be escalated by the People Directorate to MWPP: PEG.

3.2 Where there is a requirement for **any** rates up to 10% outside the agency rate card for additional duty hours, payments must be authorised in advance by the Care Group Medical Director and for any rates over 10% outside the agency

rate card must be authorised in advance by the Executive Medical Director. The (Deputy) Directorate Manager will create a rate escalation on the Retinue system for EMD approval. In the absence of the EMD, authorisation in advance could be sought from the Deputy Medical Directors or the on-call Exec OOH. There will be regular review of all rates in excess of the Rate Card per Care Group at PEG for any issues, themes and actions to be addressed.

3.4 When considering a breach, above the agency rates the overarching principle is to consider the risk to the delivery of safe services and patient care and safety, whilst also attempting to:

a) Avoid using non direct engagement medical staff
b) Consider alternative skills or workforce (i.e. ANPs, PAs or Specialist Grades)
c) Consider the rota/shift patterns
d) Take into consideration coverage through existing workforce

3.5 A report will be sent to each CG and the Executive Medical Director on a bi-monthly basis. The report will provide a breakdown of the hourly rate, the name of the doctor, length of placement, CG and the reason why the doctor has been engaged. These will be produced by Retinue. They will be overseen by the People Directorate at regular weekly meetings and then cascaded to CGs..

4.0 Agency Locum Control Framework Deployment

4.1 All rota gaps must be identified using the Health Roster system* and shifts to be filled via ADHs or agency locums. These must be approved by the relevant Directorate Manager. This approval also confirms the gaps are for posts that are within the agreed funded establishment will be reviewed and monitored at the MWPP:PEG.
* The Anaesthetics and Emergency Medicine departments in the UHB do not currently use Health Roster.

4.2 Retinue flag any placement extensions for agency locums prior to end date for approval. The department are required to explain what recruitment activity has been undertaken and the reason for the extension/placement which is monitored at MWPP PEG. Authorisation will be required from the Care Group Medical Director prior to approval. Each Care Group is required to keep a central file of these approvals for audit purposes.

4.3 All agency locums should be engaged via DE. Any requests for the engagement of a Non-DE candidate will require approval from the Care Group Medical Director. Care Group Directors will be asked to clarify reasons for using non-DE staff at the MWPP PEG monthly meetings.

4.4 All agency bookings must be made via Retinue. Care Groups must not under any circumstances engage with locum agencies directly. System functionality can be used to identify any bookings made directly with reason code 'self-arranged' being selected when the booking is created. Patterns of behaviour are identified by looking at bookings created retrospectively which also suggest potential process breach and reported to EMD/CGMD.

4.5 Retinue will encourage non DE agency locums to switch to being directly engaged.

4.5 Once a shift has been worked by an agency locum the shift must be confirmed and 'finalised' in Health Roster/Retinue Bridge by the CG Directorate Manager, and the hours worked amended if necessary.

4.7 All timesheets must be completed by the locum on the Retinue Bridge system and approved by the Directorate Manager against the Health Roster system to ensure the correct rates and hours are paid. This approval will also serve as the Care Group's approval for payment.

4.8 Once a doctor has ended their placement the Clinical Director is required to provide feedback on their performance. This is undertaken on Retinue Bridge in the form of an online questionnaire in which the doctor is rated. Any negative ratings will flag automatically if this doctor is booked again by another CSG. In addition, a doctor can be placed on a 'Do Not Use' list meaning they cannot be put forward by their agency for any future jobs within the UHB.

4.9 All agency locums booked via the DE process will be paid by the Health Board. The payments will be processed weekly by the Payroll Services of the NHS Wales Shared Service Partnership (NWSSP).

4.10 In exceptional circumstances, where an agency locum is not booked via DE, payments will be made via the Accounts Payable Services of the NWSSP.

4.11 Retinue will send a monthly consolidated invoice for agency plus a monthly consolidated invoice for Bank. It will include the agency commission, names of locums and the managed service fee as per the contract

4.12 Monthly reports will be provided by Retinue to each CG for scrutiny. These will set out the overall spend, DE rates, any escalation of rates and information on the highest earning and longest serving individuals. This information is also reported to PEG for discussion and scrutiny with the CGs.

5.0 WAITING LIST INITIATIVES (WLI)

5.1 A Waiting List Initiative (WLI) is additional work that is agreed to be undertaken in order to support waiting lists and meet Welsh Government targets.

5.2 The WLI rate is only applicable to Medical & Dental Consultants in line with the amendment to the Consultant Contract (Wales) 2003 and only when the activity is clearly defined as a WLI. The WLI rate is set out annually in the Welsh Health pay circular.

5.3 WLIs should only be agreed as additional sessions which are planned to specifically address waiting list challenges and does not include planned clinics or theatre lists. They must not be agreed for backfilling core sessions.

WLI payments are for WLIs that are designated on the **priority** list by WG or the UHB. The use of the WLI rate in the UHB will be confirmed by the (two deputy) COOs and all other backfill sessions will be at the standard agreed ADH rate, not the WLI rate. WLI rates only apply to consultants, not to SAS doctors, as per the Welsh contract.

5.4 All WLI sessions must be authorised by the Directorate Manager and submitted by the doctor to via the Patchwork App. The COO team will keep a record of WLIs authorised and not authorised. This information will be monitored via PEG.

5.5 All non-Consultant grades involved in what may be considered WLI sessions, will be remunerated as set out in the ADH rate card (*v.* 2.4 above). WLIs are not paid to grades other than Consultants.

6.0 Monitoring Arrangements

6.1 No agency locum bookings or bank shifts should be made outside of Retinue. Procurement will escalate any invoices from locum agencies which are outside of the Retinue contract/process.

6.2 Retinue produces reports with CGs which are monitored by the People Directorate at a regular weekly meeting.

6.3 Rota gaps on Health Roster will be monitored by the People Directorate and Finance Business Partner every month to ensure that any ADHs or agency locums approved are for posts that are within the agreed funded establishment.

6.4 Agency and bank rates which are up to and 10% above the agreed rate card are reported monthly via the MWPP Performance and Escalation Group (PEG), chaired by the Deputy Medical Director. The Care Groups are accountable for any breaches of the agency rates above the agreed rate card and for agency spend.

6.5 Agency, bank and WLI breaches which are above the 10% rates cards and WG cap are reported to the Audit & Risk Committee on a bi-monthly basis.

6.6 The performance of the medical managed service contract provider, Retinue, is reviewed on a quarterly basis by the People Directorate, Finance and Procurement to ensure it is delivered in line with the contractual arrangements. The outcome is shared between attendees and any escalation is to the Executive Director for People.

7.0 Payroll Authorisation Records

7.1 All payroll authorisation and monitoring records will be:

a) Properly controlled
b) Readily accessible for use, and
c) Properly archived or otherwise disposed of

7.2 This will be managed through Retinue Bridge and Patchwork Systems with a direct link to NWSSP Payroll and NWSSP Accounts Payable.

7.3 The actions taken to achieve the above should be in accordance with the NWSSP's and Health Board's Records Management Policy. These policies should be read in conjunction with other relevant FCPs.

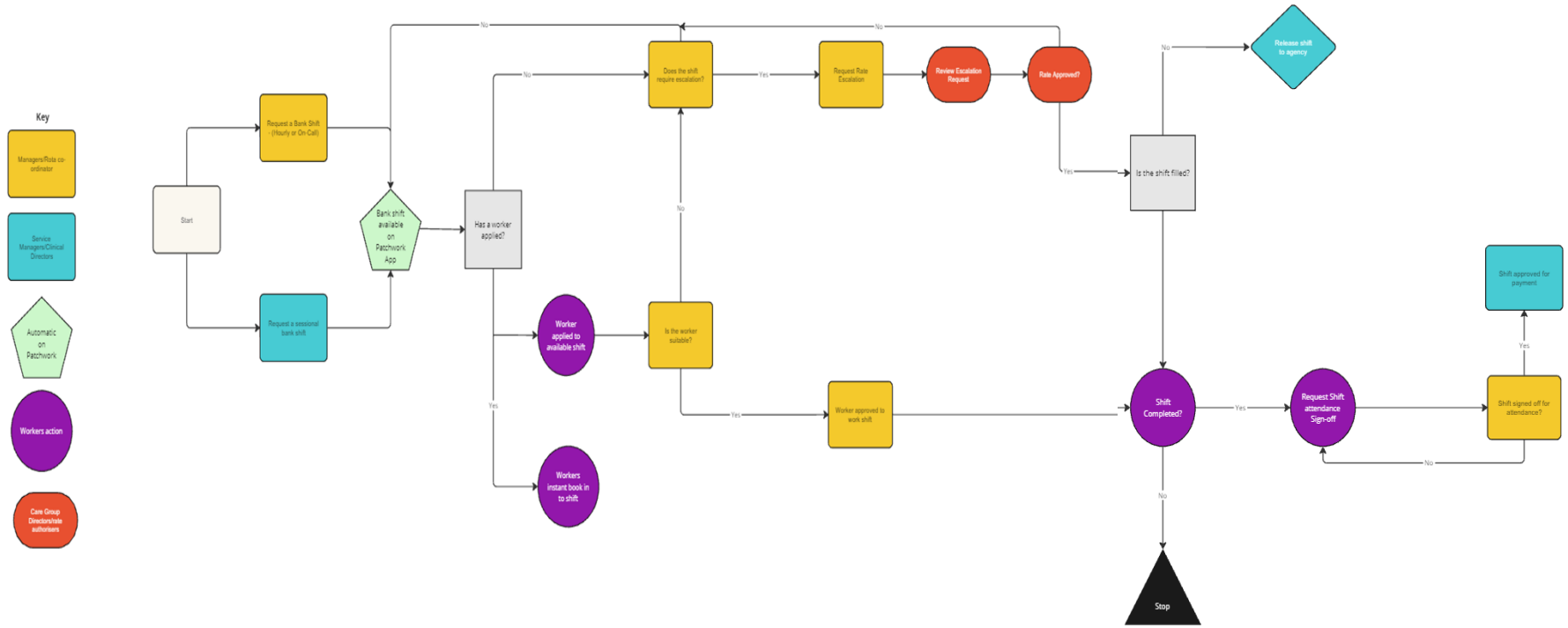
7.4 No payments can be authorised or paid outside of the prescribed process.

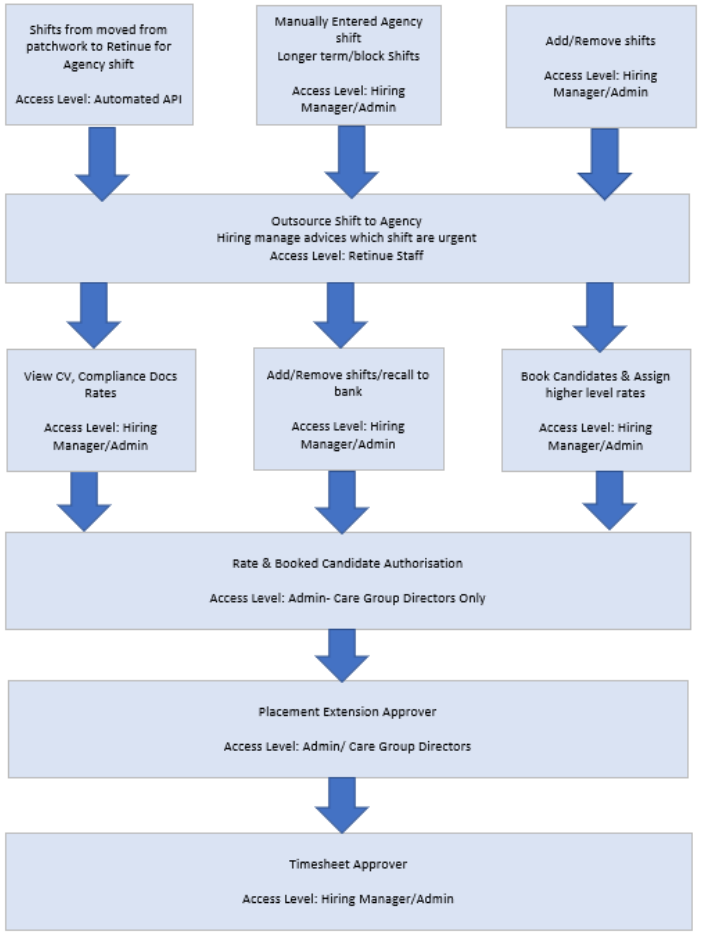
8.0 Equality Impact Assessment

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

Appendix

Flow Charts





Finance Level Access

Read only Access on systs

Access Level: Finance

Read only Access on Timesheets

Access Level: Finance

Run Payroll files

Access Level: Finance

Access invoicing Sections

Access Level: Finance

10. Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The funded establishment of any department may not be varied without the approval of the Chief Executive or an officers with delegated authority (provided that the change in funded establishment is in line with the virement of budget approver under 4E)	13.2.2	CEO	Director of Finance
B	No Board member or UHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.	13.3.1	CEO	Director of Finance

	New Appointments, Bank and agency costs	Delegated Approval / Sign Off by:
B1	Employment of all fixed term and permanent staff – except medical consultants	~~VR form signed by Clinical Service Group Managers and Finance lead prior to submission to VCP~~ Via Trac approval process
B2	Employment of fixed term and permanent staff (subject to any vacancy review policy in place)- Medical consultants only	~~VR form signed by Directorate manager and Finance lead prior to submission to Executive Catch up~~

		~~Meeting~~Via Trac approval process
B3	Nursing bank and On contract agency	Ward Manager
B4	Nursing agency Off contract	~~Clinical Service Group~~ Directorate Manager
B5	Additional Duty Hours via Patchwork i) Rate up to Standard ADH Rate Card ii) Rates up to 10% outside the ADH Rate Card iii) Rates over 10% outside the ADH Rate Card[1] NB Rates over the standard rate MUST be authorised in advance	 i) Directorate Manger ii) Care Group Medical Director iii) Executive Medical Director (in absence of EMD, authorization may be sought from Deputy Medical Directors)
B6~~5~~	Medical A~~a~~gency - On Contract - Off Contract -Engagements above ~~price caps~~Standard Rate Card ~~as determined by Welsh Government~~ (On and Off Contract): ~~Rates~~ i) Rate up to Standard ADH Rate Card ii) Rates up to 10% outside the ADH Rate Card	~~Clinical Service Group~~Directorate Manager Executive Director ~~Medical Director~~ i) Directorate Manger ii) Care Group Medical

	iii) Rates over 10% outside the ADH Rate Card[1] NB Rates over the standard rate MUST be authorised in advance	Director iii) Executive Medical Director (in absence of EMD, authorization may be sought from Deputy Medical Directors)
B7	Waiting List Initiative (WLI) i) The use of WLI rate in the UHB ii) WLI sessions authorised and submitted by doctor on Patchwork App	i) Confirmed by Deputy COOs ii) Directorate Manager
B8~~6~~	Engage non-medical, non-payroll staff (subject to contracting and tax assurance rules):*	**Director of W&OD and Head of Procurement to confirm agreement on off contract hires prior to any commitment.**
	- Below **£10k** gross commitment	~~Clinical Service Group~~ Directorate Manager
	- **£10k** to **£25k** gross commitment	Care Group Service Director / Deputy COO
	- **up to £100k gross commitment**	Board/Executive Directors

	- **> £100k gross commitment**	Director of Finance or Chief Executive

[1]Urgent Out of Hours request to be approved by the Executive Director on call

10. Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The funded establishment of any department may not be varied without the approval of the Chief Executive or an officers with delegated authority (provided that the change in funded establishment is in line with the virement of budget approver under 4E)	13.2.2	CEO	Director of Finance
B	No Board member or UHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.	13.3.1	CEO	Director of Finance

	New Appointments, Bank and agency costs	Delegated Approval / Sign Off by:
B1	Employment of all fixed term and permanent staff – except medical consultants	Via Trac approval process
B2	Employment of fixed term and permanent staff (subject to any vacancy review policy in place)- Medical consultants only	Via Trac approval process
B3	Nursing bank and On contract agency	Ward Manager

B4	Nursing agency Off contract	Directorate Manager
B5	Additional Duty Hours via Patchwork i) Rate up to Standard ADH Rate Card ii) Rates up to 10% outside the ADH Rate Card iii) Rates over 10% outside the ADH Rate Card[1] NB Rates over the standard rate MUST be authorised in advance	 i) Directorate Manger ii) Care Group Medical Director iii) Executive Medical Director (in absence of EMD, authorization may be sought from Deputy Medical Directors)
B6	Medical Agency - On Contract - Off Contract Engagements above Standard Rate Card (On and Off Contract): i) Rate up to Standard ADH Rate Card ii) Rates up to 10% outside the ADH Rate Card iii) Rates over 10% outside the ADH Rate Card[1]	Directorate Manager Executive Director i) Directorate Manger ii) Care Group Medical Director iii) Executive Medical Director (in absence of EMD, authorization may be sought from Deputy Medical Directors)

	NB Rates over the standard rate MUST be authorised in advance	
B7	Waiting List Initiative (WLI) i) The use of WLI rate in the UHB ii) WLI sessions authorised and submitted by doctor on Patchwork App	i) Confirmed by Deputy COOs ii) Directorate Manager
B8	Engage non-medical, non-payroll staff (subject to contracting and tax assurance rules):*	Director of W&OD and Head of Procurement to confirm agreement on off contract hires prior to any commitment.
	- Below **£10k** gross commitment	Directorate Manager
	- **£10k** to **£25k** gross commitment	Care Group Service Director / Deputy COO
	- **up to £100k gross commitment**	Board/Executive Directors
	- **> £100k gross commitment**	Director of Finance or Chief Executive

[1]Urgent Out of Hours request to be approved by the Executive Director on call

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Agenda Item
4.3

Audit & Risk Committee

Post Payment Verification Mid-Year Report 1st April – 30th September 2024

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Amanda Legge – All Wales Post Payment Verification Manager
Cyflwynydd yr Adroddiad / Report Presenter	Amanda Legge – All Wales Post Payment Verification Manager
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Included in the body of the report	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
Included in the body of the report.	

1. Situation /Background

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

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

In mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. It also compares the overall performance of the Health Board against the national PPV visits.

The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

2. Specific Matters for Consideration

2.1 In 2023-2024, PPV began recovering from a new General Medical Services (GMS) payment system and a backlog of work and completed 174 GMS routine visits and 29 GMS revisits across Wales. This new financial year we have concentrated on both our revisits that were overdue and routine visits and continue to maintain an excellent level of PPV across all Disciplines, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

The following key points should be noted:

General Medical Services (GMS):

Firstly, in this financial year, we will be concentrating on all outstanding revisits, and if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

In 2024-2025 we have 52 visits due for Cwm Taf Morgannwg University Health Board which is made up of 27 routine visits and 25 revisits. Currently, we have 13 visits in progress. As revisits check 100% of the services triggered from the original routine, they take a longer time to complete.

General Ophthalmic Services (GOS): The visit plan for GOS 2024-2025 is a rolling plan of 3 years. PPV began remote access options last financial year having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful. Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records and we did not manage to complete all the visits that were due.

This new financial year of 2024-2025 we are well on target with 16 visits planned and have 5 in progress. We have had to also incorporate physical visits to carry us through this transition period of electronic patient records, which is being encouraged by Welsh Government.

General Pharmacy Services (GPS): In 2024/2025 NWSSP/PPV introduced a new service check after a successful pilot, which was the Collaborative Working Scheme We now verify this service along with the Quality and Safety Scheme remotely.
We are also investigating other avenues for PPV in GPS and beginning another pilot early this year. We have currently 32 visits to complete with 13 visits in progress.

Additional Services: We are progressing with our quarterly dispensing Data checks and are introducing a robust service moving forward which may result in future financial recoveries once agreed by our Health Boards. These will be added to our PPV reports once finalised. From the pilot we carried out and informing practices of the regulations surrounding dispensing eligibility, we have the data which shows the future success of this service.

Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We were planning to conduct a pilot with the Self Assessments for Pharmacies in the next few months in 2024-2025 but this is currently on hold and in discussion.

Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks. We are also investigating other avenues of savings from the provision of Clinical Waste services and now produce a 'non-collection' report to all our HB's.

There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. These are beneficial to all parties who attend.

PPV training events continue to be delivered to our Health Boards and contractors, and we facilitate one-on-one training requirements when required, particularly for new practice staff within the Primary Care setting.

3. Key Risks / Matters for Escalation

3.1 The reports provide the PPV overall progress of visits and narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving throughout the claiming process.

4. Assessment

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

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

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

5. Recommendation

It is recommended that the Audit & Risk Assurance Committee Members **NOTE** the contents of this report. There are no options included in this report. The report is for Assurance.

6. Next Steps

Produce End of Year Report and enhance future financial reports.

Audit Report - 1st April to 30th September 2024 = Cwm Taf Morga

To Note

Above planned numbers were sent to HB for 2024/2025 Visit Plan. Numbers may change due to a

Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendati

PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns

Training/support is provided to practices after visit and throughout the year, whenever requested

GMS	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries
	Routine	27	6	137
	Revisit	25	7	269
	TOTAL	**52**	**13**	**406**

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Routine	9	6,82 %	£130,79
Practice 1	Revisit	178	11,80 %	£2 354,50
Practice 2	Routine	32	9,61 %	£2 848,49
Practice 2	Revisit	25	28,74 %	£2 281,80
Practice 3	Routine	322	4,04 %	£834,14
Practice 3	Revisit	407	3,44 %	£420,00
Practice 4	Revisit	3	0,60 %	£90,87
Practice 5	Routine	64	14,81 %	£2 391,32
Practice 5	Revisit	31	67,39 %	£682,93
Practice 6	Routine	3	1,03 %	£30,09
Practice 6	Revisit	18	7,00 %	£240,25
Practice 7	Revisit	IN PROGRESS		
Practice 8	Revisit	IN PROGRESS		

GOS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries
	Routine	16	5	4
	Revisit	0	0	0
	TOTAL	**16**	**5**	**4**

Summary of themes/findings/issues

As contractors are transistioning to electronic records, remote access and physical visits are progressing we

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Routine	3	2,91 %	£167,36
Practice 2	Routine	4	3,88 %	£174,46
Practice 3	Routine	3	2,91 %	£115,03
Practice 4	Routine	3	2,91 %	£110,92
Practice 5	Routine	IN PROGRESS		

Summary of themes/findings/issues

Nothing to report at this stage

GPS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries
Q&S Scheme / Collaborative Working Scheme	Routine	32	13	0

TOTAL	**32**

ànnwg University Health Board

d hoc visits or closures/mergers
ions
that may arise

Summary of themes/findings/issues
Revisits are taking longer that expected due to 10C
Revisits are normally expected to have higher clain

Value of recoveries	All Wales Visits Due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
£6 442,77	152	35	797	£21 802,52
£6 070,35	241	54	2212	£57 011,27
£12 513,12	**393**	**89**	**3009**	**£78 813,79**

Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
£567,77	35	301 Rolling Plan	113	£4 754,25
0	0	0	0	£0,00
£567,77	**35**	**0**	**113**	**£4 754,25**

ell

Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
£0,00	238	112	0	£0,00

)% check of claims
n error rates

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Agenda Item
5.1

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
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	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	August 2024	RISKS REVIEWED
Operational Management Board	August 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	9th September 2024	MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee	18th September 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 **701** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2.

2.9 In addition, the Health, Safety & Fire Directorate have run Managing Safely Courses during the period which has a designated section on risk. These sessions were held as follows:

- June 2024 – 7 attendees
- August 2024 -13 attendees

2.10 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.

2.11 65 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.74 out of a maximum score of 5.

2.12 100% of the 65 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 97% of the 65 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:

- *"Using the live example on Datix was very helpful."*
- *"Being a fairly new team leader, and new to Datix etc., I feel this has given me a little more insight into who should be doing what and when. I feel confident enough to share information with the team."*
- *"As a board member I wanted to understand how risk was identified, assessed and scored across the organisation. The training achieved that and I now feel I have further context to the risk reporting I see at Board."*
- *"An accessible, clear and succinct session which provides a valuable understanding of all things risk."*
- *"I've done a risk assessment before and really had no clear guidance but this is really informative and I'd feel more confident to do another one"*
- *"I felt it had good amount of information without overloading and good cadence"*
- *"Pacing was great so easy to follow… Information was provided at a level accessible to all"*
- *"Gave a good overview of how to register a risk and the scoring expectations"*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Nil.

3.2 CHANGES TO RISKS

Risk Score Increased

There were no increases in risk score for those risks escalated to the Organisational Risk Register on this occasion.

Risk Score Decreased

Patient, Care and Safety Directorate

- **Datix Risk ID 4906 - Failure to provide evidence of learning from events (Incidents and Complaints.** This risk score was proposed for de-escalation from the Organisational Risk Register in June 2024, however, the Audit & Risk Committee challenged this reduction and requested further information. This risk is now proposed for closure with the following additional narrative:
  "Risk reviewed both narrative and risk rating following a query raised by the Committee on receipt of the losses paper which informed members of recent LFER penalties. The update was approved and the risk rating remains at 12 due to the revised and improved processes in place, which despite the Health Board receiving 3 penalties in July 2024, these were the first penalties received since May 2023. These penalties are felt to be one-off penalties, as the current processes for LFERs are resulting in an improved trend. Therefore, the risk should remain at a score of 12 and be re-reviewed and re-scored, if necessary, at the next risk review."

- **Datix Risk ID 3133 - Poor compliance with Medical Gas Safety Training.** Likelihood risk score reduced from a 4 to a 3 in August 2023 as a result of a notable improvement in compliance. Over 1000 CTMUHB staff having completed the course in the past 3 months, as opposed to the 180 staff from across the entire CTMUHB in 2023, for the face to face training. Medical Gases training also changed from a classroom based session to an ESR E-Learning course which is being advertised via flyer and other mechanisms to raise awareness.

Children & Family Care Group

- **Datix Risk ID 5755 - Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit.** Risk reviewed and with mitigations in place since risk was identified. Reduced consequence to a 4 (so overall score of 16 until September 6th) From September 6th units will be fully vacated so risk will be further reduced and work will commence to remove the risk entirely after the 12 week programme of refurbishment.

Unscheduled Care

- **Datix Risk ID 1133 - Sustainability of the Emergency Department at the Royal Glamorgan Hospital.** Risk score reduced to a 12 from 15. SMT risk reviewed, nurse establishment invest to save paper completed unitising the RCN BEST tool (same tool used to review the PCH nursing workforce 2021). To substantiate 2 additional registered nurse. Invest to save paper approved and recruitment tracker in place and interviews are due the 1st week of September. Risk is currently mitigated by staffing to the agreed level by using bank and agency staff.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Patient, Care and Safety Directorate

- **Datix Risk ID 5254 - Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour.** Risk reviewed with the Assistant Director of Quality & Safety following discussion with the Executive Director of Nursing/Deputy CEO. It was agreed to close this risk and amalgamate it with risk 4907 and the Duty of Candour element has been added as a new risk with a rating of 12 (ID 5895).

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

Consequence						
5			3337 3993 4080	4664 5276 5730		
4			5820	4337 4152 4809 4417 5374 4671 4908 4907 5755	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

Planned Care – Care Group
The Planned Care - Care Group Senior Leadership Team are undertaking a risk assessment relating to inequalities in orthopaedic paediatric services aligned to the risk identified by the Wales Orthopaedic Network (National Clinical Strategy for Orthopaedic Surgery). It is anticipated that this risk once assessed and a mitigating action plan developed will be escalated to the Organisational Risk Register as appropriate.

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))*	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 required for the Organisational Risk Register. Individual risks may have been subject to QIA.
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): 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
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
2	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 Impact on the safety – Physical and/or Psychological harm	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 defib to be purchased - Capital Statement of Need ongoing. Update August 2024 - Defibrillator ordered and should be arriving w/c 26th August 2024. DTPS Care Group have been working on a new policy to allow Patients with a Conditional Cardiac Implantable device to access MRI scans in CTM (which will initially be at Prince Charles Hospital) . This has required considerable work between Radiology, Cardiology and Cardiac Physiology Teams. Care Group Medical Director has been chair of this working group. DTPS Care Group have now pulled together a policy document which is just being finalised with support and help from the appropriate teams. As soon as the defibrillator arrives they will be planning to run the service at PCH within the next fortnight on Monday, Wednesday and Friday afternoons with support of Cardiac Physiology, Cardiologist and Radiology. Whilst they have not had the service consultant Radiologist input has been given to suggest other imaging options. No Harm has been recorded to patients as a result of not having this service at present.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	4 (C4xL1)	⬌	21.03.2024	27.8.2024
3	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. Update August 2024 - awaiting costed proposal from provider. Currently no change to risk score whilst this is explored.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C4xL5	4 (C4xL1)	⬌	08.07.2024	28.08.2024
4	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update 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 if 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 follow: • PCH – 2.0 WTE consultants with 1.0 WTE vacancy • PCH – 2 WTE Clinical Nurse Specialist • 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. Update August 2024 - In order to try and mitigate this, a locum Consultant started at PCH on Tuesday 27th August to cover maternity leave, with a second fixed term locum due to start at the end of October, this will allow adequate time for the care group to work through more sustainable options. No change to risk score.	Quality & Safety Committee	20	C4xL5	12 (C4 x L3)	⬌	11.05.2021	28.08.2024
5	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	**IF**: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. **THEN** patients will not receive the necessary imaging **RESULTING IN** delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	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. Update August 2024 - risk reviewed with no change. The Care Group have a list of dates/days that SBUHB will not be manufacturing during June to December.	Quality & Safety Committee	20	C4xL5	4 C4xL1	⬌	23.10.2023	21.08.2024
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 provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update July 2024 - The 8a 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. Update August 2024 - On progress, UAT testing on begins on the 2nd Sept and will last for two months.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	⬌	26.10.2022	22.08.2024
7	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update August 2024: **Elective Demand-** There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities. The risk score has been reviewed and remains unchanged on this occasion, due to the following potential impacts. 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. Update sept 2024 - Risk remains the same given the ongoing constraints above but good progress is being made across all specialties to manage planned care position. Notably, as at the end of august, as per plan, 156 week waits have been cleared. The Single Cancer Pathway (SCP) will remain a key focus with a target of 70 % compliance by March 25 **Emergency Demand -** There has been some improvement against trajectories for emergency demand. Specifically in total reduction of lost ambulance hours. The risk score has been reviewed and remains unchanged, due to the following potential impacts. 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. Update Sept 24 - renewed focus on 1 hour ambulance handovers and 12 hour waits in ED. Reset fortnight extremely successful in resetting PCH Acute medicine to better facilitate the flow of patients out of ED and utilise SDEC resources. This work, which comes under the STAMP project, will roll out into POW and RGH in a phased approach. Strategies to reduce Delayed Transfers of Care (DToC) across CTM footprint continue through the 6 goals workstreams inc roll out of optimise and progression of the CTM 'Hospital at Home' service model.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	⬌	13.7.2023	29.08.2024
8	4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update July 2024 - risk ongoing, mitigation continues to be : ongoing increased scrutiny of pathways, focused work with urology, Gynae and colorectal, enhanced monitoring with Velindre Cancer Centre. Update August 2024 - risk ongoing, no new updates in addition to those reported in July 2024, to be reviewed in September 2024.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	⬌	01.04.2014	23.08.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
9	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**If**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WL1 clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update 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 eye 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 WGOS4 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 appt. 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. Update August 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	23.08.2024
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 Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	**If** there is insufficient capacity within the adult weight management service to meet the demand **Then** patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. **Resulting in** missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update August 2024 - Current mitigations remain in place: Pathway redesign and Demand and Capacity (D&C) oversight- Pathway redesign: 74% of level 3 patients identified as suitable for group education, this group delivery model is in progress, which has resulted in an 50% increase in annual capacity compared to the original service model of 1: 1 MDT treatment. Despite this efficiency demand exceeds capacity. D&C: Real time validation of waiting lists ensures appropriate signposting according to service specification, alongside implementation of partial booking. Referral rates continue at approx. 100/mth with service capacity of 40/mth. A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	⬌	07.06.2023	20.08.2024
11	4664	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	Detail captured in the closed session of the Audit & Risk Committee 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 Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics**,** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update 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. USC Dashboard which provides daily and ongoing trend data for performance metrics I 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 IMTP 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. Nurse establishments are being reviewed to ensure safe staffing. With sustained high level of escalation, risk rating to remain at 20. C4, likely hood 5. August 2024 - Risk remains unchanged in terms of mitigation and scoring.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	⬌	24.09.2019	28.08.2024
13	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. Update August 2024 - Risk reviewed and with mitigations in place since risk was identified. Reduced consequence to a 4 (so overall score of 16 until sept 6th) From Sept 6th units will be fully vacated so risk will be further reduced and work will commence to remove the risk entirely after the 12 week programme of refurbishment . Service Director for Children and Family Care Group has confirmed that they now know through the project and deeper assessment of the equipment batteries that they will sustain power for a minimum of 2 hours to give time for emergency electrician to attend. Since the risk was added the Care Group have looked at their contingency plans which currently now would lessen the consequence and impact of the risk as well as the likelihood of occurrence. The Care Group did not have confirmation of these points when the risk was first assessed. On this basis they would reduce the consequence score to 4 from a 5 in terms of the target score. This update will be reflected in the September iteration of the Organisational Risk Register.	Planning, Performance & Finance Committee Quality & Safety Committee	16 Decreased from a 20 in September 2024	C4xL4	C4xL2	⬇	18.04.2024	02.09.2024
14	5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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 TD 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, 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.	Update August 2024 - The Estate CCTV system contractor attended site and identified the root cause of the system failure and restored the PCH security management system headend and power to the majority of existing site cameras. The outcome and recommendation from the system contractor, Capital Major Projects team and TD s is that there is further CCTV system replacement and upgrade of hardware and software work to be undertaken. The existing Security Management Platform (SMP) which is the headend control system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced, the GF/FF contractor will also be unable to fully install the (124) new site GF/FF scheme CCTV cameras and a 'moderate' risk of future system failure remains until this work is completed. A specification and estimate of cost of a new (SMP) headend has been completed and funding has been approved. Waiting for a contractor to be allocated the work and an installation date to install the SMP system. Security Systems Risk Assessments A rolling programme of security vulnerability risk assessments is being undertaken out at a number of sites that include the suitability, compliance and provision of current CCTV and control of access systems and where systems may require replacing and upgrading or where site system provision is inadequate. Where there is a requirement for replacement/upgrade or additional systems further work is then required with support from Estates and Digital Services to complete the system technical specifications before a statement of need is provided to the Operational Capital Group for replacement or new works and security hardware/software scheme funding.	Health Safety & Fire Sub Committee Quality & Safety Committee Planning, Performance & Finance Committee	16	C4xL4	C3xL4 12	⬌	31.01.2024	30.08.2024
15	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V 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. Update August 2024 - There has been no update on progressions since the last update reported, therefore, the risk remains the same. CTMUHB continue to liaise with DHCW on seeking a solution.	Quality & Safety Committee Digital & Data Committee	16	C4xL4	8 C4xL2	⬌	26.04.2024	27.08.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
16	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. • M4 update: The M4 YTD position is a £4.1m deficit, which includes a £6.2m shortfall in savings delivery offset by other favourable variances of £2.1m. The forecast break-even position has been maintained at M4. However, the level of risks that the Health Board is now trying to manage has increased significantly with a net risk of £16.1m. At this stage, there is a significant risk that the forecast break-even position for 24/25 will deteriorate in M5. • All Care Groups and directorates with forecast overspends have been asked to prepare recovery plans to show the key actions and choices needed to deliver a break-even position in 24/25 and also recurrently. A detailed review of these recovery plans and risks will be undertaken prior to the M5 Monitoring Return submission to WG. 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	20.08.2024
17	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.	• M4 update: The M4 YTD position is a £4.1m deficit, which includes a £6.2m shortfall in savings delivery offset by other favourable variances of £2.1m. The forecast break-even position has been maintained at M4. However, the level of risks that the Health Board is now trying to manage has increased significantly with a net risk of £16.1m. At this stage, there is a significant risk that the forecast recurrent surplus of £2.1m will deteriorate in M5. • All Care Groups and directorates with forecast overspends have been asked to prepare recovery plans to show the key actions and choices needed to deliver a break-even position in 24/25 and also recurrently. A detailed review of these recovery plans and risks will be undertaken prior to the M5 Monitoring Return submission to WG. • 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	16	C4xL4	12 C4xL3	⟷	30.04.2024	20.08.2024
18	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	**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 form 48% to 80%. Children can only wait 8 wks form 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 August 2024 • Primary care have joined the 642 process to access spare theatre list across 3 hospital sites • 2 regular, additional lists were offered, however, one of the lists in PCH is now not available due to the paediatric ward not having capacity to support list. • The 2nd additional list in POW- the CDS team are shadowing the theatre on 7 October with a view to start running a new list from 1 November at the latest, there is a possibly of a bi weekly Wednesday list that is currently being discussed for us by CDS. • RGH team have been asked if CDS can have access a number of spare theatre lists during September, currently awaiting response. • Service continues to operate with only 2 lists- 876 children are currently waiting for assessment for GA, children can only be assessed within 9-10 weeks of having treatment under GA, otherwise another assessment is required, therefore without confirmed GA list children continue to wait extensively for assessment.	Quality & Safety Committee	16	C4xL4	9 C3xL3	⟷	20.04.2023	02.09.2024
19	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care	**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. Update August 2024 - Following discussion at OMB in May 2024, a meeting has been requested between DTPS with planned care to discuss next steps.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	⟷	19.12.2023	02.08.2024
20	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	**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. Update August 2024 – Progress continues to mitigate the risk. A technical workstream has been working through the implications of the proposed approach – this has included discussions on an approach to the Citrix license server, whether it should be centralised or decentralised – CTM have asked for a decentralised license server which we will manage at the UHB safeguarding our users. Letters are being worked up by DHCW and Procurement to be sent out to DoDs to move forward the procurement.	Digital & Data Committee	16	C4xL4	2 (C1xL2)	⟷	12.01.2024	22.08.2024
21	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The impact of "Right Care Right Person" approach.	**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 August 2024 - Phase 2 commencing in Sept 24, actions complete in relation to updated polices, stakeholder event next week, risk reviewed and remains the same.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	⟷	08.12.2023	28.08.2024
22	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 Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**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 August 2024 - Stakeholder engagement continues, leading to a further review of the business case. This requires continued collaboration across DTPS, Children and Family, Public Health and the Growing Well Strategy Group.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	⟷	13.10.2023	02.08.2024
23	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update August 2024 A historic review of all case files has been undertaken. The findings of the review showed a backlog in a number of areas, including Redress and Inquests. To address the backlog, overtime has been agreed and allocated to 1 member of staff within the team. A trajectory of historic cases has been developed to track progress, which is being closely monitored in the Executive Director Led Q&S meeting. From September, the trajectory of historic cases will no longer be reviewed in the Executive Director Led Q&S meeting, however will be monitored within a weekly meeting led by the Executive Nurse Director (along with the Deputy Executive Director of Nursing). As previously updated, and as expected, the implementation of the Duty of Candour has led to a surge in redress cases. Currently, Redress cases remain a high risk, which is due, in part, to capacity and sickness within the team. One member of the Legal Services team has been realigned to assist with redress cases.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	⟷	02.11.2021	28.08.2024
24	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 August 2024 All inquests have now been reviewed and graded as per their risk level. This system utilizes a Red, Amber, and Green (RAG) rating to categorise the level of risk to the Health Board for each inquest. There has been a significant upward trend in the number of inquests over recent years. A dedicated PowerPoint slide has been developed and is instrumental in tracking the progress of inquests, with a particular focus on: 1. Evidence submission requirements for the Coroner 2. Compliance status of completed witness statements This slide has facilitated scrutiny and assurance in the Executive Director Led Quality & Safety (Q&S) meeting. There has been an improvement in the timeliness of receiving witness statements from members of clinical staff across the Health Board; with response rates increasing from 45% to 80%. As noted above, this improvement is being closely monitored and the risk score will be re-reviewed in the next quarter.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	⟷	02.11.2021	28.08.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
25	5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Estate/ Infrastructure	Fulfilling our environmental and social duties	**IF:** the health board's decisions fail to reflect our values or consider the long term environmental or social impact **Then:** we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles **Resulting in:** negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases - CTM representatives attend the Welsh Government Green meeting - Update of the DAP by March 2024 - Board and Committee cover papers also now include environmental impact against 5Rs.	Update August 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	16	C4xL4	8 (C4xL2)	⟷	21.2.2023	09.08.2024
26	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	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 SPRs. Rotate staff to PCH. explore PAAR rates to encourage staff to take overtime. Update August 2024 - Risk reviewed currently still to remain at 16 but with plans in place bringing MR and NOUS waits down by December, CT plan has been agreed to include staff and mobile CT in October, however, this remains as our greatest area of risk. Risk will be revisited at the end of October to review progress and rescore.	Quality & Safety Committee	16	C4 x L4	4	⟷	01.06.2020	02.09.2024
27	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** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems, the ABHB Clinical Workstation or Local Authority system Numerous delays in NHS Wales progressing open architectural approach which results in CTM UHB being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	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. Update August 2024: On track for May 2025 deadline.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	⟷	14.10.2020	22.08.2024
28	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	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 form 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. Update August 2024 - The proposal paper was submitted to the Mental Health Care Group Health and Safety meeting with a recommendation which was not accepted. Personal Safety Advisor discussed that the option was not feasible at the latest Mental Health Care Group Health and Safety meeting July 16th. The Health and Safety Committee has requested a further options paper. Further meetings with the Mental Health Care Group underway to discuss training options. Options discussed employing dedicated team or buying in training both options involve a significant financial commitment . Further meeting arranged for September 2nd. In the meantime PMVA training will be delivered up until December 24	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	⟷	31.08.2021	28.08.2024
29	4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update August 2024 - Report received by Operational Capital Group and recommendations for work will be made to Executive Capital Management Group in September 24.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	⟷	30.09.2020	30.08.2024
30	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 Including systems and processes, Service /business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	Detail captured in the closed session of the Audit & Risk Committee due to business sensitivities.							⟷		

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
31	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	Update 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. Update: Aug 2024 - Deep Dive meetings are in place between the Medical Workforce Productivity Group and the Care groups to enable scrutiny and improvements operationally and financially. Care Groups also having scrutiny meetings with senior Exec team.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	⟷	01.08.2013	27.08.2024
32	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity. Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	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 QMB 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 A4C 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 CPD and assessments and the rest will be spent on locum SLT/CAMHS workforce, existing/overtime hours for A4C 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. Update August 2024 - Risk reviewed and currently remains at 15. Additional staff have been recruited as part of the Neurodevelopment improvement plan (WG funded), however, from September onward the capacity will meet the current demand. Backlog clearance plans will help us start reducing to below 104 weeks by end of March 2025. Risk will be reviewed again at end of October to update risk score.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	⟷	14.07.2017	02.09.2024
33	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update 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. Update August 2024 - in addition to the July update regular meetings are taking place with the fire service to update on progress, last meeting held 24th July 2024.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	⟷	31.01.2020	29.08.2024
34	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 Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	**IF:** The Health Board is not able to record information accurately and reliably, with complete and up to date information **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update 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. FHIR 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. Update August: Day forward is still within the agreed 48 hours turnaround. Time and motion study has been concluded and waiting for report to be completed. There is a broad support for a modular EPR solution by the UHB's board. A business case is being developed at WG's request for EPR modules for Mental Health and Maternity. Programme of work to develop a shared care record for CTM is in a design phase. Request made to gain complete access to CTMs diagnostic (radiology and pathology) results via an API.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	⟷	05.06.2021	22.08.2024
35	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 Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity {much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC} and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	Update 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. Update August 2024 - Paper submitted to Board un July 24 - Board have endorsed the recommendations to commenced documentation for procurement of a strategic partner to deliver a module EPR. We still awaiting to receive the report from Welsh Government developed by Healthcare	Digital & Data Committee	15	C3xL5	9 C3xL3	⟷	07.02.2022	22.08.2024
36	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of 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 August 2024 - The Health Board has continued to work with the National programme for Connecting Care, with an aim to deliver a fully integrated Mental Health solution as a priority for Cwm Taf Morgannwg University Health Board. A Business Case has been submitted to Welsh Government and we are awaiting the outcome. As a contingency measure we are also working with colleagues in another Health Board to accelerate the procurement and implementation of a Mental Health solution should the Connecting Care business case not be approved in the near future. It is expected that we will be ready to procure in the Autumn of 2024. Risk reviewed no change.	Quality & Safety Committee	15	C5xL3	6	⟷	07.11.2018	09.08.2024

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed
37	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. Update August 2024 - Risk reviewed no change. Risk will need to be transferred to new Service Director when appointed.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	⬌	15.06.2021	29.08.2024
38	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	**IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources 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 defence against infectious disease) in accordance with the NIF. 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. Update for September 2024: Risk mitigations and scores reviewed with no change at this stage. Next review scheduled for the 30.11.2024.	Population Health & Partnerships Committee Quality & Safety Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	⬌	01.07.2024	12.8.2024

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1	30.09.2024
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11	30.09.2024
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16	31.10.2024
17	02.10.2024
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36	30.09.2024

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37	30/11/2024
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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
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)	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. Further update requested at the Audit & Risk Committee in August 2024 ahead of decreasing this risk. Updated rationale as follows to support de-escalation from the Organisational Risk Register: Risk reviewed both narrative and risk rating following a query raised by the Committee on receipt of the losses paper which informed members of recent LFER penalties.The update was approved and the risk rating remains at 12 due to the revised and improved processes in place, which despite the Health Board receiving 3 penalties in July 2024, these were the first penalties received since May 2023. These penalties are felt to be one-off penalties, as the current processes for LFERs are resulting in an improved trend. Therefore, the risk should remain at a score of 12 and be re-reviewed and re-scored, if necessary, at the next risk review. 29/08/24. Risk, rating and rationale reviewed by the Executive Director of Nursing/Deputy CEO and was approved for reporting to September QSC.
3133	Executive Director of Nursing / Deputy Chief Executive	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	A notable improvement has been made with over 1000 CTMUHB staff having completed the course in the past 3 months, as opposed to the 180 staff from across the entire CTMUHB in 2023, for the face to face training.	Quality & Safety Committee. People & Culture Committee.	12 Decreased from a 16 in September 2024	8 (C4xL2)	Likelihood score reduced from a 4 to a 3 in August 2023 as a result of a notable improvement in compliance. Over 1000 CTMUHB staff having completed the course in the past 3 months, as opposed to the 180 staff from across the entire CTMUHB in 2023, for the face to face training. Medical Gases training also changed from a classroom based session to an ESR E-Learning course which is being advertised via flyer and other mechanisms to raise awareness.
1133 Linked to risk 3826	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	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.	SMT risk reviewed, nurse establishment invest to save paper completed unitising the RCN BEST tool (same tool used to review the PCH nursing workforce 2021). To substantiate 2 additional registered nurse. Invest to save paper approved and recruitment tracker in place and interviews are due the 1st week of September. Risk is currently mitigated by staffing to the agreed level by using bank and agency staff.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	12 Decreased from a 15 in September 2024	9 (C3xL3)	SMT risk reviewed, nurse establishment invest to save paper completed unitising the RCN BEST tool (same tool used to review the PCH nursing workforce 2021). To substantiate 2 additional registered nurse. Invest to save paper approved and recruitment tracker in place and interviews are due the 1st week of September. Risk is currently mitigated by staffing to the agreed level by using bank and agency staff. This Risk can now be de- escalated.

	A	B	C	D	E	F	G	H	I	J	K
1	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
2	5254	Executive Nurse Director / Deputy Chief Executive	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update August 2024: A historic review of all case files has been undertaken. The findings of the review showed a backlog in a number of areas, including Redress and Inquests. To address the backlog, overtime has been agreed and allocated to 1 member of staff within the team. A trajectory of historic cases has been developed to track progress, which is being closely monitored in the Executive Director Led Q&S meeting. From September, the trajectory of historic cases will no longer be reviewed in the Executive Director Led Q&S meeting, however will be monitored within a weekly meeting led by the Executive Nurse Director (along with the Deputy Executive Director of Nursing). As previously updated, and expected, the implementation of the Duty of Candour has led to a surge in redress cases. Currently, Redress cases remain a high risk, which is due, in part, to capacity and sickness within the team. One member of the Legal Services team has been realigned to assist with redress cases.	Quality & Safety Committee	aug-24	Risk reviewed with the Assistant Director of Quality & Safety following discussion with the Executive Director of Nursing/Deputy CEO. I t was agreed to close this risk and amalgamate it with risk 4907 and the Duty of Candour element has been added as a new risk with a rating of 12 (ID 5895). Executive Director of Nursing/Deputy CEO approved for submission to September QSC.

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

Agenda Item
5.2

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Watts, Director of Corporate Governance / Board Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	7th October 2024	Reviewed and Management Sign Off Received.

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

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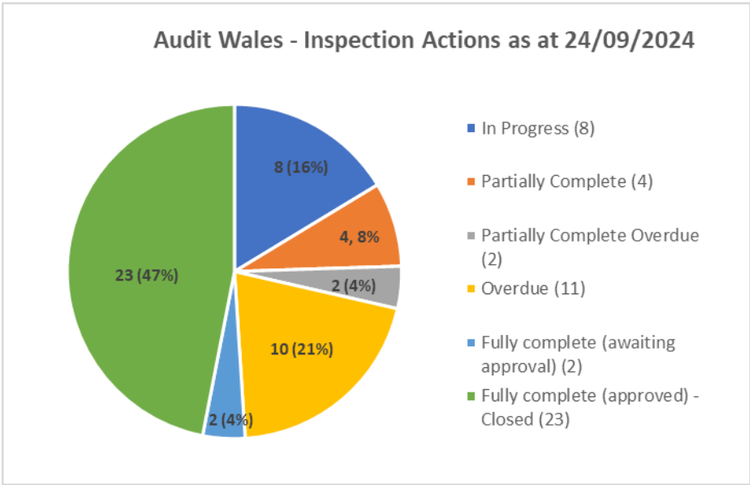
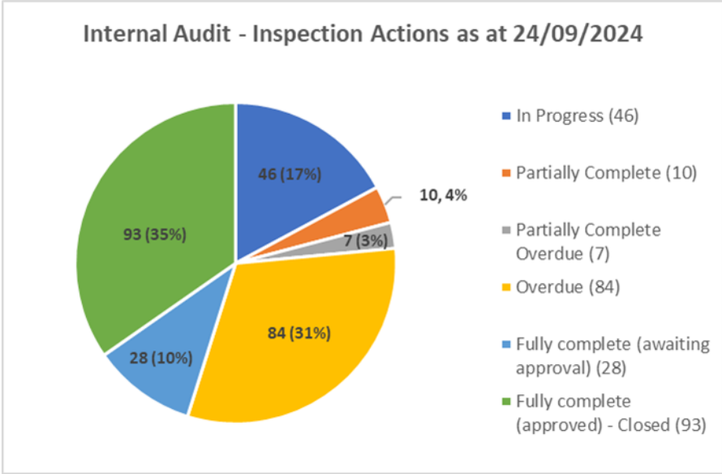
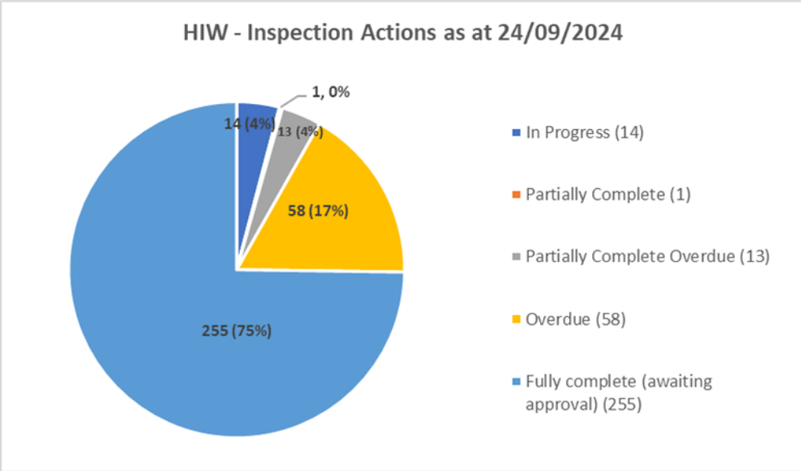
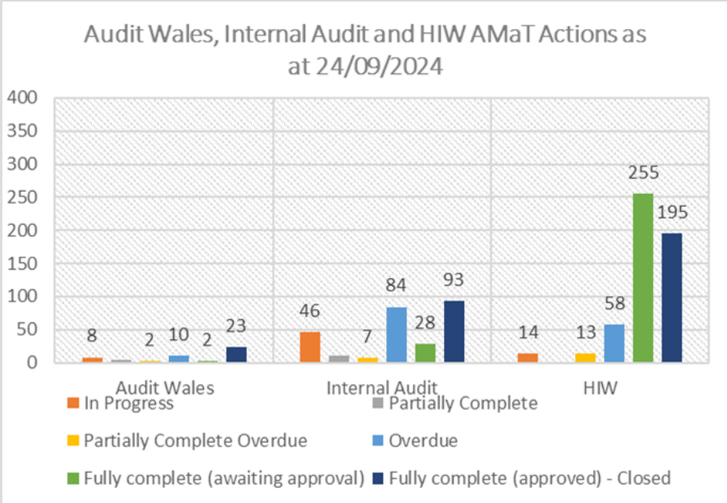
Tracker Dashboard

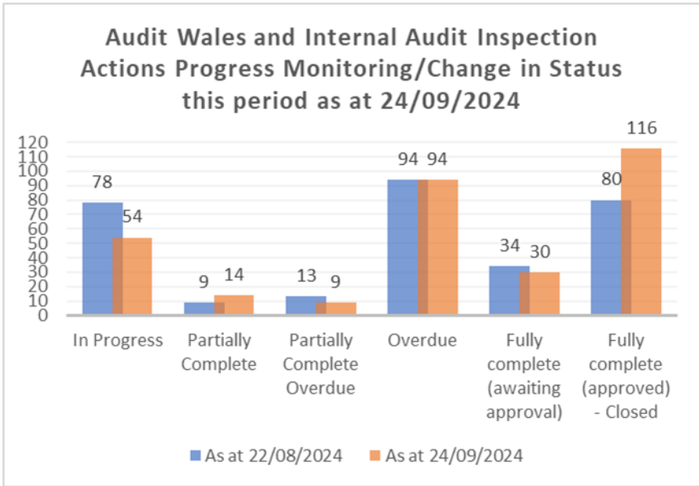
Status: Inspection Actions:



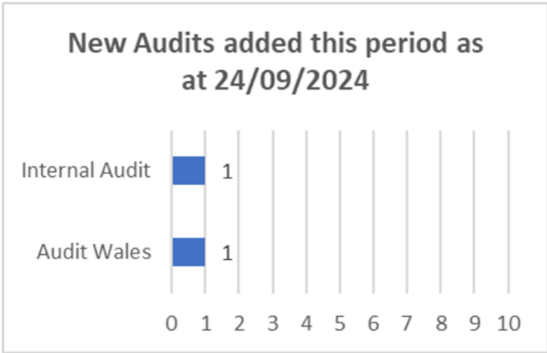


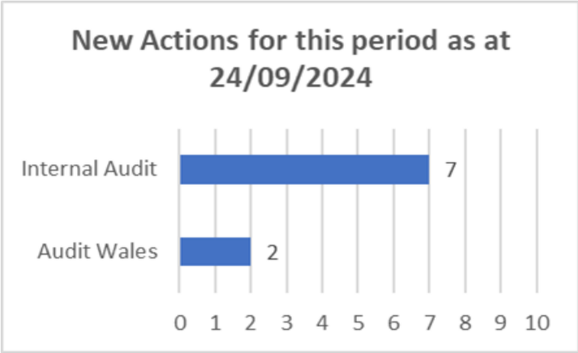






Inspections / Inspection Actions Added:





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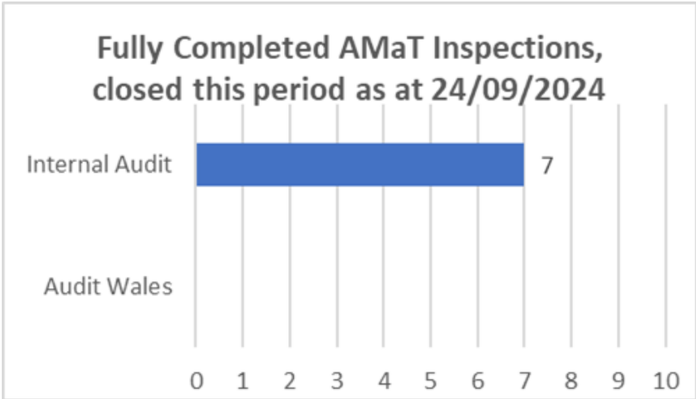

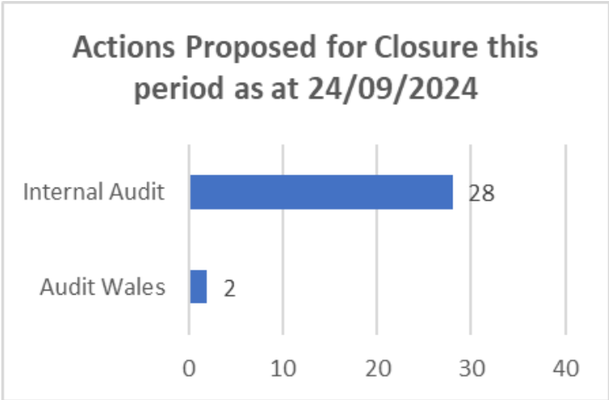

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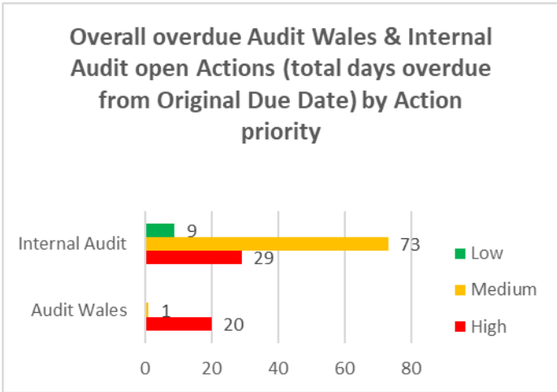
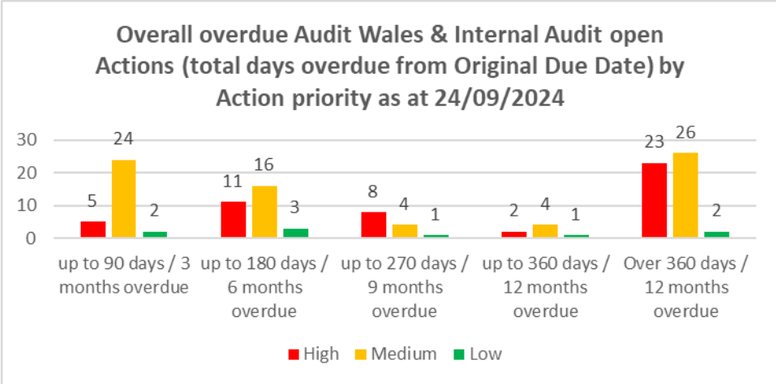
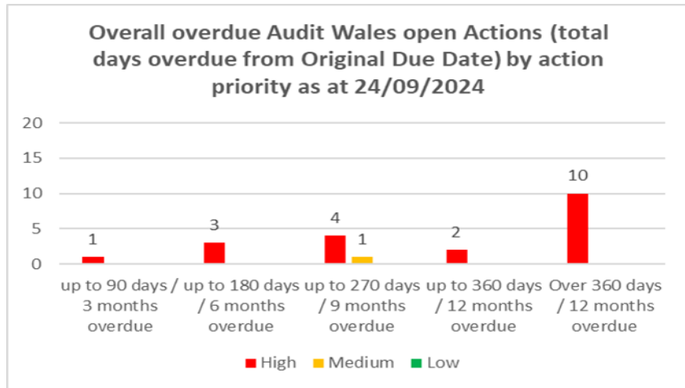
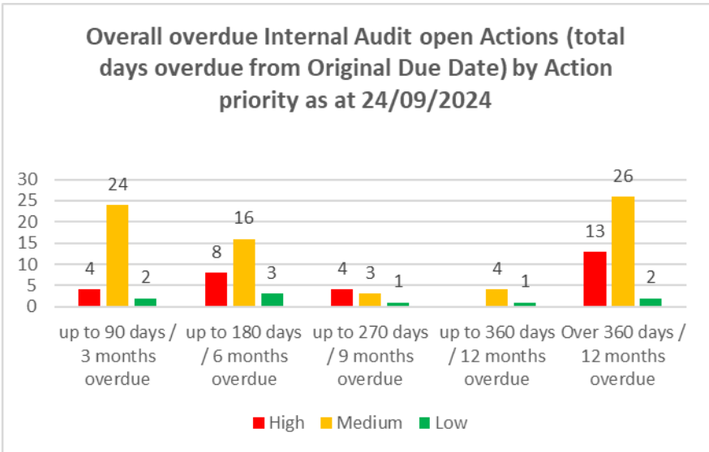
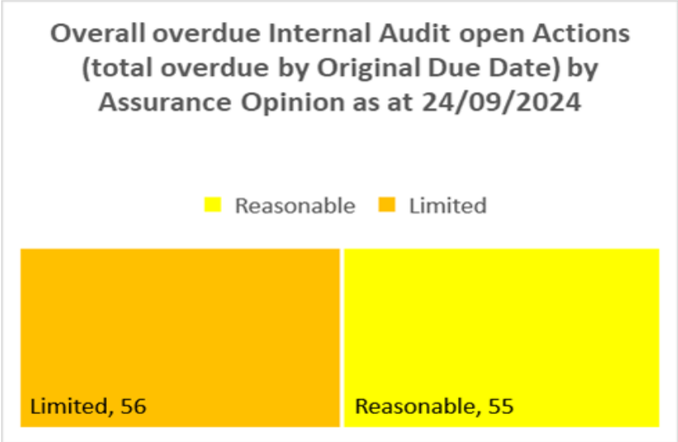
Performance Dashboard

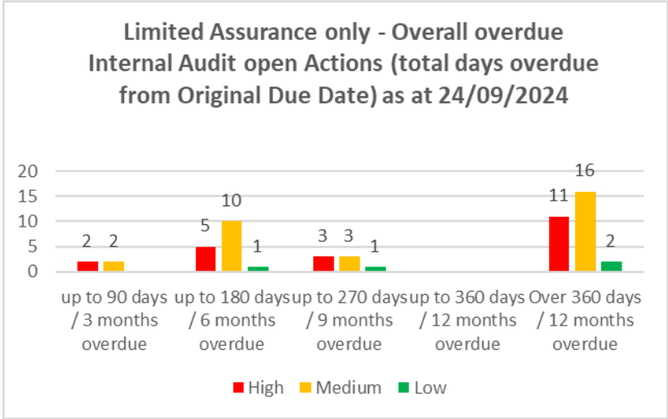












1. Situation /Background

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.

1.2 The scope of this report relates to both internal and external audit review recommendations. Information from HIW included for information only as this is considered at the Quality & Safety Committee.

2. Specific Matters for Consideration

2.1 In response to an action from the last Committee meeting, a new dashboard has been added to the report on page 3, to provide the Committee with a more detailed picture in terms of overdue actions and their correlation to a limited assurance or high priority status action. Overdue data has been extracted based on the original due date that was assigned by Health Board Officers when submitting their completed management responses.

2.2 The data highlights that there are significant numbers of overdue actions including some 26 medium priority and 13 high priority recommendations which are now over 12 months old. There is a clear need to re-set and improve this situation.

2.3 A focussed programme of work is underway with the Executive Team to review all overdue actions within their remit. The Director of Corporate Governance is working with them to review all outstanding recommendations. This will include identifying any recommendations which may need to be removed from the database for whatever reason have been superseded in the intervening period. This work will involve ongoing discussions with Executive colleagues and Internal Audit.

2.4 Progress on this work will be reported to this committee and any recommendations removed will be reported and will receive appropriate approval at the Executive Management Board before anything is taken out of the system.

2.5 Going forward there will also be greater prominence on the timeliness of returning Internal Audit Management Responses in accordance with the 15 day charter. Greater prominence will be given to this at the new monthly Executive Management Board meetings. An improvement in performance is therefore anticipated to be seen over the next six months as this focussed work progresses.

2.6 The detailed dashboard and tracker with progress updates is captured in Appendix 1, with progress updates highlighted in red. As the

enhancements to the system are awaited the report remains a hybrid approach and has still required manual manipulation for some aspects.

2.7 Engagement on CTM's development requests with the software developers continues and the current development plans are captured in Appendix 2, with the associated timeframes.

2.8 **Tracker Updates**

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

1 NEW Internal Audit Review has been added to the Audit Recommendations Tracker.

7 Internal Audit recommendations have been completed and **28** are proposed for **CLOSURE**.

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

1 NEW External Audit Review has been added to the Audit Recommendations Tracker which includes 2 new recommendations.

2 Recommendations are proposed for **CLOSURE**.

2.5.3 **Health Inspectorate Wales (HIW) -** reports from Healthcare Inspectorate Wales will be included in brief for noting and observation. The HIW tracker is included at Appendix 3, however, the Committee should note that this was received by the Quality & Safety Committee at its meeting on the 18th September 2024.

2 New agreed Improvement Plans added:

- Healthcare Inspectorate Wales (HIW)/2024/197HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)
- Healthcare Inspectorate Wales (HIW)/2024/198 HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)

This has resulted in 8 new actions.

A significant amount of work has been undertaken during the summer cleansing the HIW data and this has resulted in:

331 Inspection actions fully **complete** and a further 122 actions nearing completion but requiring further evidence.

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 with reference to the targeted programme of work referenced in 2.3 to 2.5 inclusive and the performance dashboard indicating the areas of concern.

4. Assessment

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

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

5. RECOMMENDATION

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

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: 2535A2021-22)	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: 2934A2022)	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/2023/18	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	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) ● Mark Thomas, 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 Allouni, 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 – Cwm 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
Audit Wales/2024/196	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	01.07.2024	Greg Dix, Executive Director of Nursing & Deputy CEO	● Richard Hughes, Deputy Executive Director of Nursing ● Nigel Downes, Assistant Director Quality & Safety ● [Unscheduled Care] ● cc Allison Thomas, Business Manager, Patient Care & Safety	Central Corporate Function - Patient Care & Safety	1	2	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-1920-23)	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 1920-45b)	24/01/2020	Gethin Hughes, Chief Operating Officer	● Wayne Goodfield, Head Of Clinical Engineering ● Paul Jones, Medical Electronics Engineering Manager	Care Group - Diagnostics, Therapies, Pharmacies and Specialties (Clinical Engineering)	1	1	Reasonable
Internal Audit/2021/76	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	06/08/2021	Sally May, Executive Director of Finance	● Julie Denley, Deputy COO Mental Health, Primary Care and Community Services ● Sarah Bradley, Service Director Primary Care and Community ● James Chambers, Primary Care & Community Estates Development Manager ● Darrell 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	● Sian Lewis, Lead Nurse for CHC and NHS Funded Care ● Sharon Irwin, NHS Nursing Home Co-ordinator ● Rachel Breen, CHC/FNC Admin Co-ordinator ● Ana Llewellyn, Nurse Director (Primary Care, Community & MHLD) ● cc Allison Thomas, Business Manager, Patient Care & Safety	Coporate 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: CTM 21/22-15)	15/06/2022	Gethin Hughes, Chief Operating Officer	**All Care Groups initially to establish lead** ● Carl Verrecchia, 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 Allouni, 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_2021_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 ● Carolyn Blockley, Capital Finance Manager	Corporate Function - Capital and Estates	13	13	Limited
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	24/10/2022	Gethin Hughes, Chief Operating Officer	● Carl Verrecchia, Service Director DTPS ● Sally Bolt, Medical Director DTPS ● Bronwyn Baldwin, Radiology Service Manager ● 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 ● Sallie 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 21/22-31)	15/06/2022	● Dom Hurford, Exetcutive Medical Director ● Hywel Daniel, Executive Director for People	● Natalie Price, Assistant Director, Strategic Workforce Planning ● Nicholas Price, Senior HR Manager - Medical Workforce ● Sallie 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 ● Bethan 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 ● Bahar Chowdhury, Head of Legal Services ● Kellie Jenkins Forrester, Head of Concerns & Business Intelligence ● Carla Snook, Legal Services Manager ● cc Allison Thomas, Businesss 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 ● Becky Gammon, Assistant Director of Nursing and Peoples Experience ● Filipe Leitao, Head of Nursing for Infection, Prevention & Control ● cc Allison Thomas, Businesss 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 ● Lisa Jenkins, Clinical Lead, Serious Incidents and Complex Concerns, ● Kellie Jenkins- Forrester, Head of Concerns & Business Intelligence ● cc Allison Thomas, Businesss 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: Concerns_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 Forrester, Head of Concerns & Business Intelligence ● cc Allison Thomas, Businesss 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 Allouni, 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	● Jill Venables, Divisional Director Of Facilities ● Russell Hoare, Assistant Director OSS (Facilities) ● Claire Masters, Facilities Manager	Corporare Central Function - Facilities	7	7	Limited
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	09/10/2023	Stuart Morris, Director of Digital	● Paul Chilcott, 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 ● Becky Gammon, Assistant Director of Nursing and Peoples Experience ● Claire O'Keefe, Head of Safeguarding ● Nadine Long, Deputy Head of Safeguarding ● Anthony Zdzieblo, DoLS and Mental Capacity Act Team Leader ● cc Allison Thomas, Businesss Manager - Patient Care & Safety	Corporate Central Function - Patient, Care and Safety	8	8	Reasonable

Code	Title	Date of Inspection	Executive Lead	Inspection Lead(s)	Function	Recommendations	Actions	Assurance Rating
Internal Audit/2023/37	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/2023/57	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 Allouni, 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/2023/73	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 DTPS ● Sally Bolt, Medical Director DTPS ● 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 Chilcott, 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 Advisor 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 Allouni, Director of Operations - Planned Care ● Gareth Blandford, CSG 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-2324-24)	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/2024/187	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, Businesss 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 Chilcott, 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 Hamblyn, Assistant Director of Governance and Risk ● Kellie Jenkins Forrester, Head of Concerns & Business Intelligence ● Lisa Love Gould, Clinical Director DTPS ● Carl Verrecchia, Service Director DTPS ● Sally Bolt, Medical Director DTPS ● Suzanne Hardacre, Director of Midwifery	Corporate Governance & Risk Patient Care and Safety Care Group - Diagnostic, Therapies, Pharmacy and Specialities Care Group - Children and Familiy	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**
Internal Audit/2024/195	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	01.07.2024	Sally May, Executive Director of Finance	● Tim Burns, Assistant Director of Planning (Capital & Estates) ● Jeremy Holifield, Responsible Officer PCH Construction Programme	Corporate Central Function - Capital and Estates	7	7	**Reasonable**

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: 123A2017)	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 ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	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	September 2024 - An update against this recommendation has not been provided on this occasion. August 2024 Audit Wales Progress Update - R3 is considered to be partially implemented; remains open. 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. This recommendation to be noted as partially implemented. 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 clarify 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - Complaints and Concerns compliance is now above 80% therefore real time data and learning from this is now shared with the Care Groups in a timely manner. LFERs compliance continues to improve and a new improved process for the management of Inquests is being developed. Meetings have also taken place in order to a review current methodologies to collate a more robust Patient Experience data. Following the OCP process internal Care Group Quality & Safety Governance frameworks are being developed, this will support and further clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the Care Groups. With the completion of the OCP, the structure clearly outlines the quality and safety responsibilities of both Medical and Nurse Directors. This is furthermore established at directorate and service level leadership, with established governance reporting mechanisms as well as roles and responsibilities. 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.			
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 DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	People Executive Director for People	31.08.2021	31.05.2024	High	Overdue	Revised Due Date May 2024; Unable to provide a revised date (see July 2024 update) September 2024 - An update against this recommendation has not been provided on this occasion. 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. December 2023 Update - The Health Board has reviewed its governance and procedures for the appointment of senior officers A new documented Action Plan process was piloted during the recruitment process for the Executive Director of Public Health Post in January 2023, with small amendments being made based on the lessons learnt. The process was successfully used during the recent appointment to the Executive Director of Public Health, following the post being readvertised. This process deals with all of the governance requirements and process matters, from post approval to appointment to sign off and approval by the RATs Committee. Formal and clear minutes are taken, recording the discussions and decision made by the RATs Committee in compliance with the governance arrangements. This process review is now completed. As the All Wales new Pension Policy work is not progressing at pace (it was to be issued to the Service by December 2023, this now looks uncertain) the Health Board's People Policy Review Group is currently reviewing and drafting a stand alone Retire and Return Procedure. The application form will ensure that appropriate questions are asked and answers provided which will provide transparency in respect of the consideration taken into account by the manager to either approve or reject the application business cases. The process will also confirm the process for providing retire and return information to the NWSSP Payroll and Pension Team. October 2023 Update - It has been confirmed a partnership group is being established under the Welsh Partnership Forum Business Committee to develop an All Wales Pensions Policy. The timescale for the policy to be developed is autumn 2023. The work on the CTM Pension Policy has been halted on the request of			
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: a) taking a longer-term approach to its planning beyond five years, b) ensuring greater integration between the long-term plans of the four statutory bodies of the TLPB, and c) improving involvement of all members of the TLPB to ensure an increased voice for non-statutory partners and a better understanding of the purpose of the RPB more generally.	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2024	High	Fully complete (Awaiting approval)	September 2024 Update - Recommend for closure. With the Regional Partnership Board endorsing a Memorandum of Understanding, which in turn is the basis for a Regional Section 33 Agreement scheduled for commencement in April 2025, we have 'hard wired' a long term approach into the development of an Integrated Community Care System (ICCS). Key features of the ICCS including a Population Health Management pathway, the development of integrated commissioning based around a shared understanding of the pay offs which a long term approach can provide. Through a series of 'hackathons' we have also developed regional engagement and coproduction. The recent completion of a RPB self assessment gives us a further sense of the actions we need to take to build and enduring partnership. Significant work remains to be done but we believe these actions sufficiently embed the sustainable development principle in the way we operate as a partnership. 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 opportions 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 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 (CIW and HIW). Workshop planned for 18th April to feedback results and provide opportunity for discussion. The online assessment covered the following areas - Governance systems and arrangements, Workforce strategies (development and practice), outcome measurement and frameworks, resources and progress in developing integrated models of care. January 2024 Update - The CTM Model of Integrated Community Services therefore consists of two pathways: - Urgent Community Response - Population Health Management. - Urgent Community Response To coordinate resources around the need for an urgent community response, an integrated central Navigation Hub has been established to triage and stream services appropriately. The Navigation Hub is currently able to provide advice and stream to certain responses (top areas from management information are self-care, advised to contact to GP, refer to 999, refer to GP for handover of care) with the intention to bring other existing clinically led services, social care and other community responses into scope for streaming, along with opening additional points of access into the Navigation Hub. "			
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	31.03.2025	High	In progress	September 2024 Update - Risk registers maintained and a robust approach is in place for funding programmes. The Housing with Care Funding (HCF) forms a 4-year programme, having begun in FY 22/23 with an annual budget for the first three year of £8,729,000 per annum. This means the fourth year is yet to be confirmed by Welsh Government. Whilst the region progresses into the third year of the programme with a known capital allocation, it does mean a number of large-scale projects which span into FY 23/28 could be at risk due to unknown HCF funding availability, due to construction and completion timelines. Wider than funded programs, the sensitive handling of a new ECC level 4 service, where we are seeking to increase community capacity without carving resources away from social care, demonstrates a maturing approach. We need to embed workforce planning more broadly over the coming months, and this would then provide us with a basis for closing this risk in circa 6 months time. 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 limed 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 RIF investment. March 2024 Update - On the 5th February a letter was received from WG that stated that the tapering element of the Regional Integration Fund had been removed. This news was welcomed by partners however letter reinforced other elements of RIF including - Embedding the 6 models of care consistently and equitable across Wales, focus on benchmarking against other regions, and support 'once for Wales' approach. January 2024 Update - Some challenges remain over appointing to vacant posts. Awaiting clarity from Welsh Government regarding relaxation of RIF tapering for 2024/25.			
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 overreliance on a small team."	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.12.2022	31.01.2024	High	Fully complete (Awaiting approval)	September 2024 Update - Regional Commissioning Unit vacancies, including in the ICCS program team, are being filled. Recommend this risk for closure. 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. January 2024 Update - Failed to recruit to NEST co-ordinator first time around. Readvertised and shortlisting taken place, interviews scheduled before the end of January. 3 Capital Programme Managers to be advertised January 2024, on post to focus on tech enabled care. Additional capacity Linked to Integration Director now being progressed.			
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 RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2025	High	In progress	September 2024 Update - The CTM Regional Partnership plays an essential role in shaping the health and social care system in Wales to respond to changing population need. Better continuity and coordination of care is particularly important in a society where more people are living longer, more people are living from birth with complex health conditions, and there is a significant interplay between physical and growing mental ill health. The development of a regional Memorandum of Understanding and Section 33 Agreement for our Integrated Community Care System provides us with a framework for integrated commissioning and pooled resourcing based on a shared understanding of demand and capacity opportunities and challenges. As we move to the formal agreement of these legal frameworks over the Autumn and Winter we anticipate closing this risk off in 6 months time. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - RIF 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. January 2024 Update - Challenges over mainstreaming RIF projects. Awaiting further guidance from Welsh Government over expectations.			
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 it deliver its priorities"	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.03.2025	High	In progress	September 2024 Update - Integrated Community Care System. We are taking a regional and strategic approach to the development of integrated community pathways. These pathways will be delivered by integrated teams based on a locality footprint. Program plan reviewed regularly by the Partnership Leadership Team and RPB governance. Whilst workforce challenges are an enduring feature of our sector, as we move to the formal agreement of underpinning legal frameworks for our ICCS over the Autumn and Winter we anticipate closing this risk off in 6 months time. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Review of all RIF 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. January 2024 Update - Market Stability report being updated. Challenges and opportunities to be discussed within RPB sub groups to take forward.			
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	Partially complete	September 2024 Update - The Effective Management of Board Business review which sets out the new approach for Board and Committee Business with effect from 1st January 2025 will be submitted to the Public Board meeting on the 26th September 2024. If approved the updated Terms of Reference and Cycles of Business will be shared on the public facing website which demonstrates the focus at Board and Committees on Shared Listening and Learning and the business which will be received through the Committee structure in 2025. 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 that will be in place from 1st October. March 2024 Update - A revised implementation date is requested as 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. February 2024 Update - In Progress: Head of Corporate Governance and Board Business to consider how this recommendation can be achieved to improve transparency.			
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	September 2024 - An update against this recommendation has not been provided on this occasion. 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/2023/18	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) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act. d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues.	Corporate Governance Director of Corporate Governance/Board Secretary	30.10.2023	30.09.2024	High	Partially complete	September 2024 - The Effective Management of Board Business review which sets out the new approach for Board and Committee Business with effect from 1st January 2025 will be submitted to the Public Board meeting on the 26th September 2024. If approved this will set out that all Meetings will be published with the exception of those held in closed session and Remuneration & Terms of Service Committee, Organ Donation Sub Committee, Provision of Discharge Sub Committee, Clinical Advisory Group and Local Partnership Forum. 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. March 2024 Update - Items a, c and d are complete. A revised implementation date is requested as the publication of Advisory and Sub Committee minutes is being captured in the Effective Management of Board Business Proposal which is due to conclude circa July 2024. February 2024 Update - In Progress - Update remains as reported in December 2023. The Director of Corporate Governance & Board Secretary appointed in September 2023 would also need sufficient time to attend tp review the position of the Advisory Group meetings. Will be incorporated into the Review of the Effective Management of Board Business Proposal (January 2024). Timeframe currently remains as 31st March 2024.			
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	September 2024 - An update against this recommendation has not been provided on this occasion. 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.			
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)	September 2024 - An update against this recommendation has not been provided on this occasion. 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.			

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 – CTMUHB 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 indents 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	Digital Director of Digital (Performance Information)	31.12.2023	31.12.2023	High	Overdue	September 2024 Update - An outline case for the next steps in the digital journey was supported at the Board meeting in July. We have been asked to develop a business case to to procure a strategic partner for the development of a Modular EPR. 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 been 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. 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.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 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)	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. August 2023 Update - No further update for this month.			
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R7 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	September 2024 Update - c) 4 FCPs were updated at the August ARC and further FCPs will be reviewed and updated to go to the October ARC. July 2024 Update - A number of FCPs are being brought to August ARC as part of first tranch 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. 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 received on this recommendation. August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023. June 2023 Update - a) Reviewed So &SFIs and confirmed upper limit for contracts is consistent with model Sos and SFIs. Contract in excess of £1m require WG Ministerial approval CLOSED. b) Quarterly Capital reports included on PPF agenda. c) FCP review ongoing.			
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 First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place: • Ensure that prehab services are improved by setting up a Prehabilitation Service to ensure patients are medically optimised for surgery. Both digital and face to face options to be considered. • The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board • Increase the capture of PREMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures –timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement	Planned Care Chief Operating Officer	01.05.2023	01.05.2023	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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 GIRFT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.			
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 specialties, Nurse led, Consultant led and AHPs • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
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	Planned Care Chief Operating Officer	01.04.2024	01.04.2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm 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, HEIW workforce Plans	People Executive Director for People	01.03.2025	01.03.2025	High	In progress	September 2024 Update - The first meeting of the MDT Shape and Supply Steering Group took place on 4th July. The outcome of the meeting was a workshop with key stakeholders to agree task and finish groups and objectives. This took place on 15th August and the outcomes are to be discussed at the next meeting on 3rd October. The aims of the group are to develop a collective visual of our supply pipelines across all staff groups, e.g. recruitment, student streamlining, training and development and new roles etc. This will enable us to understand our current gaps. Work is also being undertaken to review the Workforce risks on the Risk Register and developing baseline data to support ACSP. 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 – Cwm 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	September 2024 Update - Work continues as set out in the July update. Some delays have been incurred due to data errors and system challenges. However, engagement with key stakeholders across People, Finance and medical colleagues has been positive to enable the work once the data and system challenges are addressed. At this point, we are still aiming for the November deadline. 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. 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 – Cwm 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	Overdue	September 2024 Update - Working closely with Heads of People to support the role out of SWP training. An assessment of needs across the organisation is in development and discussions with L&D around SWP training being delivered as part of the Leadership Development Programme are taking place to include once the programme is launched. 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.			
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	September 2024 Update - The risk score for risk 3 of the BAF has been reviewed in accordance with the Risk Domain/ Scoring Matrix, as the original risk score may have been overstated as a L5. The workforce risk remains significant but this reduction places the risk score more appropriately within the risk domains at L4. The risks associated remain high and significant workforce planning work is taking place to reduce the score. Evidence of a reduction in turnover and sickness has been recorded but it too early to say that this is related to any particular action taken but will continue to be monitored. 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	September 2024 Update - An significant SWP update was provided to PCC on 7 August 2024. A progress update will be reported at the next PCC in November 2024. 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 - 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	September 2024 Update - A draft horizon scan is in development to be ready for October 2024 linked to the work developed by HEIW. 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.			
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	31.03.2023	31.01.2025	High	In progress	September 2024 Update - An update will be included as part of the USC Quality and Safety Committee report in November 2024 outlining the lessons learned from the temporary MIU closure and confirmation of any outcomes from the work to assess harm. August 2024 Audit Wales Update - R4 is considered ongoing.			
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	31.05.2023	31.01.2025	High	In progress	September 2024 Update - A spotlight report on MIU services was provided earlier in the year. Further updates will be included in early 2025. A full review of the MIU service provision across the HB will include an update on some of the future plans relating to Maesteg Hospital. This report will be available for Quality & Safety Committee in early 2025. August 2024 Audit Wales Update - R4 is considered ongoing.			

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	Fully complete (Awaiting approval)	September 2024 Update - The Health and Safety Team are now fully using Microsoft Forms for this and have undertaken several audits in quarter 2 and 3 this year, with one more audit scheduled in Quarter 4 (Sharps Management) prior to agreeing a new audit programme for next year using the new approach. All audits undertaken are provided to the Health, Safety and Fire Sub Committee for information (A COSHH Audit was shared at the September meeting). 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 MS Forms to undertaken 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. January 2024 Update - The Health and Safety Team will be undertaking 1 main audit and 2 flash audits using iPassport in 2024 to enable an evaluation of iPassport. These audits will take place in March, June and October and the outcomes will be provided to the Health Safety and Fire Sub Committee.			
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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. October 2023 Update - no further progress to report. Until the vacancies that exist as a consequence of phase 2 of the OCP are filled there will not be the management capacity to undertake this piece of work.			
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. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Diagnostics, Therapies, Pharmacies and Specialties (Clinical Engineering) Chief Operating Officer	01.04.2020	31.01.2024	Medium	Partially complete (Overdue)	September 2024 Update - IOT infrastructure updated and hand-held scanners now operational in POW. Additional fixed Antenna readers installed @ POW and RGH, re-siting of some antennas @ RGH completed in August 2024. Re-programming of configuration of system since antenna installs to be completed Sept 2024. Server switch over was delayed, due to remote access issues for Linux server and re-submission requirement to DHCW of access requirements. Working with ICT to resolve. Pharmacy will review cylinder tracking functionality once fully operational. Hopeful of completion by end October 2024. 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 ficed readers purchased. IOT Wi-Fi @ POW still to be resolved. Data migration and Ktrack 2 app to be completed by July 2024. WG 21-05-2024. March 2024 Update - data migration of existing data to Ktrack 2 performed and undergoing live testing and bug checking on existing server prior to switching to new server environment. Capital funding approved via WG digital funding for increased infrastructure and coverage in Feb 2024. Equipment received and to be installed ASAP. Wi-Fi limitations still an issue at POW for aspects surrounding any IOT Wi-Fi requirements, such as handheld scanners for cylinder tracking aspect. This will remain an issue until POW ICT desegregation is completed. January 2024 Update – Request submitted for WG digital Capital Slippage with regard funding of phased expansion of coverage, await answer. No further update on POW ICT connectivity /desegregation status for IOT devices. Data migration and application server now progressing, data verification and proofing server environment in place to test, prior to live switch over to operational server. Target Date RF-ID migration 31-03-2024.			
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	Fully complete (Awaiting approval)	September 2024 Update - Discussion held with cost advisor as costed risk register not provided. The cost advisor has agreed he will include an assessment each month on the adequacy of the contingency position and provisional sums to cover off this point . Detailed risk updates will also continue to be provided with costs where known. Feedback from cost advisor below To undertake a full costed risk register now would not be a worthwhile exercise because: - Many of the risks now sit with the Contractor under the Design and Build Contract - The Health Board already have a sizeable Contingency amount within their budget confirmed. - The Contract includes provisional sums (as identified in our cost advisor Report) for further unknown elements at this time. - Any changes the Health Board were looking to make were considered in the contingency amount and budget costs have been provided within the EA report for these changes (bar the room layout changes which is TBC). Following the request for these changes just over £1m of the £1,888,423.00 contingency is still available. 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. March 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	Fully complete (Awaiting approval)	September 2024 Update - As R12 - agree the cost advisor will advise in the monthly report on adequacy of the contingency based on current position. 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. March 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. January 2024 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 NWSSP 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	September 2024 Update - Lease still with GP for signing - service are working through a few queries. 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. March 2024 Update - discussions ongoing with GPs. January 2024 Update - Discussions have recommenced with GPs. December 2023 Update - At November Project Board, following confirmation of approved funding , it was agreed that Lease discussions with the GP practices can recommence . Draft Heads of Terms previously were previously shared between solicitors.			
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	Fully complete (Awaiting approval)	September 2024 Update - Service confirmed (Helen Wainwright) complete. Services model has been reviewed and agreed and accommodation assigned. 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. December 2023 Update - This will be led by the Primary and Community Care Group and the relevant steering group. At Project Board on the 23rd November ToR for the subgroups were shared with members for review with updates to be provided before the next meeting for review and sign off. This included as a key responsibility for the relevant group but as recommendation will not be complete until service model is agreed the revised implementation date has been moved to 6 months into the project.			
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	September 2024 Update - Requested as agenda item for November Project Board. July 2024 Update - no further update. 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. March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward. January 2024 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	September 2024 Update - Requested as agenda item for November Project Board. July 2024 Update - no further update. 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. March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward. January 2024 Update - Benefits will be periodically reviewed as part of the Project Board agenda moving forward.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. February 2024 Update - Final answer awaited from Finance and the recommendation will then be closed down. Update received after deadline and not included in ARC Excel Report 22nd February 2024. December 2023 Update - Following a lack of progress, a meeting has been set up in December with Finance Colleagues to finish draft and work towards finalising the Financial Control Procedure.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.			

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/2022/25	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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - opinion sought from Performance.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - email has gone from Deputy COO to all Operations Directors asking for validation to be undertaken. In addition, targeted email going to Ops Directors and Service Group Managers as appropriate, with circulation lists and areas of greatest concern outlined. In addition, discussion has taken place with Internal Audit and have asked colleagues within Performance for areas of greatest concern to			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper.			
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	Fully complete (Awaiting approval)	September 2024 Update - 'Site specific' fire safety procedures are now updated and in the red fire boxes at the main entrances to CTMUHB sites, with the exception of Prince Charles Hospital. Prince Charles Hospital is still under extensive building works on site and therefore at this stage a site specific procedure cannot be finalised. Whilst a specific procedure is awaited a general site specific procedure for PCH is available which will be updated as a final document once all building works are complete. 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. January 2024 Update - Work continues within the Fire Team to update the Site Specific Documents where site changes have taken place. Completion should have taken place by the June 2024 deadline.			
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	31.03.2025	Medium	In progress	September 2024 Update - This is in the design stage, will be applicable if business case is approved and we enter into a contract for construction. 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. February 2024 - 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 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	September 2024 Update - As per May 2024 in that the design team was competitively tendered and so will the construction stage if the business case is approved by Welsh Gov. 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: SBS 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.			
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	September 2024 Update - Likely to be Jan 2025 at the earliest. 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. February 2024 - 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.			

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 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	September 2024 Update - Likely to be Jan 2025 at the earliest. 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	September 2024 Update - As per May 2024 the only costs on the revised scheme to date are surveys and design team fees and there is no Supply Chain partner as this is now significantly smaller and thus no a longer a D4L scheme. Design team fees to get to tendered costs and BJC submission have been reported to ECMG. The cost profiling will be provided if and when we move into the construction stage. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.			
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 reprovision 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	September 2024 Update - Procurement of a modular supplier is being linked to the LHP procurement process which is using the relevant framework. Construction costs etc for the FEN works will shortly be competitively tendered and will be reported to Project Board and ECMG. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.			
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	September 2024 Update - A risk register is provided but not costed as the scale is significantly smaller than the previous D4L scheme. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.			
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	September 2024 Update - The contingency applies to the construction stage and will be part of the regular monitoring. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.			
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	September 2024 Update - As per May this will be part of the BJC. 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	September 2024 Update - As per March 2024 it will be part of regular risk monitoring. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.			
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	September 2024 Update - AS per May 2024 this will be part of the standard BJC cost forms. 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	September 2024 Update - This refers to the previous D4L contract but this is no longer in use. Discussions with NWSSP-SES will include whether there's a need for a performance bond with a smaller value contract. 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.			
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)	September 2024 Update - NOLIS and CT paper partially approved. The staffing element of the CT BC is critical for workforce planning. The team await confirmation of approval at Exec level. July 2024 Update - CT workforce paper and NOLIS 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. February 2024 Update - The 3 T&F groups are currently meeting on a monthly basis (last meeting 22/01/23). The work has been divided up on a short/medium/long term priority setting basis. The Care Group Medical Director is the nominated sponsor. The work is currently ongoing.			
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	Medium	Fully complete (Awaiting approval)	September 2024 Update - As noted in July, the Consultant rate card has been launched. This action can be closed. 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. March 2024 Update - The implementation of the consultant rate-card has been postponed due to the doctors' industrial action. We are reviewing further actions and seeking clarity around the feasibility and affordability of the proposed rate card. January 2024 Update - The non-consultant rate card launched on the 19th October 2023. As per the previous update work is progressing to develop the Consultant Rate Card ready for launch in early 2024. A decision was taken to pause progress on this work due to the Junior Doctors Industrial Action in January 2024. It is still anticipated that the Consultant Rate card will be launched in Spring 2024.			
Internal Audit/2022/95	15/06/2022	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	Medical & Dental Rostering Follow Up Review 3.1 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 Director for People Executive Medical Director	01.11.2022	30.04.2024	Medium	Partially complete (Overdue)	September 2024 Update - Final comments from the LNC are awaited. 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. January 2024 Update - Changes have been made to the policy which has now been sent for Equality Impact Assessment as well as fellow Lead Medics for review, after which we will be sending to LNC.			
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	01.09.2025	Medium	In progress	September 2024 Update - No significant update this month, work to standardise PAS continues. New proposed due date - 01/09/2025. 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 eligable 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 resourced to be able to start destruction in a timely manner across all area's. 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. March 2024 Update - Monthly meetings now established. SOPs in place and shared with Care Groups in relation to the management of patients that have care delivered across the organisation. WPAS project governance structure revised and now has medical records and operational representatives at every level to ensure a consistent approach to the management of patients for the duration of the project. January 2024 Update - Work ongoing. Business Management meeting for Medical Records now in place to review procedures and KPIs.			

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/2023/100	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 ofn 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	31.12.2024	Medium	Partially complete	September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. 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. January 2024 Update - (SM revised implementation date required). A checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. Training with the team has been undertaken. AUDIT - A set of principles and a data validation document is being developed for Claims & Redress. Audits will commence in January 2024. An audit tool for validation of open Inquest Data has been developed and run on a weekly basis. Claims and Redress dashboards are being developed to support the timely identification of discrepancies in data. Further audits of open and closed cases will commence in February 2024. Revised Implementation date aligned to date of audits for assurance.			
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	31.12.2024	Medium	Partially complete	September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. 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. January 2024 Update - All actions are complete. A set of principles and a data validation document is being developed for Claims & Redress. Audits will commence in January 2024. An audit tool for validation of open Inquest Data has been developed and run on a weekly basis. Claims and Redress dashboards are being developed to support the timely identification of discrepancies in data. Further audits of open and closed cases will commence in February 2024. Revised Implementation date aligned to date of audits for assurance.			
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	01.11.2023	Medium	Partially complete (Overdue)	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 update - Part (1a) completed. The Decontamination Policy will presented to IPC committee on the 16th April 2024 (1b). The briefing and advisory support will be issued following approval of the policy as above (1c). January 2024 Update - The Decontamination Policy was approved at Decontamination committee in December 2023: (1a completed) but will not be presented to IPC committee in January 2024 as planned due to the meeting being cancelled. No date for next meeting, awaiting feedback from Nurse Director. 1c) The briefing and advisory support will be issued following approval of the policy as above.			
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	01.10.2023	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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). March 2024 update - Part (5a) completed. Audit program ongoing (part 5b). February 2024 - An update has not been provided against this recommendation on this occasion.			
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	September 2024 Update - Work continues to progress in relation to the development of the training strategy. An outline document has been developed and the action is on track to be completed by the end of the October 2024. 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 uploaded 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	Fully complete (Awaiting approval)	September 2024 Update - All RCA investigations are supported by a member of the Quality & Safety Team who are all RCA Trained. Prior to submission of an outcome form to the NHS Executive (via the NRI Portal), a quality assurance check is completed to ensure all required fields are completed and associated documentation has been uploaded. Propose to close this recommendation. 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. January 2024 Update - The Training Strategy is being finalised and will be presented to the Executive Quality & Safety meeting on the 05.02.24 for sign off. There is some slippage in full completion of a training needs analysis as a result of the implementation of the OCP process. Revised implementation date now February 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	High	Overdue	Revised Due Date - end of Qtr1 2024/25 (30/06/2024) September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
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 IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made available to relevant staff.	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	Medium	In progress	Revised Due Date - Revised Due Date end of Quarter 3 2024-2025 (31.12.2024) September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
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	September 2024 Update - Work continues to progress in relation to the development of the training strategy. An outline document has been developed and the action is on track to be completed by the end of the October 2024. 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. January 2024 Update - The Incident Management Framework and Concerns Policy and Procedures were approved by the Quality & Safety Committee on the 23.01.24. The Training Strategy is being finalised and will			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. 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.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. 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.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
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 INNUs at an operational level which are distributed to all relevant stakeholders. These should include totals by month and by specialty/clinician so that trends and anomalies can be easily spotted and investigated. Sample checks back to patient records should be carried out to confirm all criteria had been met. The use of a checklist as recommended in Matter Arising 2 would aid this process. An appropriate mechanism should be in place for addressing any matters identified, so that corrective action can be promptly taken.	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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			

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/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 1.3 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
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 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 CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented.	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
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 5.2 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - 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. 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.			
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 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - 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. 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.			
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 arears are significantly overspent. Further control measures need to be determined, implemented and monitored.	Facilities Chief Operating Officer	01.10.2023	29.02.2024	High	Fully complete (Awaiting approval)	September 2024 Update - A Follow-up audit was conducted in July/August 2024 and the draft report issued in September 2024 (reference CTMUHB 2425-27). The report will be ratified in October Audit & Risk Committee. This report found sufficient evidence to support that this recommendation has been actioned by the management teams and the action has now been closed. 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	30.01.2025	Medium	In progress	September 2024 Update - A review of current aged assets is underway, this will be prioritised and opportunities for end of year slippage funding will be explored with WG. New Proposed Due Date: This is an ongoing risk - proposed new end date of 30/01/2025. 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. March 2024 Update - We have received further money further end of year slippage money from WG. This included £1m to improve wireless resilience, replacing older access points. £700k to replace iGels devices, and £1m to improve infrastructure across CTM, with a focus on Bridgend. February 2024 Update - CTM was awarded £990k in the recent Cyber bid - this money will be targeted at replacing older out of support devices. Welsh Government have written to boards and trusts indicating that there may be slippage for small value bids with a focus on digital opportunities. We have reiterated our all Wales Capital Bid, with a focus on End User Devices that will replace old equipment.			
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	30.03.2025	Medium	In progress	September 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 - we are hoping to remedy this by adding additional capacity to the Voice and Data team. New proposed due date 30/03/2025. 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. March 2024 Update - No further progress. Cyber staff aligned to networking and (as anticipated Solarwinds) is currently assigned to urgent firewall and routing reviews in relation to protecting the CTM perimeter and in particular the links in and out of SBU to The Princess of Wales site. Plans for Solarwinds training and ownership will require further review and potentially realignment or resourcing. February 2024 Update - The cyber team are now being onboarded, and activity on this action will start when team bedded in.			
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	Low	In progress	Revised Due Date - end of Qtr 2 2024/2025 September 2024 Update - A case has been developed for procuring a system called ARMIS will support with the detailed discovery of all network connected devices on the network. This will also allow for the recording of all asset information in a single database, although progress around making this information, and information already held available to a service desk related CMDB will need to be progressed. July 2024 Update - PoC for Armis (passive scanner for all networked devices including IOT and Medial) 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.			
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 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	Fully complete (Awaiting approval)	September 2024 Update - The DoLS SOP and policy were approved at the Safeguarding Executive Group in July and then at Operational Management Board. This action is now complete. 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. March 2024 Update - The Standard Operating Procedure is currently out for consultation and due to be presented to April Executive Group for approval. January 2024 Update - The development of a standard operating procedure is in progress.			
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	Fully complete (Awaiting approval)	September 2024 Update - This action was completed in May 2024. 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. March 2024 Update - This report is complete and will be presented to Safeguarding Executive Group in April 2024. January 2024 Update - A piece of work is ongoing to analyse four year data. A draft report will be produced by the end of February 2024 and submitted to the Deputy Director of Nursing for comment. A final version will be made available to the Safeguarding executive Group for April 24.			
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	Fully complete (Awaiting approval)	September 2024 Update - This action was completed in May 2024. 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/2023/37	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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 2024 Update - The SLA template has been reviewed and feedback provided by Procurement team. Final checks and approval of the template for use are required.			
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	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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/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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 2024 Update - Guidance documents are in development. A Head of Commissioning post is being recruited to, in order to provide capacity to facilitate oversight of all SLAs.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 2024 Update - Review timeframes to be determined for agreements in 2024. All NHS services are monitored via regular contracting and commissioning meetings with providers.			

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 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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 now 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.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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 Sandra McConnell and with Matthew Swarfield 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. 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.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report.			
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 PCH 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	Fully complete (Awaiting approval)	September 2024 Update - Completed. July 2024 Update - Meeting with CB Learning and Devlopment (18/06/24) to discuss appeals made for Consultant competencies. This is now with Learning and Development Team and SMEs. PJ/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. February 2024 Update - Issues remain in terms of allocated competencies to M&D staff and levels of Safeguarding training expectations. To update March 24.			
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 CSG should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	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	Fully complete (Awaiting approval)	September 2024 Update - Core Compliance 73.37% for end of August. Ongoing monitoring and inhouse training delivered for MH and Resus to improve compliance for classroom learning. This will be an ongoing action and therefore this recommendation will close from the tracker but will continue to be monitored by the service. 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 Manulal 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. February 2024 Update - Departmental Core Mandatory training compliance 63.12%. Further work is needed to address M&D core mandatory training compliance. This is also due to classroom training for Manual Handling and Resus. The department are in the process of training trainers to deliver in house training due shortages of courses.			
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	Partially complete (Overdue)	September 2024 Update - 73% due to 4 new starters in the department who started in this last two weeks. Still issues with Med Staffing teams not sending out notifications to prompt first sign off. A tracker and schedule has been implemented. 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%. SB 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.			
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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	6.4Consideration 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	1.1Management 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	01.03.2025	Medium	In progress	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. New proposed due date - 01/03/2025. 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 Citrix, Wireless, LAN and WAN) are reviewed for their resilience and recover ability.	Digital & Data Director of Digital	01.07.2024	01.03.2025	Medium	In progress	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. New proposed due date - 01/03/2025. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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)	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	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 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. 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/2024/169	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 Executive Medical Director	01.04.2024	01.04.2024	Medium	Fully complete (Awaiting approval)	September 2024 Update - Complete - Procedure approved and made available on SharePoint on 28/8/24. 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.06.2024	01.06.2024	Medium	Overdue	September 2024 Update - The YCR SOP supports the implementation of the incident guidance. YCR Pharmacy team have been asked to review whether this document is still required, and that as part of any update it needs to be consistent with HB guidance. 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, opiate to be reviewed and flagged to IT for removal.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.08.2024	01.08.2024	Low	Fully complete (Awaiting approval)	September 2024 Update - Complete - have reviewed SharePoint. List sent to IT to be removed. They have confirmed removed on 10/9/24. 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.09.2024	01.09.2024	High	Overdue	September 2024 Update - This allocated to Heads of Nursing/Heads of Midwifery for ward areas and Heads of Pharmacy for Pharmacy locations. All pharmacies currently undertaking updating of signatory lists. Royal Glamorgan working on spreadsheet to ensure when sheets need updating. If workable will be rolled out further. Heads of Nursing and Heads of Pharmacy have been asked for an update of 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.05.2024	01.05.2024	High	Overdue	September 2024 Update - E-mail sent out to heads of nursing to bring this to the attention of the nursing teams in the safe to start meetings. Need confirmation from Heads of Nursing that this has been completed. 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/2024/169	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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.06.2024	01.06.2024	High	Overdue	September 2024 Update - Pharmacies have started this review and now forms part of the quarterly CD review. 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.05.2024	01.05.2024	High	Overdue	September 2024 Update - Update from Heads of Pharmacy awaited. 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	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.05.2024	01.05.2024	Medium	Overdue	September 2024 Update - Confirmation from Heads of Nursing that this has been completed awaited. 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 Executive Medical Director	31.10.2024	31.10.2024	Low	In progress	September 2024 Update - Will be added as part of the CD procedure update. 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 Executive Medical Director	01.05.2024	01.05.2024	Medium	Overdue	September 2024 Update - This is allocated to Heads of Nursing/Heads of Midwifery for ward areas and Heads of Pharmacy for Pharmacy locations. Heads of Nursing and Heads of Pharmacy have been asked for an update of 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)	4.1a 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.06.2024	01.06.2024	Medium	Fully complete (Awaiting approval)	September 2024 Update - Areas are now dedicating a certain day for this to happen thus reducing risk of being missed. Recent internal audits are showing that this is now being carried out appropriately. This is ongoing. 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	31.10.2024	31.10.2024	Medium	Fully complete (Awaiting approval)	September 2024 Update - As Areas are now dedicating a certain day for this to happen thus reducing risk of being missed. Recent internal audits are showing that this is now being carried out appropriately. This is ongoing. 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.05.2024	01.05.2024	Medium	Overdue	September 2024 Update - E-mail sent to Heads of Nursing to disceminate this information in the safe to start meetings. Awaiting confirmation from Heads of Nursing that action is completed. 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 Executive Medical Director	01.06.2024	01.06.2024	Low	Fully complete (Awaiting approval)	September 2024 Update - Complete - Now Reported quarterly. 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 CDLIN 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 LIN, the importance of fully completing the reports, including the details of the ward or theatre, will be emphasised.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.04.2024	01.04.2024	Low	Fully complete (Awaiting approval)	September 2024 Update - Complete. Details of ward/department have been added to the occurrence report. 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 CDLIN 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 CDLIN highlight reports to allow analysis to take place.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.06.2024	01.06.2024	Medium	Overdue	September 2024 Update - Datix team have provided three dashboards with pharmacy information. Discussions on going with team to hone the information required. 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 Executive Medical Director	01.05.2024	01.05.2024	Low	Overdue	September 2024 Update - process being reviewed, with meeting set for October with CDAO. 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.	Diagnostics, Therapies, Pharmacies and Specialities Executive Medical Director	01.09.2024	01.09.2024	Medium	Overdue	September 2024 Update - Request put in to L&D for training to be added to ESR therefore creating an electronic record that ward/theatre managers can access. 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 Colorectal 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 PCH, 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	1.2 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	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 vetting process in line with SOP.	Planned Care Chief Operating Officer	30.09.2024	30.09.2024	Medium	In progress	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	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-Refs for LGI/Surgery. 2. link in with Records/Digital team.	Planned Care Chief Operating Officer	30.09.2024	30.09.2024	Medium	In progress	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	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 unvetted 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	1. Imbed 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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: CTMUHB-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	Partially complete (Overdue)	September 2024 Update - Updated ToR will be submitted to ESG in October for approval and Population Health and Partnerships Committee for ratification. 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: CTMUHB-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	Fully complete (Awaiting approval)	September 2024 Update - This recommendation is now complete. 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: CTMUHB-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	September 2024 Update - Work is underway to quantify actions where possible. There are no expected issues meeting delivery timescales. 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: CTMUHB-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 UHB works within its revenue and capital resource limits. For example, a key component of the UHB'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	September 2024 Update - Work is underway to review long term funding requirements. There are no expected issues meeting delivery timescales. 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: CTMUHB-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	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	31.03.2025	Medium	In progress	September 2024 Update - Work has commenced looking at the opportunities to support this action. New governance arrangements are being established which will provide an opportunity to incorporate this recommendation. July 2024 Update - This has been added to the workplan of the new sustainability manager. May 2024 Update - No update this month.			

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/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-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	Fully complete (Awaiting approval)	September 2024 Update - This recommendation is now complete. 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: CTMUHB-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 initiates 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	Fully complete (Awaiting approval)	September 2024 Update - This recommendation is now complete. 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	September 2024 Update - The new committees are currently scheduled to begin in January 2025. 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	September 2024 Update - An outline case for the next steps in the digital journey was supported at the Board meeting in July. We have been asked to develop a business case to to procure a strategic partner for the development of a Modular EPR. 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/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-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	Partially complete (Overdue)	September 2024 Update - Inspire communication plan signed off and participants contacted w/c 16th September 2024. Final draft of the Leadership Competency Framework has been developed which sets out the objectives for all leadership development. 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: CTMUHB-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	Partially complete	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. September 2024 Update - Reporting functionality has built into the new Inspire Cohorts, with reporting available once the programme is launched. The reporting will include evaluation data. Reporting will start following the launch of the Discovery Phase, in October 2024. July 2024 Update - Reporting functionality built in to new Inspire Cohorts, with reporting available once programme launched. This will include evaluation data.			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-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	Partially complete	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. September 2024 Update - Reports and a dashboard have been designed, but are not yet populated, as the programme has not yet starting. Reports will be presented to the People & Culture Committee, once the programme has started and the reports are available. 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.			
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-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	Partially complete	September 2024 Update - The newly developed programme dashboards will be populated, once the programme has started start. A Kirkpatrick evaluation framework has been designed, which will allow this data to be captured in the reports, once available. 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: CTMUHB-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	Partially complete	September 2024 Update - The newly developed dashboards will be populated, once the programme starts. A Kirkpatrick evaluation framework has been designed, which will allow this data to be captured in reports, once available. 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/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-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	31.12.2024	Medium	In progress	September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. 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: CTMUHB-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	31.12.2024	Medium	In progress	September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. 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: CTMUHB-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 1:1s 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	Fully complete (Awaiting approval)	September 2024 Update - Complete. 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: CTMUHB-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	30.09.2025	Medium	In progress	September 2024 Update - Initial stages of the development of a suite of Claims & Redress dashboards and reports are under review by the BI team to support the Legal Services with an audit programme for assurance; this work will include a roll out programme of a number of dashboards & reports. It is anticipated that this will be work in progress over the following 12 months with an anticipation completion date of 30/09/2025. 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: CTMUHB-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	Fully complete (Awaiting approval)	September 2024 Update - the SOP has been updated to clarify that Case Management Review are to be signed by two separate individuals. This has previously mentioned at the Legal Services team meeting. Action Closed. 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: CTMUHB-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	September 2024 Update - The SOP has been reviewed and is being updated with explanations to outline clearly what constitutes final payment, and the process to be followed if an invoice is disputed. Training will be provided in the Team Meeting taking place on 25 September 2024 to Claims Investigation Officers. 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: CTMUHB-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	Overdue	September 2024 Update - The September WRP Task & Finish Group for Inquest and Claims (to update Key Stage History Fields) was cancelled . We are awaiting a new meeting date to review Key Stage History Fields. Action will remain open until WRP Task & Finish Group updates the Health Board. 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: CTMUHB-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	September 2024 Update - Action continues on this recommendation: SOP being reviewed to ensure it aligns with delegated authority for payments. 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: CTMUHB-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 DCIQ system.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	31.08.2024	Medium	Overdue	September 2024 Update - Health Board's SOP will be finalised when we receive final update from the September WRP Task & Finish Group for Inquest and Claims (to update stage history fields) was cancelled. We are awaiting a new meeting date to review Key Stage History Fields. Action will remain open until WRP Task & Finish Group updates the Health Board. 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	September 2024 Update - Further disucssion with Cisco lined up for late September. Meeting also kick off held in September with BT/PSBA team around the LANWAN strategy for the Health Board in light of increased reliance on the PSBA and Cloud services. 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 Citrix). 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	September 2024 Update - Systems are being categorised and the most critical will be protected and available for quick restoration. Other services will be brought back from backup systems. A schedule and recovery time objectives are being worked up for wider review. 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	September 2024 Update - A proof of concept has been arranged with BT PSBA to stretch Layer 2 network (VLANS) between PCH and PoW to make this a more seamless operation. 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; • Failover of VM restore and restore from backup; and • Failure of system – VM restore / backup restore.	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) - Loss of DHCW services - Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet)	Digital & Data Director of Digital	30.09.2024	30.12.2024	Medium	In progress	September 2024 Update - For the 'cyber impacting affecting CTM network and services' category ongoing cyber improvement activities are being prioritised. For the 'environment impact affecting CTM network and services (e.g. utility loss, flood or fire)' category this has been alleviated somewhat using PoW as the DR site. Options also being explored to develop the PCH ACTIVE<>ACTIVE arrangement into a wider geography - i.e. explore potential of hosting second datacentre outside of the PCH site. For the 'loss of DHCW services' category, mapping of services is progressing through weekly NIS-R CAF Reviews. This activity does requires service management support, and a new Head of Digital Service Management has been appointed. For the 'loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet)' category discussions scheduled with BT/PSBA that will feed into a LANWAN strategy will address the networking challenges. August 2024 Update - Following discussion at the Audit & Risk Committee (15/08/2024) R4.1 Action was updated (Management response revised). 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.	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.	Digital & Data Director of Digital	30.12.2024	30.12.2024	Medium	In progress	September 2024 Update - Systems are being categorised and the most critical will be protected and available for quick restoration. Other services will be brought back from backup systems. A schedule and recovery time objectives are being worked up for wider review. August 2024 Update - Following discussion at the Audit & Risk Committee (15/08/2024), R5.1 Action was updated (Management response revised).			

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/2024/189	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 MAs 2,5.	Digital & Data Director of Digital	30.12.2024	30.12.2024	High	In progress	September 2024 Update - Systems are being categorised and the most critical will be protected and available for quick restoration. Other services will be brought back from backup systems. A schedule and recovery time objectives are being worked up for wider review. 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: 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	31.10.2024	Medium	Partially complete	September 2024 Update - The Assistant Director of Governance & Risk has developed a simplified service to board escalation process for risk which was shared with risk leads in care groups and central directorates on the 10th September for review and comment by the 24th September. If supported the process will be submitted to Operational Management Board for endorsement and then onto Executive Management Board for approval. Revised deadline requested of the 31st October 2024. 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)	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 QSRE 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	31.10.2024	Medium	Partially complete	September 2024 Update - The Assistant Director of Governance & Risk has set out an approach for the monitoring of risks at care group and central directorate level for risks scoring 12 and above. This new approach was shared with risk leads in care groups and central directorates on the 10th September for review and comment by the 24th September. If supported the process will be submitted to Operational Management Board for endorsement and then onto Executive Management Board for approval. Revised deadline requested of the 31st October 2024. July 2024 Update - meeting with Care Group risk leads held to agree the approach - further work is needed in this area to simplyfy 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)	4.4 Quality and Safety Corporate Directorate The terms of reference for the Quality and Safety Business Team Meeting should 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	Overdue	September 2024 Update - The August QS&I meeting facilitated discussion with regards to the groups remit and discussion with regards to the potential changes to the format of the group in line with the maturing organisational meeting structures therefore, the Quality & Safety team Business meeting Terms of Reference were not included and have been deferred to the agenda for approval at the next meeting which is being held on 15th October 2024. 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 quoracy 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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)	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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.	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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.	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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.	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	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.			
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	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.	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.	Capital and Estates Executive Director of Finance	30.09.2024	30.09.2024	Medium	Fully complete (Awaiting approval)	September 2024 Update - An analysis of potential funding sources to mitigate impact has been developed through dialogue with NWSSP SES and will be reported on each month to Project Board.			
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	1.2 The current programme funding risks should be noted at the programme risk register.	Noted. The risk presented by the VAT recovery rate matter above will be quantified in the risk register.	Capital and Estates Executive Director of Finance	30.09.2024	30.09.2024	Medium	In progress	September 2024 Update - To be incorporated in the next Risk Register update (October).			
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	2.1 The dispute on design fees for Section 7 should be agreed as a matter of priority.	Agreed. Discussions ongoing.	Capital and Estates Executive Director of Finance	31.10.2024	31.10.2024	Medium	Fully complete (Awaiting approval)	September 2024 Update - Agreement has been determined on Section 7 fees and duly instructed.			
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	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.	Agreed, noting 'design' performance indicator (not 'programme' indicator) updated accordingly since the time of audit fieldwork and issuing of draft report.	Capital and Estates Executive Director of Finance	30.09.2024	30.09.2024	Medium	Fully complete (Awaiting approval)	September 2024 Update - PM report now showing adjusted 'programme' performance dial.			
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	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.	Agreed.	Capital and Estates Executive Director of Finance	30.09.2024	30.09.2024	Medium	In progress	September 2024 Update - To be incorporated in the next Risk Register update (October).			
Internal Audit/2024/195	01.07.2024	PCH Redevelopment Programme: Key Performance Objectives Final Internal Audit Report_July 2024 (Review Reference: CTM-SSU-2324-04)	4.1 The externally appointed will verify that contractor's insurances remain current and update the progress report accordingly.	Noted and agreed. Project Manager will ascertain insurances are extant.	Capital and Estates Executive Director of Finance	30.09.2024	30.09.2024	Low	Fully complete (Awaiting approval)	September 2024 Update - Insurances received.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2021/144	01/08/2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	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 ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01/10/2021	24/09/2024	1089	31/10/2024	High	Partially complete	September 2024 - An update against this recommendation has not been provided on this occasion. August 2024 Audit Wales Progress Update - R3 is considered to be partially implemented; remains open. 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. This recommendation to be noted as partially implemented. 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 clarify 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - Complaints and Concerns compliance is now above 80% therefore real time data and learning from this is now shared with the Care Groups in a timely manner. LFERs compliance continues to improve and a new improved process for the management of Inquests is being developed. Meetings have also taken place in order to a review current methodologies to collate a more robust Patient Experience data. Following the OCP process internal Care Group Quality & Safety Governance frameworks are being developed, this will support and further clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the Care Groups. With the completion of the OCP, the structure clearly outlines the quality and safety responsibilities of both Medical and Nurse Directors. This is furthermore established at directorate and service level leadership, with established governance reporting mechanisms as well as roles and responsibilities. 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.
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 DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	People Executive Director for People	31/08/2021	24/09/2024	1120	31/05/2024	High	Overdue	Revised Due Date May 2024; Unable to provide a revised date (see July 2024 update) September 2024 - An update against this recommendation has not been provided on this occasion. 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. December 2023 Update - The Health Board has reviewed its governance and procedures for the appointment of senior officers A new documented Action Plan process was piloted during the recruitment process for the Executive Director of Public Health Post in January 2023, with small amendments being made based on the lessons learnt. The process was successfully used during the recent appointment to the Executive Director of Public Health, following the post being readvertised. This process deals with all of the governance requirements and process matters, from post approval to appointment to sign off and approval by the RATs Committee. Formal and clear minutes are taken, recording the discussions and decision made by the RATs Committee in compliance with the governance arrangements. This process review is now completed. As the All Wales new Pension Policy work is not progressing at pace (it was to be issued to the Service by December 2023, this now looks uncertain) the Health Board's People Policy Review Group is currently reviewing and drafting a stand alone Retire and Return Procedure. The application form will ensure that appropriate questions are asked and answers provided which will provide transparency in respect of the consideration taken into account by the manager to either approve or reject the application business cases. The process will also confirm the process for providing retire and return information to the NWSSP Payroll and Pension Team. October 2023 Update - It has been confirmed a partnership group is being established under the Welsh Partnership Forum Business Committee to develop an All Wales Pensions Policy. The timescale for the policy to be developed is autumn 2023. The work on the CTM Pension Policy has been halted on the request of the NHS Confederation, however our draft policy has been shared with the WPF Business Committee to inform the All Wales policy. The implementation date has been amended to December 2023, but this date will be dictated by the WPF.
Audit Wales/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	24/09/2024	543	31/03/2025	High	In progress	September 2024 Update - Risk registers maintained and a robust approach is in place for funding programmes. The Housing with Care Funding (HCF) forms a 4-year programme, having begun in FY 22/23 with an annual budget for the first three year of £8,729,000 per annum. This means the fourth year is yet to be confirmed by Welsh Government. Whilst the region progresses into the third year of the programme with a known capital allocation, it does mean a number of large-scale projects which span into FY 25/26 could be at risk due to unknown HCF funding availability, due to construction and completion timelines. Wider than funded programs, the sensitive handling of a new ECC level 4 service, where we are seeking to increase community capacity without carving resources away from social care, demonstrates a maturing approach. We need to embed workforce planning more broadly over the coming months, and this would then provide us with a basis for closing this risk in circa 6 months time. 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 limed 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 RIF investment. March 2024 Update - On the 5th February a letter was received from WG that stated that the tapering element of the Regional Integration Fund had been removed. This news was welcomed by partners however letter reinforced other elements of RIF including - Embedding the 6 models of care consistently and equitable across Wales, focus on benchmarking against other regions, and support 'once for Wales' approach. January 2024 Update - Some challenges remain over appointing to vacant posts. Awaiting clarity from Welsh Government regarding relaxation of RIF tapering for 2024/25.
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 RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31/03/2023	24/09/2024	543	31/03/2025	High	In progress	September 2024 Update - The CTM Regional Partnership plays an essential role in shaping the health and social care system in Wales to respond to changing population need. Better continuity and coordination of care is particularly important in a society where more people are living longer, more people are living from birth with complex health conditions, and there is a significant interplay between physical and growing mental il health. The development of a regional Memorandum of Understanding and Section 33 Agreement for our Integrated Community Care System provides us with a framework for integrated commissioning and pooled resourcing based on a shared understanding of demand and capacity opportunities and challenges. As we move to the formal agreement of these legal frameworks over the Autumn and Winter we anticipate closing this risk off in 6 months time. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - RIF 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. January 2024 Update - Challenges over mainstreaming RIF projects. Awaiting further guidance from Welsh Government over expectations.
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 it deliver its priorities"	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31/03/2023	24/09/2024	543	31/03/2025	High	In progress	September 2024 Update - Integrated Community Care System. We are taking a regional and stragic approach to the development of integrated community pathways. These pathways will be delivered by integrated teams based on a locality footprint. Program plan reviewed regularly by the Partnership Leadership Team and RPB governance. Whilst workforce challenges are an enduring feature of our sector, as we move to the formal agreement of underpinning legal frameworks for our ICCS over the Autumn and Winter we anticipate closing this risk off in 6 months time. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - Review of all RIF 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. January 2024 Update - Market Stability report being updated. Challenges and opportunities to be discussed within RPB sub groups to take forward.
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	24/09/2024	207	30/09/2024	Medium	Partially complete	September 2024 Update - The Effective Management of Board Business review which sets out the new approach for Board and Committee Business with effect from 1st January 2025 will be submitted to the Public Board meeting on the 26th September 2024. If approved the updated Terms of Reference and Cycles of Business will be shared on the public facing website which demonstrates the focus at Board and Committees on Shared Listening and Learning and the business which will be received through the Committee structure in 2025. 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 that will be in place from 1st October. March 2024 Update - A revised implementation date is requested as 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. February 2024 Update - In Progress: Head of Corporate Governance and Board Business to consider how this recommendation can be achieved to improve transparency.
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	24/09/2024	236	01/02/2024	High	Overdue	September 2024 - An update against this recommendation has not been provided on this occasion. 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/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 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 indents 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	24/09/2024	268	31/12/2023	High	Overdue	September 2024 Update - An outline case for the next steps in the digital journey was supported at the Board meeting in July. We have been asked to develop a business case to to procure a strategic partner for the development of a Modular EPR. 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 been 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. 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.
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R7 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	24/09/2024	268	31/12/2024	High	Partially complete	September 2024 Update - c) 4 FCPs were updated at the August ARC and further FCPs will be reviewed and updated to go to the October ARC. July 2024 Update - A number of FCPs are being brought to August ARC as part of first tranch 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. 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 received on this recommendation. August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023. June 2023 Update - a) Reviewed 5o &5Fis and confirmed upper limit for contracts is consistent with model 5os and 5Fis. Contract in excess of £1m require WG Ministerial approval CLOSED. b) Quarterly Capital reports included on PPF agenda. c) FCP review ongoing
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) Cover reports will be reviewed to incorporate requirements of the WBFG Wales Act. d) Presentation cover sheets to be reviewed to ensure authors sufficiently reflect key risks and issues.	Corporate Governance Director of Corporate Governance/Board Secretary	30/10/2023	24/09/2024	330	30/09/2024	High	Partially complete	September 2024 - The Effective Management of Board Business review which sets out the new approach for Board and Committee Business with effect from 1st January 2025 will be submitted to the Public Board meeting on the 26th September 2024. If approved this will set out that all Meetings will be published with the exception of those held in closed session and Remuneration & Terms of Service Committee, Organ Donation Sub Committee, Provision of Discharge Sub Committee, Clinical Advisory Group and Local Partnership Forum. 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. March 2024 Update - Items a, c and d are complete. A revised implementation date is requested as the publication of Advisory and Sub Committee minutes is being captured in the Effective Management of Board Business Proposal which is due to conclude circa July 2024. February 2024 Update - In Progress - Update remains as reported in December 2023. The Director of Corporate Governance & Board Secretary appointed in September 2023 would also need sufficient time to attend tp review the position of the Advisory Group meetings. Will be incorporated into the Review of the Effective Management of Board Business Proposal (January 2024). Timeframe currently remains as 31st March 2024.
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	24/09/2024	360	31/12/2023	High	Overdue	September 2024 - An update against this recommendation has not been provided on this occasion. 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.

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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	24/09/2024	389	01/09/2023	High	Partially complete (Overdue)	September 2024 - An update against this recommendation has not been provided on this occasion. 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.
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUHB 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	24/09/2024	452	30/06/2023	High	Partially complete (Overdue)	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. August 2023 Update - No further update for this month. June 2023 Update - a) this message has been disseminated and will be put into place moving forward with the development of plans, b) this is clear on all board papers and portfolios have been agreed by execs, c) there is still further work to be done in line with this as we set out our performance monitoring approach.
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 singe CD for performance and governance structure across CTMUHB.	Planned Care Chief Operating Officer	01/04/2024	24/09/2024	176	01/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
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 specialties, Nurse led, Consultant led and AHPs • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Planned Care Chief Operating Officer	01/01/2024	24/09/2024	267	01/01/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
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 First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place: • Ensure that prehab services are improved by setting up a Prehabilitation Service to ensure patients are medically optimised for surgery. Both digital and face to face options to be considered. • The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board • Increase the capture of PREMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures –timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement • Updated GIRFT action plan to be created with new CD and monitored through the reconfiguration programme. • Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved.	Planned Care Chief Operating Officer	01/05/2023	24/09/2024	512	01/05/2023	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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 GIRFT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.
Audit Wales/2024/168	01/02/2024	Review of Workforce Planning Arrangements – Cwm 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	24/09/2024	23	01/09/2024	High	Overdue	September 2024 Update - Working closely with Heads of People to support the role out of SWP training. An assessment of needs across the organisation is in development and discussions with L&D around SWP training being delivered as part of the Leadership Development Programme are taking place to include once the programme is launched. 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.
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	24/09/2024	115	01/06/2024	High	Overdue	September 2024 Update - An significant SWP update was provided to PCC on 7 August 2024. A progress update will be reported at the next PCC in November 2024. 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 - 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)	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	24/09/2024	146	01/05/2024	High	Overdue	September 2024 Update - Work continues as set out in the July update. Some delays have been incurred due to data errors and system challenges. However, engagement with key stakeholders across People, Finance and medical colleagues has been positive to enable the work once the data and system challenges are addressed. At this point, we are still aiming for the November deadline. July 2024 Update - work still underway with Data/Digital, People and Finance to align ledger with ESR staff in post to identfy 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. 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/2024/196	01/07/2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	31/05/2023	24/09/2024	482	31/01/2025	High	In progress	September 2024 Update - A spotlight report on MIU services was provided earlier in the year. Further updates will be included in early 2025. A full review of the MIU service provision across the HB will include an update on some of the future plans relating to Maesteg Hospital. This report will be available for Quality & Safety Committee in early 2025. August 2024 Audit Wales Update - R4 is considered ongoing.
Audit Wales/2024/196	01/07/2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	31/03/2023	24/09/2024	543	31/01/2025	High	In progress	September 2024 Update - An update will be included as part of the USC Quality and Safety Committee report in November 2024 outlining the lessons learned from the temporary MIU closure and confirmation of any outcomes from the work to assess harm. August 2024 Audit Wales Update - R4 is considered ongoing.

Inspection Code	Date of Inspection	Overall Assurance Rating	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates	
Internal Audit/2020/65	29/07/2020	Reasonable	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	24/09/2024	1272	31/07/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	1393	30/04/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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 b available in January 2024. October 2023 Update - no further progress to report. Until the vacancies that exist as a consequence of phase 2 of the OCP are filled there will not be the management capacity to undertake this piece of work.	29
Internal Audit/2020/74	24/01/2020	Reasonable	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. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Diagnostics, Therapies, Pharmacies and Specialties (Clinical Engineering) Chief Operating Officer	01/04/2020	24/09/2024	1637	31/01/2024	Medium	Partially complete (Overdue)	September 2024 Update - IOT Infrastructure updated and hand-held scanners now operational in POW. Additional fixed Antenna readers installed @ POW and RGH, re-siting of some antennas @ RGH completed in August 2024. Re-programming of configuration of system since antenna installs to be completed Sept 2024. Server switch over was delayed, due to remote access issues for Linux server and re-submission requirement to DHCW of access requirements. Working with ICT to resolve. Pharmacy will review cylinder tracking functionality once fully operational. Hopeful of completion by end October 2024. 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 @ POW still to be resolved. Data migration and 4track 2 app to be completed by July 2024. WG 21-05-2024. March 2024 Update - data migration of existing data to 4track 2 performed and undergoing live testing and bug checking on existing server prior to switching to new server environment. Capital funding approved via WG digital funding for increased infrastructure and coverage in Feb 2024. Equipment received and to be installed ASAP. Wi-Fi limitations still an issue at POW for aspects surrounding any IOT Wi-Fi requirements, such as handheld scanners for cylinder tracking aspect. This will remain an issue until POW ICT deseagregation is completed. January 2024 Update – Request submitted for WG digital Capital Slippage with regard funding of phased expansion of coverage, await answer. No further update on POW ICT connectivity /deseagregation status for IOT devices. Data migration and application server now progressing, data verification and proofing server environment in place to test, prior to live switch over to operational server. Target Date RF-ID migration 31-03-2024.	
Internal Audit/2021/76	06/08/2021	Reasonable	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 NWSSP 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	24/09/2024	997	30/06/2024	Medium	Overdue	September 2024 Update - Lease still with GP for signing - service are working through a few queries. 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. March 2024 Update - discussions ongoing with GPs. January 2024 Update - Discussions have recommenced with GPs. December 2023 Update - At November Project Board, following confirmation of approved funding , it was agreed that Lease discussions with the GP practices can recommence . Draft Heads of Terms previously were previously shared between solicitors.	9
Internal Audit/2021/76	06/08/2021	Reasonable	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	24/09/2024	997	29/02/2024	Medium	Overdue	September 2024 Update - Requested as agenda item for November Project Board. July 2024 Update - no further update. 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. March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward. January 2024 Update - Benefits will be periodically reviewed as part of the Project Board agenda moving forward.	
Internal Audit/2021/76	06/08/2021	Reasonable	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	24/09/2024	997	29/02/2024	Medium	Overdue	September 2024 Update - Requested as agenda item for November Project Board. July 2024 Update - no further update. 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. March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward. January 2024 Update - Benefits will be periodically reviewed as part of the Project Board agenda moving forward.	
Internal Audit/2022/161	14/02/2022	Reasonable	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	24/09/2024	877	30/04/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. February 2024 Update - Final answer awaited from Finance and the recommendation will then be closed down. Update received after deadline and not included in ARC Excel Report 22nd February 2024. December 2023 Update - Following a lack of progress, a meeting has been set up in December with Finance Colleagues to finish draft and work towards finalising the Financial Control Procedure.	55
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	754	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - opinion sought from Performance.	56
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	754	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.	
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	754	30/04/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - opinion sought from Performance colleagues.	
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	785	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.	
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	785	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.	

Inspection Code	Date of Inspection	Overall Assurance Rating	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	785	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	785	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - email has gone from Deputy COO to all Operations Directors asking for validation to be undertaken. In addition, targeted email going to Ops Directors and Service Group Managers as appropriate, with circulation lists and areas of greatest concern outlined. In addition, discussion has taken place with Internal Audit and have asked colleagues within Performance for areas of greatest concern to inform the above. Specific Bridgend information also requested.
Internal Audit/2022/25	15/06/2022	Limited	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	24/09/2024	785	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.
Internal Audit/2022/43	29/07/2022	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	632	31/03/2025	Medium	In progress	September 2024 Update - This is in the design stage, will be applicable if business case is approved and we enter into a contract for construction. 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. February 2024 - 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	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	632	31/03/2024	Medium	Overdue	September 2024 Update - As per May 2024 in that the design team was competitively tendered and so will the construction stage if the business case is approved by Welsh Gov. 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: SBS 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.
Internal Audit/2022/43	29/07/2022	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	POW Theatres Fire Safety Works 9.1 Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Agreed. This will be undertaken at the future procurement.	Capital and Estates Executive Director of Strategy & Transformation	01/01/2023	24/09/2024	632	30/11/2024	Medium	In progress	September 2024 Update - Procurement of a modular supplier is being linked to the LHP procurement process which is using the relevant framework. Construction costs etc for the FEN works will shortly be competitively tendered and will be reported to Project Board and ECMG. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2022/43	29/07/2022	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	632	31/10/2024	Low	In progress	September 2024 Update - AS per May 2024 this will be part of the standard BJC cost forms. 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	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	785	31/01/2025	Medium	In progress	September 2024 Update - Likely to be Jan 2025 at the earliest. 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. February 2024 - 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	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	785	31/01/2025	Medium	In progress	September 2024 Update - Likely to be Jan 2025 at the earliest. 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	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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: • contracted 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	24/09/2024	785	29/02/2024	Medium	Overdue	September 2024 Update - As per May 2024 the only costs on the revised scheme to date are surveys and design team fees and there is no Supply Chain partner as this is now significantly smaller and thus no a longer D4L scheme. Design team fees to get to tendered costs and BJC submission have been reported to ECMG. The cost profiling will be provided if and when we move into the construction stage. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2022/43	29/07/2022	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	785	31/01/2025	Medium	In progress	September 2024 Update - A risk register is provided but not costed as the scale is significantly smaller than the previous D4L scheme. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2022/43	29/07/2022	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	785	31/01/2025	Medium	In progress	September 2024 Update - The contingency applies to the construction stage and will be part of the regular monitoring. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2022/43	29/07/2022	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	785	31/12/2023	Medium	Overdue	September 2024 Update - As per May this will be part of the BJC. 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	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	785	31/12/2023	Medium	Overdue	September 2024 Update - As per March 2024 it will be part of regular risk monitoring. 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. February 2024 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2022/43	29/07/2022	Limited	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-D1)	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	24/09/2024	785	31/01/2024	Low	Overdue	September 2024 Update - This refers to the previous D4L contract but this is no longer in use. Discussions with NWSSP-SES will include whether there's a need for a performance bond with a smaller value contract. 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.

Inspection Code	Date of Inspection	Overall Assurance Rating	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2022/67	24/10/2022	Reasonable	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	24/09/2024	664	31/12/2023	High	Partially complete (Overdue)	September 2024 Update - NOUS and CT paper partially approved. The staffing element of the CT BC is critical for workforce planning. The team await confirmation of approval at Exec level. July 2024 Update - CT workforce paper and NOUS 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. February 2024 Update - The 3 T&F groups are currently meeting on a monthly basis (last meeting 22/01/23). The work has been divided up on a short/medium/long term priority setting basis. The Care Group Medical Director is the nominated sponsor. The work is currently ongoing.
Internal Audit/2022/95	15/06/2022	Reasonable	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	Medical & Dental Rostering Follow Up Review 3.1 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 Director for People Executive Medical Director	01/11/2022	24/09/2024	693	30/04/2024	Medium	Partially complete (Overdue)	September 2024 Update - Final comments from the LNC are awaited. 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. January 2024 Update - Changes have been made to the policy which has now been sent for Equality Impact Assessment as well as fellow Lead Medics for review, after which we will be sending to LNC.
Internal Audit/2022/97	10/10/2022	Reasonable	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	24/09/2024	85	01/09/2025	Medium	In progress	September 2024 Update - No significant update this month, work to standardise PAS continues. New proposed due date - 01/09/2025. 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 eligiable 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 resourced to be able to start destruction in a timely manner across all area's. 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. March 2024 Update - Monthly meetings now established. SOPs in place and shared with Care Groups in relation to the management of patients that have care delivered across the organisation. WPAS project governance structure revised and now has medical records and operational representatives at every level to ensure a consistent approach to the management of patients for the duration of the project. January 2024 Update - Work ongoing. Business Management meeting for Medical Records now in place to review procedures and KPIs.
Internal Audit/2023/100	31/05/2023	Reasonable	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	24/09/2024	481	31/12/2024	Medium	Partially complete	September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. 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. January 2024 Update - (SM revised implementation date required). A checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. Training with the team has been undertaken. AUDIT - A set of principles and a data validation document is being developed for Claims & Redress. Audits will commence in January 2024. An audit tool for validation of open Inquest Data has been developed and run on a weekly basis. Claims and Redress dashboards are being developed to support the timely identification of discrepancies in data. Further audits of open and closed cases will commence in February 2024. Revised Implementation date aligned to date of audits for assurance.
Internal Audit/2023/100	31/05/2023	Reasonable	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	24/09/2024	481	31/12/2024	Medium	Partially complete	September 2024 Update - Confirmed Claims audit tool developed and report generated. Further feedback is required to implement on a monthly basis. Development of Redress dashboard in progress - anticipated time scale of completion 31.12.24. 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. January 2024 Update - All actions are complete. A set of principles and a data validation document is being developed for Claims & Redress. Audits will commence in January 2024. An audit tool for validation of open Inquest Data has been developed and run on a weekly basis. Claims and Redress dashboards are being developed to support the timely identification of discrepancies in data. Further audits of open and closed cases will commence in February 2024. Revised Implementation date aligned to date of audits for assurance.
Internal Audit/2023/107	08/08/2023	Reasonable	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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). March 2024 update - Part (5a) completed. Audit program ongoing (part 5b). February 2024 - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/107	08/08/2023	Reasonable	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	24/09/2024	328	01/11/2023	Medium	Partially complete (Overdue)	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. March 2024 update - Part (1a) completed. The Decontamination Policy will presented to IPC committee on the 16th April 2024 (1b). The briefing and advisory support will be issued following approval of the policy as above (1c). January 2024 Update - The Decontamination Policy was approved at Decontamination committee in December 2023: (1a completed) but will not be presented to IPC committee in January 2024 as planned due to the meeting being cancelled. No date for next meeting, awaiting feedback from Nurse Director. 1c) The briefing and advisory support will be issued following approval of the policy as above.
Internal Audit/2023/107	08/08/2023	Reasonable	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	24/09/2024	359	01/10/2023	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 2024 Update - Strategic review of IPC service ongoing. Led by Richard Hughes, Deputy Executive Director of Nursing.
Internal Audit/2023/113	08/08/2023	Reasonable	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	24/09/2024	328	31/10/2024	Medium	Partially complete	September 2024 Update - Work continues to progress in relation to the development of the training strategy. An outline document has been developed and the action is on track to be completed by the end of the October 2024. 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. January 2024 Update - The Training Strategy is being finalised and will be presented to the Executive Quality & Safety meeting on the 05.03.24 for sign off. There is some slippage in full completion of training needs
Internal Audit/2023/117	28/07/2023	Reasonable	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 fo 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	24/09/2024	267	30/06/2024	High	Overdue	Revised Due Date - end of Qtr1 2024/25 (30/06/2024) September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
Internal Audit/2023/117	28/07/2023	Reasonable	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 IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made available to relevant staff.	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	24/09/2024	632	31/12/2024	Medium	In progress	Revised Due Date - Revised Due Date end of Quarter 3 2024-2025 (31.12.2024) September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
Internal Audit/2023/124	31/05/2023	Reasonable	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	24/09/2024	359	31/10/2024	Medium	Partially complete	September 2024 Update - Work continues to progress in relation to the development of the training strategy. An outline document has been developed and the action is on track to be completed by the end of the October 2024. 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. January 2024 Update - The Incident Management Framework and Concerns Policy and Procedures were approved by the Quality & Safety Committee on the 23.01.24. The Training Strategy is being finalised and will
Internal Audit/2023/146	11/10/2023	Limited	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 INNUs at an operational level which are distributed to all relevant stakeholders. These should include totals by month and by specialty/clinician so that trends and anomalies can be easily spotted and investigated. Sample checks back to patient records should be carried out to confirm all criteria had been met. The use of a checklist as recommended in Matter Arising 2 would aid this process. An appropriate mechanism should be in place for addressing any matters identified, so that corrective action can be promptly taken.	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	24/09/2024	207	01/03/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
Internal Audit/2023/146	11/10/2023	Limited	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-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 DNOs 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 CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented.	Planned Care Chief Operating Officer	01/03/2024	24/09/2024	207	01/03/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
Internal Audit/2023/146	11/10/2023	Limited	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-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	24/09/2024	207	01/03/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - 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. 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.

Inspection Code	Date of Inspection	Overall Assurance Rating	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/146	11/10/2023	Limited	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-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	24/09/2024	207	01/03/2024	Low	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - 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. 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.
Internal Audit/2023/146	11/10/2023	Limited	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	24/09/2024	267	01/01/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. 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.
Internal Audit/2023/146	11/10/2023	Limited	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 NHSDC 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	24/09/2024	267	01/01/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
Internal Audit/2023/146	11/10/2023	Limited	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-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	24/09/2024	267	01/01/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
Internal Audit/2023/146	11/10/2023	Limited	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	24/09/2024	389	01/09/2023	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. 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.
Internal Audit/2023/148	09/10/2023	Reasonable	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	24/09/2024	86	30/01/2025	Medium	In progress	September 2024 Update - A review of current aged assets is underway, this will be prioritised and opportunities for end of year slippage funding will be explored with WG. New Proposed Due Date: This is an ongoing risk - proposed new end date of 30/01/2025. 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. March 2024 Update - We have received further money further end of year slippage money from WG. This included £1m to improve wireless resilience, replacing older access points. £700k to replace iGels devices, and £1m to improve infrastructure across CTM, with a focus on Bridgend. February 2024 Update - CTM was awarded £990k in the recent Cyber bid - this money will be targeted at replacing older out of support devices. Welsh Government have written to boards and trusts indicating that there may be slippage for small value bids with a focus on digital opportunities. We have reiterated our all Wales Capital Bid, with a focus on End User Devices that will replace old equipment.
Internal Audit/2023/148	09/10/2023	Reasonable	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	24/09/2024	86	30/03/2025	Medium	In progress	September 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 - we are hoping to remedy this by adding additional capacity to the Voice and Data team. New proposed due date 30/03/2025. 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. March 2024 Update - No further progress. Cyber staff aligned to networking and (as anticipated Solarwinds) is currently assigned to urgent firewall and routing reviews in relation to protecting the CTM perimeter and in particular the links in and out of SBU to The Princess of Wales site. Plans for Solarwinds training and ownership will require further review and potentially realignment or resourcing. February 2024 Update - The cyber team are now being onboarded, and activity on this action will start when team bedded in.
Internal Audit/2023/148	09/10/2023	Reasonable	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	24/09/2024	177	30/09/2024	Low	In progress	Revised Due Date - end of Qtr 2 2024/2025 September 2024 Update - A case has been developed for procuring a system called ARMIS will support with the detailed discovery of all network connected devices on the network. This will also allow for the recording of all asset information in a single database, although progress around making this information, and information already held available to a service desk related CMDB will need to be progressed. July 2024 Update - PoC for Armis (passive scanner for all networked devices including IOT and Medial) 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.
Internal Audit/2023/37	06/06/2023	Limited	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	24/09/2024	389	30/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 2024 Update - The SLA template has been reviewed and feedback provided by Procurement team. Final checks and approval of the template for use are required.
Internal Audit/2023/37	06/06/2023	Limited	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	Commissioning Executive Director of Strategy & Transformation	01/09/2023	24/09/2024	389	30/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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/2023/37	06/06/2023	Limited	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	24/09/2024	389	30/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 2024 Update - Guidance documents are in development. A Head of Commissioning post is being recruited to, in order to provide capacity to facilitate oversight of all SLAs.
Internal Audit/2023/37	06/06/2023	Limited	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	24/09/2024	389	31/01/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. January 2024 Update - Review timeframes to be determined for agreements in 2024. All NHS services are monitored via regular contracting and commissioning meetings with providers.
Internal Audit/2023/57	03/04/2023	Limited	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	24/09/2024	420	30/04/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.
Internal Audit/2023/57	03/04/2023	Limited	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	24/09/2024	420	30/04/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report.
Internal Audit/2023/57	03/04/2023	Limited	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	24/09/2024	452	30/04/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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&B) under Medical Records. Discussions with Sandra McConnell and with Matthew Swarfield 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. 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.
Internal Audit/2023/57	03/04/2023	Limited	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	24/09/2024	513	30/04/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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 now 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.
Internal Audit/2023/73	08/08/2023	Reasonable	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	24/09/2024	360	31/12/2023	Low	Partially complete (Overdue)	September 2024 Update - 73% due to 4 new starters in the department who started in the last two weeks. Still issues with Med Staffing teams not sending out notifications to prompt first sign off. A tracker and schedule has been implemented. 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%. SB 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.

Inspection Code	Date of Inspection	Overall Assurance Rating	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/162	06/02/2024	Limited	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	24/09/2024	115	01/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Low	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	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	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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.	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	24/09/2024	85	01/03/2025	Medium	In progress	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. New proposed due date - 01/03/2025. 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	Reasonable	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 Citrix, Wireless, LAN and WAN) are reviewed for their resilience and recover ability.	Digital & Data Director of Digital	01/07/2024	24/09/2024	85	01/03/2025	Medium	In progress	September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024. New proposed due date - 01/03/2025. 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/2024/169	11/04/2024	Reasonable	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.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/09/2024	24/09/2024	23	01/09/2024	High	Overdue	September 2024 Update - This allocated to Heads of Nursing/Heads of Midwifery for ward areas and Heads of Pharmacy for Pharmacy locations. All pharmacies currently undertaking updating of signatory lists. Royal Glamorgan working on spreadsheet to ensure when sheets need updating. If workable will be rolled out further. Heads of Nursing and Heads of Pharmacy have been asked for an update of 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	Reasonable	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.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/09/2024	24/09/2024	23	01/09/2024	Medium	Overdue	September 2024 Update - Request put in to L&D for training to be added to ESR therefore creating an electronic record that ward/theatre managers can access. 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	Reasonable	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.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/06/2024	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - The YCR SOP supports the implementation of the incident guidance. YCR Pharmacy team have been asked to review whether this document is still required, and that as part of any update it needs to be consistent with HB guidance. 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	Reasonable	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.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/06/2024	24/09/2024	115	01/06/2024	High	Overdue	September 2024 Update - Pharmacies have started this review and now forms part of the quarterly CD review. 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	Reasonable	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 CDLIN 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 CDLIN highlight reports to allow analysis to take place.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/06/2024	24/09/2024	115	01/06/2024	Medium	Overdue	September 2024 Update - Datix team have provided three dashboards with pharmacy information. Discussions on going with team to hone the information required. 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	Overall Assurance Rating	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/169	11/04/2024	Reasonable	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.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/05/2024	24/09/2024	146	01/05/2024	High	Overdue	September 2024 Update - E-mail sent out to heads of nursing to bring this to the attention of the nursing teams in the safe to start meetings. Need confirmation from Heads of Nursing that this has been completed. 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	Reasonable	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.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/05/2024	24/09/2024	146	01/05/2024	High	Overdue	September 2024 Update - Update from Heads of Pharmacy awaited. 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	Reasonable	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	24/09/2024	146	01/05/2024	Medium	Overdue	September 2024 Update - Confirmation from Heads of Nursing that this has been completed awaited. 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	Reasonable	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 Medical Director	01/05/2024	24/09/2024	146	01/05/2024	Medium	Overdue	September 2024 Update - This is allocated to Heads of Nursing/Heads of Midwifery for ward areas and Heads of Pharmacy for Pharmacy locations. Heads of Nursing and Heads of Pharmacy have been asked for an update of 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	Reasonable	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.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01/05/2024	24/09/2024	146	01/05/2024	Medium	Overdue	September 2024 Update - E-mail sent to Heads of Nursing to disseminate this information in the safe to start meetings. Awaiting confirmation from Heads of Nursing that action is completed. 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	Reasonable	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 Medical Director	01/05/2024	24/09/2024	146	01/05/2024	Low	Overdue	September 2024 Update - process being reviewed, with meeting set for October with CDAO. 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	Limited	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 Colorectal 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 PCH, 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	24/09/2024	86	30/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-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	24/09/2024	86	30/06/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-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	24/09/2024	86	30/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-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	24/09/2024	147	30/04/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Limited	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-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	24/09/2024	85	31/07/2024	Medium	Partially complete (Overdue)	September 2024 Update - Updated ToR will be submitted to ESG in October for approval and Population Health and Partnerships Committee for ratification. 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/2024/187	06/06/2024	Reasonable	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-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	24/09/2024	55	31/07/2024	Medium	Partially complete (Overdue)	September 2024 Update - Inspire communication plan signed off and participants contacted w/c 16th September 2024. Final draft of the Leadership Competency Framework has been developed which sets out the objectives for all leadership development. 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/2024/188	11/06/2024	Reasonable	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - The September WRP Task & Finish Group for Inquest and Claims (to update Key Stage History Fields) was cancelled. We are awaiting a new meeting date to review Key Stage History Fields. Action will remain open until WRP Task & Finish Group updates the Health Board. July 2024 Update - Staff member identified to attend task and finish group.
Internal Audit/2024/188	11/06/2024	Reasonable	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-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 DCIQ system.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31/08/2024	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - Health Board's SOP will be finalised when we receive final update from the September WRP Task & Finish Group for Inquest and Claims (to update stage history fields) was cancelled. We are awaiting a new meeting date to review Key Stage History Fields. Action will remain open until WRP Task & Finish Group updates the Health Board. July 2024 Update - Awaiting SOP updates and update form WRP Task and Finish Group.
Internal Audit/2024/190	03/06/2024	Reasonable	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	24/09/2024	55	31/10/2024	Medium	Partially complete	September 2024 Update - The Assistant Director of Governance & Risk has developed a simplified service to board escalation process for risk which was shared with risk leads in care groups and central directorates on the 10th September for review and comment by the 24th September. If supported the process will be submitted to Operational Management Board for endorsement and then onto Executive Management Board for approval. Revised deadline requested of the 31st October 2024. 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	Reasonable	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 QSRE 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	24/09/2024	55	31/10/2024	Medium	Partially complete	September 2024 Update - The Assistant Director of Governance & Risk has set out an approach for the monitoring of risks at care group and central directorate level for risks scoring 12 and above. This new approach was shared with risk leads in care groups and central directorates on the 10th September for review and comment by the 24th September. If supported the process will be submitted to Operational Management Board for endorsement and then onto Executive Management Board for approval. Revised deadline requested of the 31st October 2024. 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	Reasonable	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 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	24/09/2024	55	31/08/2024	Medium	Overdue	September 2024 Update - The August QS&I meeting facilitated discussion with regards to the groups remit and discussion with regards to the potential changes to the format of the group in line with the maturing organisational meeting structures therefore, the Quality & Safety team Business meeting Terms of Reference were not included and have been deferred to the agenda for approval at the next meeting which is being held on 15th October 2024. 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	Reasonable	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	3.1b 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 quoracy 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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	24	31/08/2024	Low	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	24	31/08/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	55	31/07/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	55	31/07/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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	Reasonable	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	24/09/2024	55	31/07/2024	Low	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.

Inspection Code	Date of Inspection	Overall Assurance Rating	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Original Due Date	Reporting Date	Days Overdue	Current / Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/592	04/06/2024	Reasonable	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	24/09/2024	55	31/07/2024	Medium	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/592	04/06/2024	Reasonable	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	24/09/2024	86	30/06/2024	High	Overdue	September 2024 Update - An update against this recommendation has not been provided on this occasion. 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.

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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	September 2024 Update – This enhancement is marked as High Priority. Expected Q1 2025. 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 ANTICIPCATED TIMESCALE/IMPLEMENTATION DATE** July 2024 Update – Enhancement requested, awaiting approval and allocation to DevLog.
12. Full Inspection Action History	**COMPLETE**	AMaT System developers	September 2024 Update – COMPLETE. This enhancement has been implemented to include due date and area edited. 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 ANTICIPCATED 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 ANTICIPCATED TIMESCALE/IMPLEMENTATION DATE** July 2024 Update - Enhancement requested, awaiting approval and allocation to DevLog.

Code	Title	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022	**Planned Care** Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/136	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	**Primary Care and Community** Lucie Williams, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
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 (Maesteg Hospital) (Ref: 3189)]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	**Children & Families** Suzanne Hardacre, Director of Midwifery
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)]	**Children & Families** Suzanne Hardacre, Director of Midwifery

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)]	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2022/36	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
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)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
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 & 02 August 2023 (Ref: 3399)]	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	**Primary Care and Community** Lucie Williams, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/154	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	**Unscheduled Care** Emma James, Nurse Director
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)]	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director

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)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/159	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/160	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
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)	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/184	Appendix A - Ysbyty Cwm Rhondda Ward B2 (Ref: 03467)	**Primary Care and Community** Lucie Williams, Nurse Director
Healthcare Inspectorate Wales (HIW)/2024/185	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	**Diagnostics, Therapies, Pharmacies and Specialities** Sharon O'Brien
Healthcare Inspectorate Wales (HIW)/2024/197	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	**Primary Care and Community** Lucie Williams, Nurse Director

Healthcare Inspectorate Wales (HIW)/2024/198	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	**Primary Care and Community** Lucie Williams, Nurse Director

HIW Inspections 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 by the Committee. Once approved by the Committee actions will be closed on AMaT.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWIS, 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 eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement 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. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	01.03.2023	Overdue	August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme. E-referral software under national tender, CTM contributing to DHCW's national working groups to establish necessary minimum standards of ERS. Primary care optometry M365/NHS email rollout progressing (84% live across HB) which will support direct email referral into secondary care (until ERS in place). No recent local progression with EPR rollout beyond glaucoma clinics (no OpenEyes business project manager), await EPR programme updates from DHCW.
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, NWIS, 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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Overdue	August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme.
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 (phacoemulsification) 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 • OP17: Macular Hole Surgery	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Overdue	August 2024 Update - No update received this period.
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-specialty 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	01.04.2024	Overdue	August 2024 Update - No update received this period.
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	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - No update received this period.

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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	01.04.2024	Overdue	August 2024 Update - No update received this period.
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	01.04.2024	Overdue	August 2024 Update - Recruitment in progress for additional permanent non-medical staff to create additional capacity in glaucoma clinics (Band 3 tech, Band 4 tech, Band 8a Optometrist)
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	01.04.2024	Overdue	August 2024 Update - AMD referral refinement pathway working well, moving to direct optometrist inter-practice referral 2/9/24 (currently coordinated by hospital team). This will reduce admin burden and shorten turnaround time for patients.
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	01.04.2024	Overdue	August 2024 Update - No update received this period.
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	01.04.2024	Overdue	August 2024 Update - August 2024 Update - complete - CTM actively participating in regional CIN work to share/ratify JDs and SOPs where appropriate. Not marked as fully complete as need QSRE sign off.
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	01.04.2024	Overdue	August 2024 Update - No further update, complete. Not marked as fully complete as need QSRE sign off.
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 collab and directorate meeting.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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	01.04.2024	Overdue	August 2024 Update - CTM Optometry presented proposal to develop a Welsh Hospital Optometry forum, at CIN June '24 which was well supported. Initial planning meeting to develop national subgroup reporting to CIN 6/9/24. Heads of Service vacancies (Optometry/Orthoptics) still ongoing.
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 IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - Additional 8a optometrist for glaucoma services in recruitment.

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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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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/compliments)	Unscheduled Care	01.03.2021	01.03.2021	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. 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 establishment, current vacancies 2.37 wte RN and 2.22 HCSW, the Band 7 is 100% supernummary. 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.
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	01.03.2021	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. 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 IPCT. 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=84.6%% and 72% HCSW xxx%. ANTT RN= xxx% . 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	01.03.2021	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. 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	01.12.2020	Fully complete (Awaiting approval)	August 2024 Update - Action Complete. Strategic review of Infection, Prevention & Control (IP&C) undertaken resulting in an IP&C Strategy 2024-2026. Review outcome received at the Quality & Safety Committee in May 2024. IPC Strategy received at the May 2024 Quality and Safety Committee (QSC) and approved by Board in May 2024.
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	01.10.2020	Overdue	August 2024 Update - The Emergency Preparedness Resilience and Response Manager is following up with Operational colleagues on the development of the Emergency Pressures Escalation Procedure. Draft version is developed and confirmation of approval is being sought. Once confirmed this action will be marked as closed.
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	10.08.2021	10.07.2021	Partially complete (Overdue)	August 2024 - Ongoing monitoring via the MHLD Care Group in relation to compliance
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.06.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.

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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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.11.2024	Partially complete (Overdue)	August 2024 - MHLD has one outstanding action to be discussed at next QRSE in September 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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	31.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.

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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	31.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.03.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	01.12.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 night 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	30.11.2021	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	The heath 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	30.11.2021	Overdue	August 2024 Update - Remains overdue
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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 Senor Nurse to monitor compliance	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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 (Ability 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	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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	28.04.2023	Overdue	August 2024 Update - remains overdue
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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 QSRE meetings	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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	21.02.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

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Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (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 QSRE meetings standard agenda to maintain monitoring of the review	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE 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)]	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	01/09/2023 31/01/2025	Overdue	August 2024 Update - Business Case currently on hold as from early September, there will be a temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW) to allow for essential maintenance works on both units. This action will be revisited in January 2025.
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	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. This now forms part of the Annual Record Keeping Audit and Spot Checks by Senior Midwifery Team.
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	01.08.2022	Fully complete (Awaiting approval)	August 2024 Update - Complete. Stamps procured and audits routinely undertaken.
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	01.08.2022	Overdue	August 2024 Update - Update requested from the Medical Director in the Children and Family Care Group.
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	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete and new system in place.
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	01.10.2023	Overdue	August 2024 Update - KIT update to be taken to next Care Group Workforce meeting on the 28th August and the Local Partnership Forum.
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	01.10.2023	Overdue	August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.
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	30.04.2024	Fully complete (Awaiting approval)	August 2024 Update - BFI Compliant in Bridgend and working towards re-accreditation in 2025.
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	31.01.2024	01.02.2023	Fully complete (Awaiting approval)	August 2024 - Complete and now forms part of the record keeping audit.
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)]	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	31.01.2024	01.02.2023	Fully complete (Awaiting approval)	August 2024 - Complete - fully funded and recruiting to birthrate plus compliance and recommendations. Nurse Director met with Finance Team to review and agree set budgeted establishment in July 2024.
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: 3326)]	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	01.02.2023	Overdue	August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Department's, this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use.
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: 3326)]	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	01.12.2023	Overdue	August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Department's, this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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	28.04.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 (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	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 (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	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 will be communicated to all staff through Ward training boards, daily safety briefing etc.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 : Consultation with patients and carers Consultation with the multi-disciplinary team Benchmarking with other mental health services	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	The Safe Discharge Workstream will develop standardised discharge communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstreams 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework).	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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.	WARRN 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	Care and Treatment Planning	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	Information Governance Compliance for WARRN and CTP will be reported monthly and monitored through the Risk Steering Group. This will be monitored via Clinical Service Group performance meetings.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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.	This will also enable reporting of training compliance through monthly Integrated Performance meeting chaired by the Care group Service Director.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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.	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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream will develop standardised approaches for recording multi-disciplinary meetings across the Care Group.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstreams 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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstreams 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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 workstreams 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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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.	As part of recommendation 7 the Safe Discharge Workstream will develop standardised discharge recording and communication processes across the Care Group.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstreams 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 tile 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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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 Workstream. The workstream 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream. 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream. See response to recommendation 15	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream. 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 workstream and the Rehabilitation Programme.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream. 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 Llidiard whilst recognising that the wider care group has additional challenge in terms of scale and complexity."	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 Workstream 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

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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	30.06.2023	Overdue	August 2024 Update - this remains on going
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 WCCIS implementation for the Health Board. A CTMUHB WCCIS Workshop is scheduled for 15th June 23 led by MHLD Service Director. CTMUHB WCCIS Programme Board to start from 25th July 23 chaired by the Deputy Chief Operations Officer and Executive Director for Digital. A WCCIS Operational Group	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream. As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstream and Safe Discharge workstream 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstreams 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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstream , 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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 QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 Workstream will provide solutions for the monitoring of discharge follow up by community teams using different record systems.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 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 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 •Skill mix review •Exploration of Band 4 roles •Overseas recruitment •HCSW to registered nurse training pathways	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 issue s and the effectiveness of the approaches detailed through a monthly Nursing Staffing and Workforce meeting.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream. The PCH Crisis Assessment Space is now operational within PCH Emergency Department.	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	30.09.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 provide to HIW assessment 30 Sept 2023.	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstream and Safe Discharge workstream 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstreams 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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. Workstreams 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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%) Specialty 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:	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream.	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 workstream will review current facilities and scope out potential new areas and facilities. Whilst the workstream 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	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	Mental Health & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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.	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	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream. Please refer to the response to recommendation 8.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 workstreams a full training needs analysis will be completed to identify further opportunities for skills development.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 WARRN, 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 PADR to develop a training needs analysis.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	31.08.2023	31.05.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 Workstream. 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	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 Llidiard 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 form 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	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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 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	31.07.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	31.07.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 ToR at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	August 2024 Update - •21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •36 under review (17 have slipped completion dates from June/July to Sept/Oct/Nov 24) as below:
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 organisational 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	01.06.2024	Overdue	August 2024 Update - 21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •36 under review (17 have slipped completion dates from June/July to Sept/Oct/Nov 24) as below:
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 dually 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	Mental Health & Learning Disabilities	30.11.2024	30.11.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	31.10.2024	In progress	August 2024 Update - No update received 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 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 amd 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	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	01.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. June 2024 Update - Complete. AMaT audit In place for assurance completed by Senior Nurses.
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 - Current Training Compliance:- ED •Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. •An 8a 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	30.06.2024	Partially complete (Overdue)	August 2024 Update - CDU BLS - 94%, ILS 40%. ED BLS - 80% ALS 65% (CDU- Clinical Decisions Unit- (BLS) Basic Life support (ILS) Immediate Life Support (ED) Emergency Department (BLS) Basic Life support (ALS) Advanced Life Support.)
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	31.05.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
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	31.08.2023	Overdue	August 2024 Update - ongoing with Pharmacy lead and GP in HMP parc
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	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
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	30.09.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
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	31.10.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
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 workstream 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	30.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
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	31.08.2023	Overdue	August 2024 Update - Ongoing with Pharmacy lead and GP in HMP parc.
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. Childrens ward plan to implement same. See further information below. Digitalisation of equipment checks presentation	Children & Families	30.11.2023	30.11.2023	Fully complete (Awaiting approval)	August 2024 - Complete - QR Systems in place and working well.
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 AMaT system monthly and compliance monitored at the CYP monthly safety and effectiveness service level meetings.	Children & Families	31.10.2023	31.10.2023	Fully complete (Awaiting approval)	August 2024 - Complete - QR code daily resus checking is fully implemented on the childrens 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 Amat 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.
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	01.04.2024	Overdue	August 2024 Update - This work is ongoing and forms part of long term engagement and partnership working via the stroke programme board.
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. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - "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. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support."

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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.	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	01.04.2024	Overdue	August 2024 Update - "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."
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. These clearly outline triggers, escalations and actions. 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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed and Signed off by DoN for USC as achieved and ongoing. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
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 6goals 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	01.11.2023	Overdue	August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every other Q&S committee as part of the board update.
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	01.04.2024	Overdue	August 2024 Update - 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.
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	01.04.2024	Overdue	August 2024 Update - this action is not being progressed as - 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.
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	31.12.2024	In progress	August 2024 Update - we remain in collaboration with the NHS exec on this however as an organisation we do not yet have predicted demand modelling available to us which constrains our ability to progress this work.
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	01.04.2024	Overdue	August 2024 Update - 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.
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	01.04.2024	Overdue	August 2024 Update - a proposal has been shared with the board for extension of the CNS workforce with Senior nurse oversight. this requires resource allocation.
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	01.04.2024	Overdue	August 2024 Update - 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.
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	01.10.2024	In progress	August 2024 Update - this work remains a focus and is part of ongoing discussions as programme board - 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.
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	31.01.2025	In progress	August 2024 Update - collaborative work with WAST in relation to patient pathways is ongoing.
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	01.10.2024	In progress	August 2024 Update - this remain ongoing - 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.
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	01.10.2024	In progress	August 2024 Update - 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.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	01.01.2025	In progress	**August 2024 Update - Case submitted to Board in January 2024 and rejected - 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.**
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	01.01.2025	In progress	**August 2024 Update - case submitted to board in January 2024 - 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.**
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	**August 2024 Update - remains ongoing with digital team - 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.**
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	31.01.2025	In progress	**August 2024 Update - this remain a priority - 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.**
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	31.01.2025	In progress	**August 2024 Update - USC Care Group continue to work towards equity across our sites and this forms part of stroke programme board discussions.**
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.	Brainomix 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	01.01.2024	Fully complete (Awaiting approval)	**August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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	01.01.2024	Overdue	**August 2024 Update - this work is continuous - 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.**
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	31.10.2024	Fully complete (Awaiting approval)	**August 2024 Update - closed - updated guidance in wide use, Closure agreed by USC DoN.**
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	01.10.2024	Fully complete (Awaiting approval)	**August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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	01.10.2024	In progress	**August 2024 Update - USC Care Group continue to explore regional solutions however this remains multifaceted and complex - 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.**
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	01.04.2024	Fully complete (Awaiting approval)	**August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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	01.04.2024	Fully complete (Awaiting approval)	**August 2024 Update - closed - USC DoN advised closure as this is always documented.**
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 in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	**August 2024 Update - this work is ongoing as was a focus as part of the recent 'reset fortnight' - 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 in continuously monitored and re/evaluated as required.**
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	01.04.2024	Overdue	**August 2024 Update - this continues to be a priority - 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.**
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	01.12.2023	Fully complete (Awaiting approval)	**August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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	01.01.2024	Overdue	**August 2024 Update - 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.**
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	01.04.2024	Overdue	**August 2024 Update - this remains ongoing - 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.**

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	01.04.2024	Overdue	**August 2024 Update - this remains ongoing - 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.**
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	01.04.2024	Overdue	**August 2024 Update - we continue to review this as a risk -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.**
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	01.11.2024	Fully complete (Awaiting approval)	**August 2024 Update - this can be closed - "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."**
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	01.11.2024	Fully complete (Awaiting approval)	**August 2024 Update - this can be closed - 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.**
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	01.03.2024	Fully complete (Awaiting approval)	**August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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	01.12.2023	Fully complete (Awaiting approval)	**August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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 MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	**August 2024 Update - significant work ongoing under the optimise project to address MCA challenges with supported intervention from Head of nursing ot maintain training and standards on their sites.**
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 AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Overdue	**August 2024 Update - this is ongoing - 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 AMaT purposes).**
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	01.04.2024	Overdue	**August 2024 Update - this is ongoing but being prioritised - "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."**
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 POW 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	01.01.2024	Overdue	**August 2024 Update - this remains ongoing and requires capital funds - 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 POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.**
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 POW 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	01.01.2024	Overdue	**August 2024 Update -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 POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.**
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	01.10.2024	In progress	**August 2024 Update - this work is ongoing with digital colleagues - 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.**
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	01.04.2024	Fully complete (Awaiting approval)	**August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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	01.04.2024	Fully complete (Awaiting approval)	**August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**
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	01.04.2024	Fully complete (Awaiting approval)	**August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.**

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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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
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 Cwm 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	31.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - Process established.
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	31.08.2024	Overdue	August 2024 Update - refurbishment of area now complete. Awaiting display boards and once in situ this action will be completed.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 Angelton Clinic. This will be carried out in the Spring where plants and bulbs will be planted. The Angelton 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	01.04.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Angelton 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	28.12.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	01.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 Angelton 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 Highlight report and update at the Health and Safety Meeting.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 Angelton clinic to identify and address any additional maintenance issues.	A full environmental audit within Angelton Clinic will be completed to address and identify any further additional maintenance issues.	Mental Health & Learning Disabilities	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 Angelton Clinic. Audit completed on AMAT, current compliance 85.3%	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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. Any issues identified to be brought to Ward Managers attention for dissemination to ward staff.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 HB compliance standard is 85% but both wards will aim for 100% compliance.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

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Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 Angelton Clinic has been put in place by the catering Lead to meet the nutritional standards and offer a variety of food for Angelton Patients.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 recommenced 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 QSRE report.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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	10.07.2024	Overdue	August 2024 Update - The HoN is working with the Business Intelligence Manager in the Patient Care and Safety team on the development of a Quality Dashboard, the mapping of the new Care Group structure is complete and we are awaiting implementation.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton 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 reoccurrence.	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.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

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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.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	Mental Health & Learning Disabilities	28.02.2024	28.02.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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	30.06.2024	Overdue	August 2024 - MHLD to update in readiness for next report.
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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 COSSH 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	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

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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.	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. 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	30.04.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 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.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	01.06.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting 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	31.03.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting 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 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 Workstream 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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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.	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 report on compliance at Adult Mental Health Integrated performance meeting in April 2024.	Mental Health & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in 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 the ECA suite is not used as a bedroom area and should only be used for its intended purpose.	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.	Mental Health & Learning Disabilities	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting 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 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 Llidiard 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.	Mental Health & Learning Disabilities	28.02.2024	28.02.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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	01.02.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	01.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	01.02.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	01.03.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	30.09.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	01.12.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	01.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 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	01.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 audit, update and share guidelines and policies related maternity care.	Staff updated via email and staff social media Comms to ensure awareness of extension of these guidelines.	Children & Families	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now 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 audit, update and share guidelines and policies related maternity care.	There is a maternity/ gynaecology/ISH guideline group which monitors guidelines which are coming out of date.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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.	Each young person has an individualised care plan in line with their recovery care outcomes and inclusive of their holistic care needs. 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.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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 Facilities dept have a schedule for garden maintenance works, additionally the local management team carry out monthly environmental checks and request additional garden maintenance as required. The Ty Llidiard 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.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	01.05.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	01.05.2024	Fully complete (Awaiting approval)	August 2024 Update - approved for closure by the QSRE in August.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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 form 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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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 Llidiard 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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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 Ty Llidiard dietician 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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	01.05.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	While it may be the case that 12-hour shifts may not be appropriate for Tŷ Llidiard, 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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (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	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	30.04.2024	Fully complete (Awaiting approval)	August 2024 Update - this can be closed. GPAU corridor has now closed, SDEC is open and patients are flowing via this area and reducing the pressure on the ambulatory care area.
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed SOP and huddles in place.
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 2021) 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed - GPAU now closed and SDEC open to support ambulatory flows.
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	31.12.2024	In progress	August 2024 Update - capital work ongoing - 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.
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	01.04.2024	Overdue	August 2024 Update - work 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 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	01.09.2023	Overdue	August 2024 Update - part of ongoing capital plans - 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.
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	Unscheduled Care	01.12.2023	01.12.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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.	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 "RED2GREEN" in June 2023, with further training planned-whereby preventing deconditioning. -PJ 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised this action can be closed - updated signage in place.
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 E White 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	Unscheduled Care	01.03.2024	01.03.2024	Overdue	August 2024 Update - this work is ongoing - 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 7Active	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 Illustrations to ensure consent-and supports grading of pressure damage. This can be accessed in and out of hours. The	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 6 weekly via the Unscheduled Care Workforce Meetings-trends are	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 Datix is generated.	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update -USC DoN advised this can be closed - as of April - 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.04.2024	Overdue	August 2024 Update - 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. ED MCA now 77% and fire 85%
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	01.04.2024	Overdue	August 2024 Update - 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. CDU fire is 100%
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 'TEDtalk' 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-	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 AMaT 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 QSRE meeting and	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 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.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - monitored carefully though daily acuity. Rotation of specialist staff providing extra shifts. Started using Bank Agency. 17 new midwives starting in September 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 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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - restricted access achieved immediately in response to recommendation.
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 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.	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	01.02.2024	Fully complete (Awaiting approval)	August 2024 - Complete - No international midwifes to recruit to at this stage.
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 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	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - flexible working arrangements reviewed and completed to ensure fairness and that the needs of the service are met.
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 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.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - Care Group are working closely with the Care Group People Business Partners to ensure staff are supported through the attendance at work policy.
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 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.	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	01.02.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - work will continue in relation to embedding the new principles of safe care through workforce meetings. Plans are established to evaluate and this action is now embedded as business as usual practice.
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 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	01.02.2024	Partially complete (Overdue)	August 2024 Update - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW)
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 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.	h)The Service is moving from the Birthrate + 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	01.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - "Safe Care" acuity system implemented.
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 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	31.01.2024	Partially complete (Overdue)	August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.
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 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.	j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.
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 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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. There is a rolling advert that is used should any vacancies arise. Proactive approach to advertise as soon as additional midwives are needed.
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 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.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and considered in conjunction with birthrate plus and the needs of the service for the future.
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 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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete. System and process in place and working well.
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 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	13.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.
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 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.	o)Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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	30.01.2024	Fully complete (Awaiting approval)	August 2024 Update -Complete - dashboard developed and captures identified metrics.
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 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.	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	12.01.2024	Partially complete (Overdue)	August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.
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 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	31.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and ward manager now based on ward 21 so regular huddles held during the day to ensure acuity and workforce needs align.
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 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.	s)Temporary cease midwifery rotation to other areas.	Children & Families	13.01.2024	13.01.2024	Fully complete (Awaiting approval)	August 2024 - completed and held until staffing situation improved.
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 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	31.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - 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)	Midwifery staffing levels on night shift 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	11.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - CTMUHB are represented at the Perinatal Steering Group.
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 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.	v)Review night time rosters to determine whether any cultural concerns which may impact attendance at work.	Children & Families	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - monitored via Head of Midwifery, Wellbeing support and workforce colleagues. Also captured via Datix. No further concerns identified.
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 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.	w)Bank & Overtime Hours offered to midwives.	Children & Families	17.01.2024	17.01.2024	Fully complete (Awaiting approval)	August 2024 -Complete. Bank and overtime hours offered to staff.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Control of Substances Hazardous to Health (COSHH) 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.	a)Locks to be replaced an all COSHH cupboards – Estates colleagues contacted during the Inspection. Locks changed on 4 cupboards.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Closed as completed and locks 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)	Control of Substances Hazardous to Health (COSHH) 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	19.01.2024	Fully complete (Awaiting approval)	August 2024 - Closed as completed and locks 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)	Control of Substances Hazardous to Health (COSHH) 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.	c)Domestic Supervisors have shared a safety briefing with her team, to ensure they are aware of the requirement.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Completed and 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)	Control of Substances Hazardous to Health (COSHH) 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 though monitoring through the AMaT ward audit schedule.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Completed and in place.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Visiting times 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	04.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - reviewed visiting times and extended visiting hours for partners.
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. Mythbusting – 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	01.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete -all mechanisms in place to monitor. This activity will be 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	01.05.2024	Overdue	August 2024 Update - In response to a recent positive inspection audit there are a few actions underway. Accreditation being sought in the next couple of months.
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	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. Will continue to be monitored through supervision and audited through NICE Safe Midwifery Staffing standards as a red maternity flag if there is a delayed medication.
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - reviewed and action considered to be complete.
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	01.07.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - Annual Prem Report presented. No actions outstanding.
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)	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	01.07.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete and the Care Group are continuing to work to achieve cultural competence. Training with diverse cymru. Led by Consultant Midwife for Population Health. Developed a transgender guideline. Training compliance will continue to be monitored.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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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)	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed as an immediate action.
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	01.05.2024	Fully complete (Awaiting approval)	August 2024 Update - Supervisors just completed annual records keeping assessment and outcomes and any learning shared.
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	16.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - reviewed and action considered to be complete.
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	15.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - reviewed and action considered to be complete.
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	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - flexible working arrangements reviewed and completed to ensure fairness and that the needs of the service are met.
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - Care Group are working closely with the Care Group People Business Partners to ensure staff are supported through the attendance at work policy.
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - work will continue in relation to embedding the new principles of safe care through workforce meetings. Plans are established to evaluate and this action is now embedded as business as usual practice.
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	01.03.2024	Overdue	August 2024 Update - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW)
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 Service is moving from the Birthrate + 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	01.03.2024	Fully complete (Awaiting approval)	August 2024 Update - August 2024 Update - Complete - "Safe Care" acuity system implemented.
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	31.01.2024	Overdue	August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.
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 Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Overdue	August 2024 Update - August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. There is a rolling advert that is used should any vacancies arise. Proactive approach to advertise as soon as additional midwives are needed.
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and considered in conjunction with birthrate plus and the needs of the service for the future.
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	22.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete. System and process in place and working well.
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	13.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.
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	12.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.
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	30.01.2024	Fully complete (Awaiting approval)	August 2024 Update -Complete - dashboard developed and captures identified metrics.
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	12.01.2024	Partially complete (Overdue)	August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and ward manager now based on ward 21 so regular huddles held during the day to ensure acuity and workforce needs align.
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	31.01.2024	Fully complete (Awaiting approval)	August 2024 - completed and held until staffing situation improved.
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	31.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - Monitoring in Place at ward and directorate level and reported via WESSEE and SWAG forums
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	11.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - CTMUHB are represented at the Perinatal Steering Group.
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	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - monitored via Head of Midwifery, Wellbeing support and workforce colleagues. Also captured via Datix. No further concerns identified.
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	17.01.2024	Fully complete (Awaiting approval)	August 2024 -Complete. Bank and overtime hours offered to staff.
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	01.03.2024	Overdue	August 2024 - Complete - monitored carefully though daily acuity. Rotation of specialist staff providing extra shifts. Started using Bank Agency. 17 new midwives starting in September 2024.
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	01.03.2024	Overdue	August 2024 Update - Update requested from Children and Family Care Group.
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 SMDT. 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	Children & Families	01.04.2024	01.04.2024	Overdue	August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete.
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	30.06.2024	Overdue	August 2024 Update - installation date agreed for 27th August.
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	30.06.2024	Partially complete (Overdue)	August 2024 Update - partially completed. ongoing monitoring of actions implemented 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	26.04.2024	Fully complete (Awaiting approval)	August 2024 Update - completed and all staff have personal safety alarms for use. Updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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. Update EP1 and IRPP	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP1 and IRPP have been updated 1.7.2024. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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) have been reviewed with any terminology changes made during this process	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as delegated authorisation guidelines (DAGs) have been reviewed with any terminology changes made during this process: Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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. Training forms removed EP2 updated and NM03 removed	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. Complete. DTPS Care Group confirmed that this action has been completed training forms removed EP2 updated and NM03 removed Complete 4/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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 has been updated to reflect that the use of the Medical Appraisal Revalidation System (MARS) is used for the training records of practitioners. Update EP2	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. Complete. DTPS Care Group confirmed that this action has been completed as references to MARS added to EP2 Complete 25.6.24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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. EP6 updated	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. Complete. DTPS Care Group confirmed that this action has been completed as EP6 updated Complete 5/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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 proceduresNM34 updated to reflect paediatric age of 18 or below	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as NM34 updated to reflect paediatric age of 18 or below Complete 2/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024/	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. New updated NM QA introduced.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as New updated NM QA introduced Complete 2/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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.Email sent to all staff reminding them of the process if insufficient information is on the request form.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as email sent to all staff reminding them of the process if insufficient information is on the form Complete 5/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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 b	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as: Remove NM64 and only have updated EP24: Remove NM12 and only have updated EP18: Remove NM24 and only have updated EP22: Remove NM30 and only have updated EP10: EP23 updated: EP7 updated Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the lists of local and national DRL's are combined into a single list with the DRL's used for each procedure for display in the injection room.	A single List of Diagnostic Reference Levels (DRLs) has now been placed in the injection room	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update -Complete. DTPS Care Group confirmed that this action has been completed as a single List of Diagnostic Reference Levels (DRLs) has now been placed in the injection room Complete 15/5/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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 have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as entitlement records have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks. Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that: 1. Entitlement documentation is completed in full, with appropriate information on entitlement. 2. Training records of the staff should be updated to ensure that staff competencies were assessed by an appropriate individual who has been delegated the task by the employer.	Entitlement records have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks. This will remove the additional 'date of entitlement'. Training records have been updated to ensure correct authorisation of training.	Diagnostics, Therapies, Pharmacies and Specialities	30/9/24	30/9/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as entitlement records have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks. This will remove the additional 'date of entitlement'. Training records have been updated to ensure correct authorisation of training. Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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.	Letters sent out from Clinical Director to all Clinical Directors in Health board (inc. GP's and Dentists)	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as Letters sent out from Clinical Director to all Clinical Directors in Health board (inc. GP's and Dentists) Complete 27/6/24.Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that: 1. Employers procedures includes instructions on how to evidence patient identification checks have been made where there are multiple exposures or operators involved.2. Completion of referral forms are clear where there are multiple operators and contact points	Employers procedure have been updated to cover this situation. EP7 updated	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP7 Updated Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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	EP8 has been updated to ensure we are working safely. A further review of pregnancy checking and recording of responses and providing risk information is going to be completed across the Health Board.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP8 has been updated to ensure we are working safely. A further review of pregnancy checking and recording of responses and providing risk information is going to be completed across the Health Board. Complete 24/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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 have been updated with any duplication addressed. EP18 amended, NM12 withdrawn.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP18 amended with medical physics comments. NM12 withdrawn. Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that audit reports are updated to include evidence of how practice was changed, actions required, who was responsible for actions and how the completion of actions was verified is always included.	Audit documentation has been updated to include evidence of how practice was changed, along with action taken. The action owner is responsible for sharing the audit outcome via email, CPD workshops and feedback sessions.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as Audit documentation has been updated to include evidence of how practice was changed, along with action taken. The action owner is responsible for sharing the audit outcome via email, CPD workshops and feedback sessions. Complete 15/5/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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 has been updated to address this. EP22 updated NM24 removed	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP22 updated NM24 removed Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	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: 1. Delete references which were not relevant to the procedure.2. Update the definition of a significant accidental or unintendendexposure to reference the guidance supported by HIW. 3. Refer to the notification criteria required by HIW.	Employers procedure has been updated to address this issue. EP23 updated	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP23 updated Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer should consider the comments of staff and inform HIW of the actions they will take to resolve these.	We have informed all staff that there is an open door policy. If anyone needs to discuss any concerns they are aware of who they can come to. We used the following methods to address this : Section heads meeting; All staff meeting; Email from Radiology Services Manager to all staff. The department aims to support staff and takes all concerns seriously.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as they have informed all staff that there is an open door policy. If anyone needs to discuss any concerns they are aware of who they can come to. DTPS Care Group used the following methods to address this : Section heads meeting; All staff meeting; Email from Radiology Services Manager to all staff. The department aims to support staff and takes all concerns seriously. Complete 15/5/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the individual signing the form as referrer is acknowledged as the referrer	The current Employers procedures (EP) are clear regarding who the Referrer is under the Regulations. All forms (paper and electronic) identify the Referrer for the examination and also the Senior Responsible Clinician who will receive the reports following completion of the examination	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as the current Employers procedures (EP) are clear regarding who the Referrer is under the Regulations. All forms (paper and electronic) identify the Referrer for the examination and also the Senior Responsible Clinician who will receive the reports following completion of the examination. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.

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Agenda Item
5.4

Audit & Risk Committee

CONSULTANT JOB PLANNING

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Miss Nicola Evans, Interim Assistant Director of Strategic Workforce Planning Mr Nicholas Price, Senior Medical Workforce Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dr. Dom Hurford Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
ADH	Additional duty hours
AMD	Assistant Medical Director

CTM	Cwm Taf Morgannwg
DCC	Direct Clinical Care
FG	Framework Group
LNC	Local Negotiating Committee
MWPP	Medical Workforce Productivity Programme
SPA	Supporting Professional Activities
PEG	Performance and Escalation Group
UHB	University Health Board

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1. Situation /Background

The purpose of this paper is to provide the Audit & Risk Committee with an update on the progress around job planning.

2. Specific Matters for Consideration

2.1 Job plan completion and sign-off

- Job planning is a contractual requirement for consultants and SAS Doctors.
- The current and correct state of job planning is as follows: 128 (27%) of Consultant and 48 (24%) of SAS job plans have been signed off in the last 12 months.
- Of great concern, it must be noted that 160 medics do not have a signed off job plan from any date in the past.
- Figures per Care Group are shown in the table below

Row Labels	In discussion - Never Signed Off	Signed - In Date	Grand Total	% Signed Off
Consultant	**104**	**128**	**481**	27%
Children and Families Care Group	7	49	71	69%
Diagnositc, Therapies, Pharmacy and Sciences Care Group	8	12	49	24%
Mental Health and Learning Disabilities Care Group	3	5	32	16%
Planned Care	49	46	209	22%
Primary and Community Care Group	4	1	9	11%
Unscheduled Care	33	15	111	14%
SAS Doctor	**56**	**48**	**199**	24%
Children and Families Care Group	3	23	35	66%
Diagnositc, Therapies, Pharmacy and Sciences Care Group	2		3	0%
Mental Health and Learning Disabilities Care Group	7	4	15	27%
Planned Care	33	17	95	18%
Primary and Community Care Group	2		14	0%
Unscheduled Care	9	4	37	11%
Grand Total	**160**	**176**	**680**	**26%**

- The 60% target set for 1st August 2024 was not reached.
- It is unlikely the target of 85% by 30th November will be reached.
- The Care Group Medical Directors have a responsibility to ensure that the job planning process is being completed appropriately within their Care Group. The Care Groups have appointed new Clinical Directors and Directorate Managers who are instrumental in ensuring that job planning is completed.
- The SPA guidance for Consultants is currently being revised.
- SPA guidance is being developed for SAS Doctors.
- The UHB job planning guidance has been updated and agreed with the LNC.
- The Chief Operating Officer is given on a monthly basis a table of all consultants and SAS doctors, showing the status of each job plan. The Care Groups will be asked to complete this, giving a schedule of when job plans will be undertaken. This is overseen by PEG to achieve the 85% target.

2.2 Weekly number of sessions, activities and outcomes

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

2.3 Clear personal outcomes within the job plan

- As part of the job planning training, it is stated that clear personal outcomes should be factored into the process and be recorded in new job plans. The job plans should have clear outcomes regarding the site where the activity is to be undertaken, the type and duration of activity, and clarity around whether the activity constitutes a DCC or a SPA.
- However, further work is needed to quantify the specific amount of the clinical activity that is expected from the specified duration of the DCC.
- The new SPA document deals with ways of seeking objective evidence of the activity undertaken as an SPA.

2.4 Medical Workforce Productivity Programme: Performance and Escalation Group and Framework Group

- The work of the Job Planning Quality Assurance Group has been incorporated into the MWPP.
- PEG and FG feed into the MWPP Board, which in turn reports to the V&E Portfolio Board which further reports into the ELG/Transformation Board.
- PEG will exclusively focus on the following areas: ADH/Agency Spend/Rate Card, Job Planning, Establishment, including Recruitment and Retention. For Job Planning, PEG aims to review, assess and challenge on plans to manage:
    - job plan compliance across specialties and health board;
    - ensure all substantive doctors have an up to date job plan;

- establishing a standard approach and consistent application of job planning guidelines and policy for all specialties and individuals within and across Care groups.

- The aims of the FG are to develop and deliver a standardised and consistent approach to our medical and dental workforce arrangements across CTM UHB, which will create the right conditions for them to thrive. Building a more sustainable, affordable, appropriately skilled, flexible and motivated workforce to meet the changing health and wellbeing needs of our population The main areas of focus is job planning standardisation

2.5 Additional Duty Hours (ADH)

- Executive colleagues agreed a consultant rate card which went live on 18th June 2024.
- The Non-Consultant Rate Card had already been launched on 19th October 2023.
- PEG oversees expenditure and works with Care Groups to develop robust plans to reduce rates of ADH Spend and Agency Spend.
- Monitoring against the control process once the rates of pay are implemented.
- The Financial Control Procedure for Medical Variable Pay outlines the control processes around agency and ADH spend. It has been revised and submitted to Audit & Risk Committee in October 2024.

3. Key Risks / Matters for Escalation

3.1 None.

4. Assessment

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

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	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: Correct and current job plans allows for better planning around staff levels and DCC sessions. This has a direct impact on quality, safety and experience.	If no, please include rationale below:
Cydraddoldeb 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): POSITIVE/NEUTRAL NEGATIVE	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	Yes (Include further detail below)	
	Recruitment and retention perspective, good job planning is key	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Good job planning leads to better use of resources	

5. Recommendation

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

6. Next Steps

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

6.2 Discuss revision of SPA guidance with LNC.

6.3 Continuous monitoring by PEG.

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Agenda Item
5.5

Audit & Risk Committee

Medical Rostering Progress Report

Dyddiad y Cyfarfod / Date of Meeting	17/10/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Andrew Stocken, Medical & Dental E-Systems Manager; Nicholas Price, Senior HR Manager - Medical Workforce, Medical Personnel and Esther Flavell, Assistant Medical Director
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AMD	Assistant Medical Director
BMA	British Medical Association
ED	Emergency Department
MD	Medical Director

MWSG	Medical Workforce Sustainability Group
LNC	Local Negotiating Committee

1. Situation /Background

1.1 The purpose of this paper is to give the committee an update on the progress achieved in relation to the audit report on Medical Rostering.

2. Specific Matters for Consideration

2.1 **Recommendation 3.1**
Responsible person: AMD for Workforce
"The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff."

Update – In progress
The policy was updated and submitted back to the LNC. Full comments have not yet been received.

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

Update – In progress
A comparison of the old CT and ABMU Study and Professional Leave policies has been given to the Medical Director to share with the LNC.

3. Key Risks / Matters for Escalation

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

4. Assessment

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

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb 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): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not a policy
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

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

6. Next Steps

6.1 Both policies will be discussed at the LNC Meeting in December 2024.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

October 2024

NWSSP Audit and Assurance Services

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

Contents

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3 Delivering the Plan 3

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6 Other activity 4

Appendix A – Tables showing detailed progress against audit plans

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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 09 October 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 August meeting of the Committee six reports have been finalised, one report is in draft, and we have ongoing fieldwork in relation to eleven reviews, which includes one review for the Joint Commissioning Committee (JCC). A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
Follow up – Patient pathway appointment management (Included in 2023/24 annual report)	2	1	-	3	Limited
Follow up – Medical variable pay (Included in 2023/24 annual report)	1	1	-	2	Reasonable
Follow up – Reasonable offer (Included in 2023/24 annual report)	-	2	2	4	Reasonable
Embedding the quality framework	1	3	1	5	Reasonable
Information provision – Intelligence led organisation	-	6	-	6	Reasonable
Follow up – Facilities governance arrangements	-	1	1	2	Substantial

3 Delivering the Plan

3.1 Our work in 2024/25 is ongoing. The detail of our work is included in appendix A to this report.

4 Performance reporting

4.1 We monitor aspects of the Internal Audit service and report this information in our annual report. Our agreed performance indicators, as at the time of this progress report, are set out in table 2 below:

Table 2 – Performance Indicators 2024/25

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100% (3/3)	95%	v>20%	10%<v ≤20%	v≤10 %
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Amber	67% (2/3)	80%	v>20%	10%<v ≤20%	v≤10 %
Report turnaround: time from management response to issue of final report [10 days]	Green	100% (3/3)	95%	v>20%	10%<v ≤20%	v≤10 %

5 Feedback

5.1 A post audit questionnaire is issued to the key health board staff that we have worked with have 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. However, this year to date, we have received two completed feedbacks relating to the finalised reports for 2024/25.

6 Other activity

Joint Commissioning Committee (JCC)

6.1 We have agreed a programme of work for 2024/25 with officers of the JCC (Appendix A – Table 3). We have started the fieldwork for our first review relating to the JCC's Mental Health directorate.

Meetings

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

6.3 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.

New Global Internal Audit Standards

6.4 In January 2025 new Global Internal Audit Standards (GIAS) will become effective. The body that sets Internal Audit Standards for UK Public Sector Organisations, the UK Public Sector Internal Audit Standards Advisory Board (the IASAB), has

determined that the new Standards will apply to Public Sector audits from 1 April 2025 to align with the financial year. As the new Standards have been developed to apply to all sectors, the IASAB will be producing a practice note setting out any sector specific interpretations or other material needed to make them suitable for UK public sector use.

6.5 The new GIAS requirements seek to elevate internal audit practice in five domains that cover the profession's purpose, ethics and professionalism, governance, management and performance.

6.6 We are currently undertaking preparatory work to understand the impact of the new GIAS on our work, and to ensure that we can appropriately apply these standards from 1 April 2025.

6.7 At this point we do not anticipate that there will be many changes needed to our audit approach. However, one potential change is around how we monitor and evidence the implementation of agreed management actions.

6.8 We will update the Committee at the next meeting if we identify that any other changes are needed to our approach.

Appendix A – Programme of work

Table 3: 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. Some feedback on low priority recs received, but not everything.
-	Follow up – Patient pathway appointment management	Limited	Final	Draft report issued 09.05.24. Management responses received 25.09.24
23	Follow up – Medical variable pay	Reasonable	Final	Draft report issued 24.05.24 Management responses received 13.09.24.
25	Follow up – Reasonable offer	Reasonable	Final	Draft report issued 17.06.24. Management responses received 25.09.24

Table 4: 2024/25 Core programme of work for Q1-Q3

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~~ Oct	Final	Y	N	Draft report issued 30.07.24. Debriefed 02.08.24. Management responses received 13.09.24.
T07	Information provision – Intelligence led organisation	Reasonable	Q1	Oct	Final	Y	Y	-
T27	Follow up – Facilities governance arrangements	Substantial	Q1	Oct	Final	Y	Y	-
T10	Duty of candour	-	Q1	~~Oct~~ Dec	Drafting	-	-	Fieldwork completed – Audit file and report being reviewed.
T19	Energy management	-	Q2	~~Oct~~ Dec	Drafting	-	-	Fieldwork complete. Debrief 11.10.24. Draft report being reviewed.
T16	Additional medical pay	-	Q1	~~Oct~~ Dec	WIP	-	-	Fieldwork concluding.
-	PCH – Supply chain partner management –	-	-	~~Oct~~ Dec	WIP	-	-	Waiting for information to complete. Understand

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
	Brought forward from 2023/24							management annual leave.
T18	Capital systems	-	Q2	~~Oct~~ Dec	WIP	-	-	Fieldwork started 10.07.24. Paused while waiting information.
T31	Follow up – Financial savings	-	Q1	~~Oct~~ Dec	WIP	-	-	Fieldwork started 28.06.24. Delayed due to annual leave on both sides. (Capacity)
T20	Charitable funds	-	Q2	~~Oct~~ Dec	WIP	-	-	Fieldwork started 29.07.24. Nearing completion but delay in information supply.
T22	Vaccination policy implementation	-	Q2	~~Oct~~ Dec	WIP	-	-	Engagement delays. Initial meeting now 14.10.24.
T17	Medical job planning	-	Q2	~~Oct~~ Dec	WIP	-	-	Fieldwork started 20.09.24.
T23	Regional integration fund	-	~~Q2~~ Q3	~~Oct~~ Dec	WIP	-	-	Fieldwork started 07.10.24.
T28	Follow up – Performance	-	Q2	~~Oct~~ Dec	Planned	-	-	Brief agreed. To start in October.

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
	management – 4-hour target							
T29	Follow up - INNU	-	Q2	~~Oct~~ Dec	Planned	-	-	Brief agreed. Initial meeting 14.08.24. Has been pushed back due to all Wales working group – To meet CTM again 22.10.24 for update
T33	Follow up – SLA arrangements	-	Q2	~~Oct~~ Dec	Planned	-	-	Brief agreed. Management request to delay start until Autumn due to new staff members. Initial meeting 15.10.24.
T15	New PDR process	-	Q1	~~Oct~~ Dec	Planned	-	-	Brief agreed 03.10.24. Work to start late October.
T01	New care group model	-	Q2	~~Dec~~ Feb	Planning	-	-	Initial discussion planned for September. CTM cancelled meeting, rescheduled to early October, now early November.
T02	Cancer tracking process	-	Q3	Feb	Planning	-	-	Scoping meeting 15.10.24

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T03	Elective care criteria	-	Q3	Feb	Planning	-	-	Initial discussion planned for September. CTM cancelled meeting, rescheduled to early October, now early November.
T04	End of life care management	-	Q3	Feb	Planning	-	-	Initial discussion planned for September. CTM cancelled meeting, rescheduled to early October, now early November.
T09	Clinical coding	-	Q3	Feb	-	-	-	-
T09	Continuing Health Care	-	Q3	Feb	-	-	-	-
T12	Ensuring quality when commissioning care services	-	Q3	Feb	-	-	-	-
T21	Core financial systems	-	Q3	Feb	-	-	-	Scoping meeting on 11.10.24
T24	Stroke	-	Q3	Feb	-	-	-	-

Table 5: Plan for Joint Commissioning Committee (JCC) 2024/25

Ref.	Review	Rating	Status	Notes
1	Mental Health quality assurance process	-	WIP	-
2	Financial systems	-	Planning	Scoping meeting 19.11.24
3	Governance systems	-	Planning	Scoping meeting 11.10.24

Follow-up: Medical Variable Pay – Agency Costs

Final Internal Audit Report

September 2024

Cwm Taf Morgannwg University Health Board

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

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

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Review reference:	CTMUHB-2324-23
Report status:	Final
Fieldwork commencement:	07 March 2024
Fieldwork completion:	21 May 2024
Draft report issued:	24 May 2024
Management response received:	13 September 2024
Final report issued:	16 September 2024
Auditors:	Warren Alexander, Principal Auditor Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Dom Hurford, Executive Medical Director
Distribution:	Nerys Conway, Assistant Medical Director Workforce Nicholas Price, Senior HR Manager – Medical Workforce
Committee:	Audit and Risk Committee

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

Acknowledgement

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

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Executive Summary

Purpose

Our review followed up on the recommendations made in our previous Medical Variable Pay – agency spend report. We sought to evaluate and determine the adequacy of the systems and controls that have been put in place to address those recommendations.

Overview of findings

We identified six matters arising in our original review, which included five high priority recommendations, and three medium priority recommendations.

From our analysis of data, review of documentation and meetings with staff, we have confirmed that seven recommendations have been implemented or partially implemented. The areas that require additional work are:

- The review and updating of the medical variable pay financial control procedure and the medical agency locums standard operating procedure.
- Ensuring the Retinue system captures authorisation information when higher rates of pay are agreed, and that information is accessible to the Health Board for monitoring purposes.

Follow-up Report Classification

		Trend
Reasonable	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Progress Summary[1]

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Design and use of policies and procedures	High		High
2	Use of directly engaged locums	Medium		Closed[2]
3	Authorisation of higher value payments	High		Medium
4	Authorisation for longer-term cover	High		Closed[2]
5	Monitoring medical agency spend	Medium		Closed[2]
6	Formal approval of the use of agency staff	High		Closed[2]

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.
[2] While these items are closed, the FCP needs to be updated to reflect these changes.

1. Introduction

1.1 Our follow-up review of the Medical Variable Pay – Agency Costs recommendations was completed in line with the 2023/24 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original audit was undertaken in late 2022 and the report was finalised in February 2023. We issued a 'limited' assurance opinion and raised six high or medium priority matters arising. Management provided responses to address the related recommendations, and during 2023/24 the Audit and Risk Committee has monitored the progress made in implementing the management actions, via the Internal Audit tracker.

1.3 The risks considered in our original review were:

- Additional costs and pressures on the Health Board where medical agency workers are used unnecessarily.
- Inconsistent approaches to the engagement of medical agency workers and their rates of pay.
- Inappropriate or unauthorised payments made at higher rates.

1.4 The Executive lead for this review is the Medical Director.

2. Findings

2.1 While there were six overarching matters arising, two of the matters arising had a number of parts, meaning that there were eight recommendations to follow up. The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	5	-	4	1
Medium	3	1	2	-
Low	-	-	-	-
Total	**8**	**1**	**6**	**1**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**. Where action is ongoing we have re-

assessed the priority rating for the recommendation and revised these where appropriate.

2.3 Generally, we found that there have been improvements with respect to the administration of agency bookings. For the recommendations that have been closed or partially closed, management have taken action to address the matters arising in our original report. This includes:

- Approvals of agency placements are now administered via the Retinue system, and details of managers who have approved placements are recorded appropriately.
- Efforts have been made to promote direct engagement bookings, and thereby minimise non-direct engagement bookings.
- Longer term bookings are being reviewed and more emphasis placed on substantive recruitment.
- Relevant financial information is reported, including to the Audit and Risk Committee.

2.4 A significant proportion of the recommendations made in the original audit related either directly or indirectly to the Medical Variable Pay Financial Control Procedure (FCP) and Medical Agency Locums Standard Operating Procedure (SOP). Whilst work to update the FCP has started, at the time of our fieldwork, it is not complete. Four of the six partially completed recommendations relate to this matter and a single new recommendation has been made in relation to a revised FCP.

Appendix A: Management Action Plan

Previous Matter Arising 1: Policy and procedure need updating (Design)			
Original Recommendation			**Original Priority**
1.1a	A review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be undertaken. From considering the findings from the audit report and reviewing current processes, both documents should be updated to reflect the processes and controls that staff should be adhering to when engaging medical agency staff.		**High**
1.1b	Updated copies of the updated FCP and SOP should be accessible to all staff and staff should be made aware of their existence.		
1.1c	Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.		
Management Response		**Target Date**	**Responsible Officer**
1.1a	The Financial Control Procedure (FCP) and Standard Operating Procedure (SOP) will be reviewed immediately and updated in line with recommendations within this report. They will then go through a ratification process to ensure this is also compliant with the Health Board's scheme of delegation and in place policy and procedures. Both the FCP and SOP were due to be reviewed at the start of this audit, however this was delayed to ensure the recommendations contained in this audit could be incorporated into both documents.	June 2023	Nerys Conway, Assistant Medical Director / Paul Harrison, Head of Workforce Productivity & eSystems.
1.1b	The June target date is used as the FCP will have to go through a ratification process. Both the FCP and SOP will be hosted on the agency intranet page, also available from the People Directorate on request and issued by Retinue to current users. Every time a new area is added to the system, all staff with access to book agency workers will be issued with the documents, along with training on how to use the system.	June 2023	

1.1c	All areas using the agency booking system will be provided with refresher training. A training plan will be developed and provided to all existing users, once the new FCP and SOP are in place. A record will be kept of what areas have had this training and when.	August 2023	

Current findings		Residual Risk
1.1a to 1.1c	We understand a review of the Medical Variable Pay Financial Control Procedure (FCP) was started, but then paused while approval for the non-consultant rate card was sought. Whilst approval for the rate card was then obtained, it appears that the review of FCP was not completed. The Medical Variable Pay FCP and Medical Agency Locums Standard Operating Procedure (SOP) in place at the time of our follow up fieldwork, remain the same as our original audit. As such, there has not been any refresher training.	Inconsistent approaches to the engagement of medical agency workers and their rates of pay. Inappropriate or unauthorised payments at higher rates.
Conclusion: The FCP and SOP have not been updated and the matter arising is **not implemented.**		

New Recommendations		Priority
1.1a	The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: • Information on the agreed rate card values and the authorisation process should those values need to be exceeded. • Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. • The process for extending agency worker placements. • The process for managers to approve the use agency workers to cover roster gaps.	**High**
1.1b	Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence.	
1.1c	Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	

Management Response		Target Date	Responsible Officer
1.1a	It was recognised through the medical workforce programme that greater control and assurance was required hence the need to revise the FCP and SOP. Scrutiny revealed longstanding inconsistencies throughout the Health Board therefore addressing these issues has taken longer than originally anticipated. The investment of time in completing this work is essential to meet our organisational workforce financial controls and assurance. The FCP is being revised in line with the new Care Group structure and the Scheme of Delegation and will be submitted to Audit Committee in October 2024.	October 2024	Esther Flavell, Assistant Medical Director/Nicola Evans Interim Assistant Director SWP/Nicholas Price Senior Medical Workforce Manager.
	Following this, the SOP will also be revised.	November 2024	
1.1b	The revised SOP and FCP will be available on the Intranet.	December 2024	
1.1c	The training provision timetable will be discussed and agreed at the Medical Workforce Productivity Framework Group.	December 2024	

Previous Matter Arising 2: Limited challenge when using non-direct engagement agency staff (Operation)			
Original Recommendation			**Original Priority**
2.1a 2.1b	The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff. .		**Medium**
2.2	The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
2.1a 2.1b	The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	June 2023	Nerys Conway, Assistant Medical Director / Paul Harrison, Head of Workforce Productivity & eSystems.
2.2	All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health board, which will allow the organisation to target and reduce DE use.	June 2023	Nerys Conway, Assistant Medical Director / Paul Harrison, Head of Workforce Productivity & eSystems.

Current findings		Residual Risk
2.1a & 2.1b	As reported in Matter Arising 1, the FCP and SOP have not been updated and training has not been provided. As the FCP and SOP have not been updated, there remains a lack of clarity with respect to the exceptional circumstances whereby the use of a non-DE arrangement would be appropriate, or the authorisation process that should be followed in such cases.	Additional financial costs to the Health Board.
2.2	We saw improvements with respect to promoting the use of DE agency staff. We reviewed booking information from the Retinue system for the period October 2023 to March 2024. During this period, only 9/151 individuals had been engaged under a non-DE arrangement and during the time period, one moved from non-DE to DE. The non-DE engagements equated to 4% of Retinue bookings.	
Conclusion: Work has been carried out by the Health Board and Retinue to reduce numbers. We consider this matter arising to be **partially implemented**, with the residual aspect in relation to updating the FCP reported under Matter Arising 1.		

Previous Matter Arising 3: Payments above WG cap (Operation)			
Original Recommendation			**Original Priority**
3.1a	The process for authorising payments that exceed the WG cap rates should be reviewed, with suitable authorisation taking place to approve higher value payments.		**High**
3.1b	The FCP and SOP should be updated to reflect the correct process to be followed and should provide greater clarity on the cost elements that need to be included when determining if a rate exceeds guidance rates. There should be consistent use of terminology across the FCP, SOP and Retinue system.		
3.2	Approval of higher rate payments should be retained in a suitable format that allows future reference if needed.		**High**
Management Response		**Target Date**	**Responsible Officer**
3.1a	The process for payments exceeding the WG cap rates will be fully reviewed as part of the development of the new FCP and SOP.	June 2023	Nerys Conway, Assistant Medical Director / Paul Harrison, Head of Workforce Productivity & eSystems.
3.1b	The recommendations of this audit will be incorporated into the FCP and SOP. The new FCP and SOP will fully address and unify the inconsistent terminology used currently, to reduce any confusion going forwards. The documents will also clearly set out the authorisation process required for rates that exceed WG cap rates. The process for requesting above WG cap rates will also be included in the refresher training to all areas using agency workers.		
3.2	All authorisation of higher rates payments will be recorded fully and provided on request. The way this is captured and accessible for audit will be included in the FCP and SOP for future reference.	June 2023	Nerys Conway, Assistant Medical Director / Paul Harrison, Head of Workforce Productivity & eSystems.
Current findings			**Residual Risk**
3.1a	In October 2023, a rate card for additional shifts worked was introduced with respect to non-consultant engagements. Work is still progressing in relation to agreeing the rate card for consultant engagements. It us		Inappropriate or unauthorised payments at higher rates.

& 3.1b	our understanding that the rate card values are now used in place of the ten-year-old WG cap rates, with approval required to exceed these rates. Approval now takes place at a Care Group Director level, as opposed to the Medical Director approving all payments. However, as noted in Matter Arising 1, the FCP and SOP documents have not been updated to include information about the rate card values, and the authorisation process to be followed should those rates be exceeded. Payments in excess of the WG rate cap are reported to the Audit & Risk Committee, where details relating to the payment of higher rates and longer placements are reported.	
3.2	Our original audit identified that nearly all payments sampled were above the WG cap rate, some as much as 90% above the rate. Whilst acknowledging the rate card values are higher than WG cap rates, we reviewed the Retinue data for the period October 2023 to March 2024 and identified that there were 549 bookings above the rate card values. This equates to 30% of all bookings for the period. Our analysis of these higher rates shows: **% above rate card value** / **Number** / **Percentage** Less than 5% / 255 / 46% 5% - <10% / 101 / 18% 10% - <15% / 56 / 10% 15% - <20% / 62 / 11% more than 20% / 75 / 14% These payments amount to £177k being paid above the agreed rate. However, we also saw instances where bookings were made at a rate below the highest level available on the rate card. We have been informed that the approval of rates is now through the Retinue system. During our fieldwork we obtained a Retinue report to show the authorising officer's name. However, information on the report was not complete in all instances. Where information was included, the authorisation was appropriate. We understand that Retinue are investigating why the report is not collating all information. As such, we cannot confirm that the authorisation control built into the system is operating effectively and that payments made above the agree rate card values are appropriately authorised.	
Conclusion: Whilst the approval process is now built into the Retinue system, we could not confirm this was operating effectively. As such, this matter arising is **partially implemented**.		

New Recommendation			Priority
3.1	The Health Board should work with Retinue to ensure complete management information can be obtained from the system that allows the Health Board to review booking information and be assured that rates above agreed rate card values have been appropriately authorised.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
3.1	Action complete. Non-consultant and consultant rate cards introduced. All rates above cap are reviewed at monthly Medical Workforce Productivity Programme Performance and Escalation Group.	Complete	Dr Dom Horford. Executive Medical Director

Previous Matter Arising 4: Authorisation of longer-term placements (Operation)			
Original Recommendation			**Original Priority**
4.1	It should be ensured that suitable processes are in place and adhered to for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum. Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used.		**High**
Management Response		**Target Date**	**Responsible Officer**
4.1	The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension. Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role.	August 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.
Current findings			**Residual Risk**
The FCP and SOP have not been updated to provide clarity on extending agency worker placements. However, our review of booking data identified that longer-term placements, which represent a minority of engagements, were subject to regular re-approval via the Retinue system. We saw evidence that management have worked to substantively recruit longer term agency staff in some cases. Details of individual longer-term placements are reported to the Audit & Risk committee, and reasons are provided to explain their necessity.			Additional costs and pressures on the Health Board where medical agency workers are used unnecessarily.

Conclusion: Whilst the FCP and SOP have not been updated, work has been carried out by the Health Board to reduce the numbers of longer-term placements. We consider this matter arising **partially implemented**, with the residual aspect in relation to updating the FCP reported under Matter Arising 1.	

Previous Matter Arising 5: Monitoring Medical Agency spend (Operation)			
Original Recommendation			**Original Priority**
5.1	Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
5.1	Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	June 2023	Sue Holroyd, Assistant Director of Finance / Nerys Conway, Assistant Medical Director /Paul Harrison, Head of Workforce Productivity & eSystems.
Current findings			**Residual Risk**
Managers have access to monthly medical agency expenditure information, and that a report detailing medical agency expenditure is shared with Care Group Directors via the Medical Productivity Group. Breaches of the WG rate cap and details with respect to longer-term placements are reported to the Audit & Risk committee. Detailed monitoring procedures were due to be incorporated into the revised FCP. **Conclusion:** Whilst it has been confirmed that the relevant financial information is being appropriately disseminated, there remains an outstanding requirement to incorporate details of financial monitoring procedures into the revised FCP. We consider this matter arising **partially implemented**, with the residual aspect in relation to updating the FCP reported under Matter Arising 1.			Actions not taken to address issues in relation to medical agency spend.

Previous Matter Arising 6: Formal approval of the use of agency staff (Operation)			
Original Recommendation			**Original Priority**
6.1a	The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate.		**High**
6.1b	The FCP and SOP should be updated to reflect the correct process to be followed.		
Management Response		**Target Date**	**Responsible Officer**
6.1a	A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff.	August 2023	Nerys Conway, Assistant Medical Director. Paul Harrison, Head of Workforce Productivity & eSystems.
6.1b	The recommendations and subsequent processes developed will be included in the FCP and SOP.		
Current findings			**Residual Risk**
The FCP and SOP are yet to be updated to include information on the process for authorisation for the use of agency staff. However, as the process is now undertaken via the Retinue system, we confirmed appropriate manager approval of bookings from our review data relating to bookings for the period October 2023 to March 2024. **Conclusion:** Whilst the FCP and SOP have not been updated, we were able to evidence booking approvals via the Retinue system. We consider this matter arising **partially implemented**, with the residual aspect in relation to updating the FCP reported under Matter Arising 1.			Additional costs and pressures on the Health Board where medical agency workers are used unnecessarily.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

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

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

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

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Follow-up: Reasonable Offer
Final Internal Audit Report

October 2024

Cwm Taf Morgannwg University Health Board

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Review reference:	CTM-2324-25
Report status:	Final
Fieldwork commencement:	22 February 2024
Fieldwork completion:	29 May 2024
Draft report issued:	11 June 2024
Management response received:	25 September 2024
Final report issued:	2 October 2024
Auditors:	Paul Dalton – Head of Internal Audit Emma Samways – Deputy Head of Internal Audit Andrea Calise – Audit Manager
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Committee:	Audit and Risk Committee

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

Acknowledgement

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Executive Summary

Purpose

To provide the Health Board with assurance regarding the implementation of the agreed management actions from our 2022/23 Reasonable Offer review.

Overview of findings

Of the original five matters raised, some agreed actions need to be completed for four of the matters, but these are of a lower priority. The key matters we have raised within this report relate to:

- The Waiting List Management Standard Operating Procedures are currently under review, with further revisions required on the new reporting lines as a result of the recent organisational restructure.
- A training needs analysis to ensure a standard approach to reasonable offer training across the Health Board is yet to be carried out. Work on this will align with the move to a single WPAS.
- Enhancing the data validation exercises for reviewing application of the waiting list rules and using information to identify training needs.

Follow-up Report Classification

		Trend
Reasonable	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	⇧

Progress Summary[1]

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Standard Operating Procedures	Medium	⇧	Low
2	WPAS Training and Support (PoW site)	Medium	⇧	Closed
3	WPAS Training Needs Assessment	Medium	⇨	Medium
4	Waiting Time Adjustments	High	⇧	Low
5	WPAS Data Validation	High	⇧	Medium

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

1. Introduction

1.1 This follow-up review of the Reasonable Offer audit has been completed in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 The objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Reasonable Offer review that was reported as part of our 2022/23 work programme. The original report identified five matters arising with a total of seven recommendations, and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original review. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

1.4 The risks considered as part of the original audit were:

- Patients not treated equitably if the SOP is interpreted inconsistently.
- Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	-	2	-
Medium	4	2	2	-
Low	1	1	-	-
Total	**7**	**3**	**4**	**-**

2.2 Full details of the recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

2.3 For the recommendations that have been closed or partially closed, management have taken action to address the matters arising in our original report. These include:

- Older, out of date versions of the Waiting List Management Standard Operating Procedure have been removed from the Health Board's intranet.

- There has been a review of booking process training at the Bridgend site and improved training plans for Bridgend staff have been developed. WPAS training delivery and system support provision is now jointly provided by the RTT Manager and by the WPAS Compliance and Management Team.
- WPAS system related training materials, checklists and guidance documentation have been developed for booking staff based at the Bridgend site and are available on the Health Board's intranet. The training documentation will need to be standardised across the Health Board when the two WPAS systems have merged.
- Management have reviewed the structure of the booking teams at the Bridgend and former Cwm Taf sites and a position paper has been presented to the Chief Operating Officer setting out the proposed changes and the expected benefits and efficiencies.
- We obtained a report from the WPAS system of outpatient appointments activity between January and May 2024. Our sample testing confirmed:
    - That the SOP and RTT rules were followed for our sample of appointments, and evidence was recorded on the WPAS system confirming that the booking process involved the patient.
    - Our testing of a sample of patient pathways where the original appointment had been cancelled, either by the patient, by the hospital, or where the patient did not attend confirmed that waiting time adjustments had been applied.

2.4 The actions listed above have either resulted in the recommendation being implemented, or partially implemented. Where action is ongoing, in all cases, we have re-assessed the priority rating for the recommendation with the residual rating being lower than the original one.

Appendix A: Management Action Plan

Previous Matter Arising 1: Review of Standard Operating Procedures (Operational)		
Original Recommendation		**Original Priority**
As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.		**Medium**
Management Response	**Target Date**	**Responsible Officer**
Standard Operating Procedures to be reviewed and updated with approval at OMB and Executive Leadership Group. Once approved, the SOP will be published and issued to all booking teams.	End of April 2023	Tarek Allouni – Director of Operations Planned Care Matthew Swarfield – Head of Clinical Administration Transformation
Current findings		**Residual Risk**
Our original recommendation related to reviewing the Reasonable Offer section of the Waiting List Management Standard Operating Procedure (SOP). We confirmed that the SOP had been reviewed and amended and shared with senior clinical management for feedback. We acknowledge that management is aware that further amendments may be required to the SOP to reflect the April 2024 changes to the operating model. **Conclusion:** Partial implementation		Patients not treated equitably if the SOP is interpreted inconsistently or where older versions remain in circulation.

New Recommendation			Priority
1.1	The review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to Operational Management Board (OMB) and the Executive Leadership Group (ELG) for final approval.		**Low**
Management Response		**Target Date**	**Responsible Officer**
1.1	To be added to the agenda for OMB following the review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to Operational Management Board (OMB) and the Executive Leadership Group (ELG) for final approval.	End of November 2024	Tarek Allouni – Service Director, Planned Care Matthew Swarfield - Head of Clinical Administration Transformation

Previous Matter Arising 3: Reasonable Offer appointments (WPAS Training Needs Assessment) (Operation)		
Original Recommendation		**Original Priority**
The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.		**Medium**
Management Response	**Target Date**	**Responsible Officer**
A training needs assessment and compliance sign off will take place post implementation of the agreed SOP.	August 2023	CSGMs & for all operational/booking team managers
Refresher training to be organised where required for staff identified.	August 2023	Matthew Swarfield - Head of Clinical Administration Transformation
Current findings		**Residual Risk**
The Health Board continues to operate with two WPAS systems. Bridgend site patient data resides on a WPAS system hosted by Swansea Bay University Health Board, while the rest of the Health Board's data is on the CTM WPAS system. A single system is planned to be in place by April 2025. We note that the Health Board is working through the latter stages of changes to its operating model. As such, the training needs assessment exercise will be undertaken when structural changes have been implemented and in relation to a single system. Interim arrangements are that service and clinical area management are responsible for identifying training needs and directing staff to the WPAS compliance and management team for training sessions. Our discussions with the WPAS compliance and training team confirmed that referrals for training are received and managed on an ongoing basis. **Conclusion:** Partial implementation		Patients not treated equitably if the SOP is interpreted inconsistently.

New Recommendation			Priority
2.1	Following completion of changes to the operating model and the merge to one WPAS system, the Health Board should perform a training needs assessment of staff responsible for booking appointments, including the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
2.1	An additional training needs assessment and compliance sign off will take place post WPAS merge in May 2025.	August 2025	Matthew Swarfield -Head of Clinical Administration Transformation

Previous Matter Arising 4: Incorrect application of Waiting Time Adjustments (Operation)		
Original Recommendation		**Original Priority**
Training in relation to application of waiting time adjustments should be provided to all booking staff to ensure they are fully aware of and complying with the relevant RTT rules.		**High**
Management Response	**Target Date**	**Responsible Officer**
An audit of the 'all users with WPAS compliance' report to take place and training arranged for identified staff.	August 2023	Tarek Allouni – Director of Operations Planned Care Matthew Swarfield - Head of Clinical Administration Transformation
Current findings		**Residual Risk**
A comprehensive training needs analysis is yet to be completed and compliance reports that will help identify training requirements are not yet run. We understand that when the changes to the operating model have been completed, new teams created and posts occupied, a review of the training arrangements will be undertaken and reported weekly via the team performance meetings. In the meantime, we understand that additional mechanisms have been put in place to strengthen the training arrangements for staff at the Bridgend site with WPAS training delivery and system support provision now jointly provided by the RTT Manager and by the WPAS Compliance and Management Team. Furthermore, individual managers continue to seek training for staff within their teams if a need is identified. We tested a random sample of cases to confirm compliance against the RTT rules for 'Reasonable Offers' and the application of waiting time adjustments within the WPAS system. We did not identify any issues. **Conclusion:** Partial implementation.		Patients not treated equitably if the SOP is interpreted inconsistently. Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed. Detrimental impact on the Health Board's ability to manage waiting lists effectively. Costs incurred and resources wasted if patients fail to attend.

New Recommendation			Priority
3.1	Management should pursue their original management response of generating WPAS compliance reports as a mechanism to identify staff training requirements.		**Low**
Management Response		**Target Date**	**Responsible Officer**
3.1	Following OCP phase 3, an additional audit of the 'all users with WPAS compliance' report to take place and training arranged for identified staff. Directorates will review and identify where they need training. Monthly Monitoring to enable staff training requirements.	TBC	Matthew Swarfield - Head of Clinical Administration Transformation

Previous Matter Arising 5: WPAS Data Validation		
Original Recommendation		**Original Priority**
A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.		**High**
Management Response	**Target Date**	**Responsible Officer**
Identification of WPAS reports to allow for identification of compliance.	July 2023	Tarek Allouni – Director of Operations Planned Care
Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements.	August 2023	Matthew Swarfield - Head of Clinical Administration Transformation
Current findings		**Residual Risk**
Currently the following data validation exercises are being undertaken: • Reports on duplicate records are available to all teams via SharePoint and are updated daily. • Weekly report on 'Closed pathways' but where patients still have a status of waiting is circulated to all teams. • A validation team is in place for stage 1 waiting lists (administrative validation to ensure the waiting list is accurate and up to date). In addition to the above data validation controls, further scope remains to:		Poor management/oversight of waiting lists. Patient dissatisfaction leading to complaints/distrust in the service. Inaccurate Waiting List Management reporting.

• Update the Waiting List Management SOP to reflect changes to the data validation process. • Standardisation of training requirements to be strengthened further upon the merger of the two WPAS systems (See section 2.3). **Conclusion:** Partial implementation	Patients not treated equitably if the SOP is interpreted inconsistently.

New Recommendation		Priority
4.1	Post-restructure, a full review of the approach to data validation should be undertaken to ensure compliance with the Waiting List Management SOP and RTT rules. The outcome of this 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.	**Medium**

Management Response		Target Date	Responsible Officer
4.1	Planned Care to undertake a review of the validation process across CTMUHB. Outcome of review to be shared with the Improving Care Board.	January 2025	Paula Goode, Deputy Service Director, Planned Care

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

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

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

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

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Follow-up: Patient Pathways
Final Internal Audit Report

September 2024

Cwm Taf Morgannwg University Health Board

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Shared Services Partnership
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Review reference:	CTM 23/24- 31
Report status:	Final
Fieldwork commencement:	October 2023
Fieldwork completion:	April 2024
Draft report issued:	May 2024. Revised draft June 2024
Debrief meeting:	June 2024
Management response received:	25 September 2024
Final report issued:	27 September 2024
Auditors:	Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Gethin Hughes – Chief Operating Officer
Distribution:	Sarah James – Deputy Chief Operating Officer
Committee:	Audit and Risk Committee

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Executive Summary

Purpose

Our review followed up on the recommendations made in our previous patient pathways follow up audit. We have sought to ensure that for recommendations deemed to be implemented by management, suitable actions have been taken. We have also considered if adequate progress has been made against those recommendations that remain open.

Overview of findings

We identified three matters arising in our original review, which included nine high priority recommendations, and one medium priority recommendation.

From our analysis of data, review of documentation and meetings with staff, we have confirmed that four recommendations have been implemented relating to:

- Actions had been taken by management to ensure 'outcomes not booked' and 'closed pathways' reports are complete.
- Distribution lists of those receiving reports were reviewed by management and staff are reminded to keep lists up to date.

There is ongoing work to implement the remaining recommendations.

Follow-up Report Classification

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations	

Progress Summary[1]

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Outcomes not booked	High	⇔	High
2	Closed Pathways	High	⇔	High
3	Watch lists	Medium	⇔	Medium

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

1. Introduction

1.1 As part of our 2023/24 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board') we have reviewed the progress against the agreed management actions identified as outstanding in our 2021/22 follow up of the Patient Pathway Appointment Management Process.

1.2 Our original Patient Pathway was finalised in October 2019. We issued a 'limited' assurance report with two high and three medium priority recommendations. The main findings related to ensuring that: following outpatient appointments, the correct outcomes were recorded on the patient administration system; that suitable training was provided to the medical secretaries responsible for inputting data; and a consistent approach to monitoring patient records, where diagnostic results were needed, was implemented.

1.3 In January 2021 we reported our follow up work on the progress that had been made implementing the agreed management actions. While a significant amount of preparatory work had been undertaken to implement the management actions, due to the pandemic and the retirement of key officers, there was little progress to address the specific points in our report. The Health Board's progress was also affected by changes in both its operating model and in the officers responsible for implementation. Therefore, the assurance rating remained 'limited'.

1.4 We undertook a second follow up review in March 2022 and confirmed that of the five original recommendations, two, in relation to training and use of temporary medical secretaries, had been implemented. The other three recommendations were outstanding, and the overall opinion remained as 'limited' assurance.

1.5 During 2023 we continued to monitor the Health Board's progress implementing the outstanding management actions through the Health Board's audit tracker.

1.6 The risks considered in our original review were:

- Inaccurate reporting of the Referral to Treatment Time (RTT) performance as a result of the Booking Process Pathway not being adhered to.
- RTT targets not achieved if issues are not identified at an early stage, reported and addressed.

1.7 The Executive lead for this review is the Chief Operating Officer.

2. Findings

2.1 While there are three overarching matters arising, two of the matters arising have a number of parts, meaning that there were ten recommendation parts to follow up. The table below provides an overview of progress in implementing the previous internal audit recommendations.

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	9	7	1	1
Medium	1	-	1	-
Low	-	-	-	-
Total	**10**	**7**	**2**	**1**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**. Where action is ongoing we have re-assessed the priority rating for the recommendation and revised these where appropriate.

2.3 For the recommendations that have been closed, management have taken action to address the matters arising in our original report. This includes:

- Revising the way in which the data contained in reports provided to service managers is generated. The reports now include data originating from the Cwm Taf patient administration system and information that continues to be held on Swansea Bay patient administration system.
- Undertaking a review of distribution lists for each service area to ensure the right people are in receipt of the reports each week/month. Report recipients are continuously reminded of the need to review the distribution lists.

2.4 One recommendation, in relation to the roll out of electronic outcome forms, is now obsolete, as these forms are not used in the way we initially thought.

Appendix A: Management Action Plan

Previous Matter Arising 1: Patient outcomes not booked (Operation)

Our original audit identified that large numbers of patients were not having the outcome of their outpatient appointment booked on the WPAS system. This may have been caused by outcome forms not being completed by the medic following appointments and / or the outcome form not being input on WPAS by outpatient receptionists and not checked by medical secretaries when patient notes and letters are typed.

On a weekly basis the WPAS team issue emails to managers listing those patients who are reporting as having their outcome not booked. The patient lists should be reviewed by services, and WPAS system updated with the correct outcome.

Previous Recommendation		Previous Priority
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.	**High**
1.2	Management should ensure that outcome reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that they action the outcomes recorded. The WPAS team should liaise with senior managers in each ILG to identify who is the most appropriate person in each CSG to receive the monthly reports.	
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.	
1.4	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.	
1.5	Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	

Previous Management Response		Target Date	Responsible Officer
1.1	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.	31 August 2022	ILG Directors of Operations / Head of Information
1.2	Each ILG will work with colleagues in the WPAS team to identify the correct staff members.	31 August 2022	ILG Directors of Operations / Head of Information
1.3	ILGs will ensure that they undertake this action.	31 August 2022	ILG Directors of Operations / Head of Information
1.4	ILGs will work with colleagues in Performance to ensure that the reports produced are suitable to allow the appropriate monitoring to take place.	31 August 2022	ILG Directors of Operations / Head of Information
1.5	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022.	30 September 2022	ILG Directors of Operations / Head of Information

Current findings		**Residual Risk**
1.1	The process for generating reports has changed. Individual speciality 'outcome not booked' reports are now in place and are emailed to managers each week. **Conclusion: Recommendation implemented**. Action has been taken in line with recommendation / management response.	Patients not appropriately moving to the next stage in their pathway in a timely manner or receiving treatment as required if outcomes are incorrectly recorded. Health Board inaccurately reports its position against performance targets.
1.2	Work that has been undertaken to review the distribution lists to ensure the right people within specialities are receiving the weekly WPAS reports. Targeted messages with distribution lists were sent to the seven main speciality areas to confirm accuracy. In addition to the targeted messages, the weekly emails sent by the WPAS team containing the 'outcomes not booked' reports are clear in reminding staff to ensure the distribution lists are accurate. **Conclusion: Recommendation implemented**. Action has been taken in line with recommendation / management response.	

1.3	Our review of 'outcomes not booked' data shows there has been a drop in reported numbers from approximately 6,000 in March 2023, to just over 3,000 in February 2024. This reduction is largely a result of work undertaken by the WPAS team to target specialities with the oldest outcomes not booked. As of February 2024, Ophthalmology, Paediatrics, Rheumatology and General Medicine specialities had the highest numbers of patients with outcomes not booked, which accounts for 31% of all cases. We met with a sample of service managers from these specialities to discuss the processes they follow for reviewing and acting on the reports received, and how they attempt to identify trends and take corrective action. Some common points were identified: • It appears that the weekly reports are not pro-actively reviewed to identify trends. We identified that in 2 of the 3 specialities, it was apparent most of their numbers related to either one medic, or one part of the service. Had this been identified, the root cause of issues in these areas could be established and corrective action taken that would hugely improve their overall position. • There is an assumption that others receiving the reports within the speciality i.e. the medical secretaries, booking clerks, sub-speciality managers are acting upon them. There is no checking, chasing, or confirmation sought that action is being taken when the reports are received. • There is a lack of clarity amongst staff around who is responsible for inputting data (outcoming the patient) in the first instance to prevent patients appearing on the report. We also note a lack of clarity in terms of responsibility for correcting errors. For the specialities that we reviewed, there did not appear to be process in place for addressing the information received in the weekly reports. However, we understand that service managers approach the WPAS team for assistance, and the WPAS team continue to provide support to specialities, including the provision of further guidance and training for staff. We note that the weekly emails request staff to '*arrange for appointment outcomes to be urgently updated for patient safety and reporting accuracy*'. We have seen stronger worded emails used in the past referencing the clinical risk to patient and the need for clinics to be outcome within 24 hours. **Conclusion: Recommendation partially implemented**. While overall numbers have improved and training has been provided, we saw no evidence in the specialities of action undertaken in line with the recommendation.	
1.4	Under the new operating model responsibility for oversight of specialities sits with the directors of the Care Groups. We understand weekly RTT meetings take place with the Directorate Managers where validation work is	

	discussed. Whilst these meetings are led by the Director of Operations for Planned Care, they cover all Health Board specialities and specialties outside of Planned Care will also be held to account. The individual Care Group Performance meetings are used as platform for feeding back into the Care Group **Conclusion: Recommendation implemented**. Action has been taken in line with recommendation / management response.	
1.5	There has been no further roll out of electronic outcome forms since our original audit. However, while electronic forms eliminate the risk of lost paper forms, there is no interface between the electronic forms system and WPAS. As such, outcomes recorded on the electronic forms must still be input on to WPAS. **Conclusion: Recommendation obsolete**. Electronic outcome forms are not used in the way initially identified.	
New Recommendations		**Priority**
	For clarity in this report – this recommendation relates to current finding 1.3, above.	**High**
1.1a	To minimise the number of patients on the 'outpatients not booked' reports, following outpatient appointments, WPAS should be accurately updated in a timely manner. Each speciality should be clear who is responsible for performing this role and ensure relevant staff are aware of their responsibilities.	
1.1b	Each speciality should set out who is responsible for actioning 'outcomes not booked' reports. Staff should be made aware of their responsibilities.	
1.1c	As reports are received each week, speciality managers should ensure they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data and those staff or department that are facility to rectify errors. Where necessary appropriate action should be taken including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for.	
1.2	The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken.	**Low**

Management Response		Target Date	Responsible Officer
1.1a	Directorates working with admin staff & records department to ensure they are taking back to source and to identify if any training requirements.	January 2025	Directorate Managers / Head of Information
1.1b	Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team.	October 2025	Planned Care Service Director / Deputy Director / Head of Information
1.1c	Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support.	November 2024	Directorate Managers / Head of Information
1.2	Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams.	November 2024	Planned Care Service Director / Deputy Director Head of information

Previous Matter Arising 2: Closed Pathways (Operation)

Our original audit identified that following initial appointments a large number of patients were incorrectly placed on a 'closed' pathway suggesting no further treatment was needed. On a monthly basis the WPAS team issue emails to managers listing those patients who are incorrectly reported as being on closed pathways. The lists of reported patients should be reviewed by services, and WPAS system updated with the correct pathway.

Previous Recommendation		Previous Priority
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.	**High**
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.	
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.	
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.	

Previous Management Response		Target Date	Responsible Officer
2.1	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	31 August 2022	ILG Acute Services General Managers / Head of Information
2.2	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	31 August 2022	ILG Acute Services General Managers / Head of Information

2.3	ILGs will ensure that they undertake this action.	31 August 2022	ILG Acute Services General Managers
2.4	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	30 September 2022	ILG Acute Services General Managers / Head of Information

Current findings		Residual Risk
2.1	Since October 2023 the closed pathway reports generated include data from both the Cwm Taf and PoW WPAS. A monthly report is issued with recipients filtering the data for their speciality. **Conclusion: Recommendation implemented**. Action has been taken in line with recommendation / management response.	Clinical risk for patients if further appointments or treatment is not arranged. Health Board inaccurately reports its position against performance targets.
2.2	Management has reviewed the distribution lists to ensure the right people within specialities are receiving the monthly WPAS reports. Targeted messages with distribution lists were sent to the seven main speciality areas to confirm accuracy. As reports are issued each month, we note reminders are included to emphasise the importance of validating the reports and ensuring the distribution lists are correct. **Conclusion: Recommendation implemented**. Action has been taken in line with recommendation / management response	
2.3	The monthly email issued by the WPAS team state that patients listed on the report are on an incorrect pathway and the urgent need for staff need to validate the cases and correct errors. The consequences to patients of not validating is not set out. This is something we have seen on previous 'outcomes not booked' emails. Detailed guidance notes have been issued to report recipients setting out how to ensure patients remain on open pathways and how to re-open them if closed in error. Despite these ongoing reminders, our review of 'closed pathways' data shows that numbers have increased from 800 in October 2023 to 950 in April 2024. On average 70% of the cases reported each month have been brought forward from the previous month. Ophthalmology, Gynaecology and Trauma & Orthopaedics specialities had the highest numbers of patients incorrectly on closed pathways as at April 2024, and collectively account for 66% of cases. Our meeting with service managers from these specialities identified:	

	• Managers assume that reports are being acted upon by staff within the speciality such as a medical secretary, booking clerk or sub-speciality managers. However, staff responsibility for correcting errors is not clear. • There is no checking or confirmation sought that action is being taken when the reports are received. • The weekly reports are not being pro-actively reviewed to identify trends. Pro-active monitoring would show the proportion of brought forward cases each month and where high, indicate that the reports are not being acted upon. We understand that service managers approach the WPAS team for assistance and in turn the WPAS team provide support. WPAS have also provided further guidance and additional training for staff. However, there does not appear to be a clear process in place to address matters identified in the monthly report. The monthly report covers all specialities, and each speciality must filter the data to see their own patients. Whilst none of the specialities we spoke to raised any concerns about this format, the 'outcomes not booked' reports are specific to the speciality and are potentially more user friendly. This also means the distribution list of each report is more targeted. **Conclusion: Recommendation not implemented**. The number of patients incorrectly on closed pathways continues to rise, there was no evidence that specialities have taken action in line with the recommendation / management response.	
2.4	Our review of the closed pathways email distribution list identified that the Care Group Director of Operations for Planned Care receives the monthly emails. We understand that weekly RTT meetings take place with Directorate Managers, chaired by the Care Group Director of Operations, where validation work is discussed. These meetings cover all specialities and not just those sitting within Planned Care. The individual Care Group Performance meetings are used as platform for feeding back into the Care Group. **Conclusion: Recommendation implemented** Action has been taken in line with recommendation / management response.	
New Recommendations		**Priority**
2.1a	For clarity in this report – this recommendation relates to current finding 2.3, above. Each speciality should set out who is responsible for actioning 'closed pathway' reports when they are received each month. Staff should be made aware of their responsibilities.	**High**

2.1b	To minimise the number of patients incorrectly on closed pathways, as reports are received each month, speciality managers should ensure they analyse the data to identify those departments with high numbers of brought forward cases, and trends such as those staff or departments that are continually failing capture information correctly. Appropriate action should be taken, including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for.	
2.2a 2.2b	The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken. Consideration should be given to issuing separate 'closed pathways' reports to each speciality, as opposed to one generic report that has to be filtered.	**Low**

Management Response		Target Date	Responsible Officer
2.1a	Directorate and Directorate Support Managers receive data and actions to be set at local Directorate performance meetings. To be rolled out across all Directorates. Updates are recorded and discussed at weekly Planned Care Weekly Performance Meeting – chaired by Director of Ops.	November 2024	Directorate Managers
2.1b	Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team. Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support.	October 2025	Directorate Managers
2.2a	Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams.	November 2024	Planned Care Service Director / Deputy Director / Head of information
2.2b	New updated distribution lists will ensure correct services and teams are receiving relevant report for their areas/specialties.	October 2025	Planned Care Service Director / Deputy Director /Head of information

Previous Matter Arising 3: Watch lists (Operation)		
Medical secretaries are required to monitor patients who are awaiting diagnostic investigation results. Our original review identified different approaches to this including the use of the 'watch list' function in WPAS. However, this approach meant that each medical secretary could only view their own watch list, so monitoring by others could not happen during periods of absence. A subsequent review identified that the WPAS system used by Bridgend staff allows medical secretaries to view one another's watch lists.		
Previous Recommendation		Previous Priority
Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members.		**Medium**
Previous Management Response	Target Date	Responsible Officer
This will be addressed by the ILG with colleagues from Performance.	30 September 2022	ILG Directors of Operations / Head of Information
Current findings		**Residual Risk**
The Health Board encourages the use of the 'QL' (Quick Look) reports, accessed via the Health Board's SharePoint to monitor patients who are waiting further diagnostic test results. The QL dashboard does not have the previous restrictions of 'watch lists', meaning action can be taken to monitor and move patients along pathways, if staff are absent from work. Instructions on use of the QL tool are available in the 'Secretary Information' guide that has been published by the WPAS team. However, we understand that not all medical secretaries have switched to using the QL dashboard, and some continue to use 'watch lists'. **Conclusion: Partially implemented**. The QL reporting function should now be used for monitoring, though some medical secretaries have not yet requested access to the tool.		Ongoing delays in treating patients awaiting diagnostic test results if 'watch lists' continue to be used.

New Recommendation			Priority
3	Those medical secretaries that do not yet have access to QL reporting tool should request access and if necessary, training, in order to be sure monitoring of patients awaiting diagnostic test results can be done in a consistent way across the Health Board, with no restrictions, such as those created by using 'watch lists'.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
3	To be discussed and action set with new structure Directorate Managers and ops teams.	November 2024	Planned Care Service Director / Deputy Director /Head of information

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

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

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

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

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Embedding the Quality Framework
Final Internal Audit Report

September 2024

Cwm Taf Morgannwg University Health Board

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

GIG CYMRU NHS WALES
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Review reference:	CTMUHB-2324-15
Report status:	Final
Fieldwork commencement:	31 May 2024
Fieldwork completion:	5 July 2024
Debrief meeting:	2 August 2024
Draft report issued:	25 July 2024
Management response received:	13 September 2024
Final report issued:	16 September 2024
Auditors:	Elizabeth Vincent – Principal Auditor Emma Samways – Deputy Head of Internal Audit
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Committee:	Audit & Risk Committee

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

Acknowledgement

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

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Executive Summary

Purpose

In early 2023 the Health Board approved an updated Quality Governance & Patient Safety framework. Our review has sought to provide assurance on the embedding of the framework within the Health Board. Our testing focussed on the Children & Families, and the Diagnostics, Therapies, Pharmacy & Specialties care groups

Overview

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

- Ensuring key participants attend Quality, Patient Safety and Experience meetings and that meetings cover all items set out in its terms of reference.
- Ensuring care groups map their assurance framework structures.
- Having a consistent approach to annual quality work plans in clinical service groups, and having plans in place at a care group level.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	The framework and strategy set out how the Board will receive assurance on quality matters.	Substantial
2	Care groups have appropriate arrangements in place to allow effective monitoring of quality.	Reasonable
3	Quality work plans and quality indicators are in place to focus the delivery of quality objectives.	Limited
4	Monitoring and reporting of quality matters is evident.	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Quality, Patient Safety and Experience meetings terms of reference	2	Operation	Medium
2	Content of Quality, Patient Safety and Experience meetings	2	Operation	Medium
3	Care group assurance framework	2	Design	Medium
4	Annual quality work plans	3	Design	High

1. Introduction

1.1 Our audit of 'Embedding the Quality Framework' was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board').

1.2 To achieve the aspiration of having a quality-led health service, organisations need to operate within an effective quality management system. In 2021, to drive this aspiration, Welsh Government (WG) published its Quality and Safety Framework: *Learning and Improving*, which identified the key elements required to ensure continuous improvement in quality. This includes the requirements of the Health and Social Care (Quality and Engagement) Act 2020, which sets out a strengthened Duty of Quality and Duty of Candour for the NHS in Wales.

1.3 The Health Board had a Quality Governance & Patient Safety framework in place, but in light of the revised WG guidance it has reviewed the framework. In early 2023 the Health Board approved a revised Quality and Safety framework (the 'framework') and a quality strategy.

1.4 The relevant lead for this review is the Executive Director of Nursing, Midwifery and Patient Care.

1.5 The following risks were considered as part of this review:

- Unclear structures or responsibilities impacting flow of assurance from ward to Board.
- Lack of indicators or standards to assess the quality of services and outcomes.

2. Detailed Audit Findings

Objective 1: The Health Board's Quality Management Framework and Quality Strategy identify how the Board will receive assurance through quality governance arrangements.

2.1 The Health Board's 'Quality and Safety Framework: Learning and Improvement 2022 -2025' was approved by the Board in January 2023. The framework has been developed to align with the Health Board's quality strategy, that was also approved in 2023. Both documents are available to staff via the Health Board intranet site.

2.2 The framework sets out the quality management system and governance structures that should be in place to ensure the Board receives assurance on quality. The framework uses a 'four lines of defence' model.

2.3 The first line of defence is at a Clinical Service Group (CSG) level, where daily 'safe to start' meetings, and regular Quality, Patient Safety and Experience (QPSE) meetings should take place. The CSG QPSE meetings report into Care Group QPSE meetings. These QPSE care group meetings, along with the Shared Listening and Learning Forum and Executive Leadership Group, form part of the second line of defence.

2.4 The third line of defence arises from the independent challenge provided by the Quality and Safety Committee and the Health Board. External independent reviews

from Health Inspectorate Wales and Internal and External Audit provide the fourth line of defence.

2.5 The framework provides further details in relation to the requirement for CSGs and their Care Groups to have frameworks in place describing how they will provide service to Board assurance, the use of standardised terms of reference and reporting formats for committees and the need for Annual Quality Work Plans for the QPSE groups.

Conclusion:

2.6 The framework provides comprehensive information setting out the governance arrangements that should be in place to ensure effective service to Board quality assurance processes. We have provided substantial assurance opinion against this objective.

Objective 2: There are consistent and appropriate governance arrangements within care groups with responsibilities set out, to allow effective monitoring of quality matters and reporting to the Board.

2.7 The framework provides information on the governance arrangements to be in place within each care group. We reviewed these arrangements for the Children & Families and the Diagnostics, Therapies, Pharmacy & Specialities (DTPS) care groups.

2.8 The framework includes a template term of reference (ToR) for care group QPSE meetings which sets out the responsibilities of the care group when monitoring quality. Using the ToR helps ensure there is appropriate focus on embedding the six characteristics of quality: safe, effective, patient centred, timely, efficient and equitable care. The QPSE meeting ToR in both care groups appropriately aligned to the template ToR as did the frequency of meetings. We note that the terms of reference for the Children & Families Care Group was due for review in October 2023. **(Matter Arising 1)**

2.9 Whilst the quoracy arrangements within the ToR are not clear, we confirmed that all care group clinical service areas were represented at each meeting. Our testing identified that the Children & Families QPSE meetings were attended by more than 30 people, which may not be an efficient use of time. We also note some occasions where the quality and patient safety lead was not present, and that there was no finance representative at any meetings, despite this being a requirement of the ToR. **(Matter Arising 1)**

2.10 We identified that the care groups approach the QPSE meetings differently. For example, Children & Families meeting focus on key topics such as assurance, quality planning, quality improvement and managing risk. Whereas the DTPS meetings are structured around the CSGs that make up the care group.

2.11 The framework provides a template slide deck for CSGs to use when reporting into their care group QPSE meeting, which covers incidents and concerns, risk registers and shared learning. While this was used within DTPS, it was not used by Children & Families CSGs. As such, it was not clear if all areas set out in the template slide decks were discussed. **(Matter Arising 2)**

2.12 The QPSE ToR lists the key duties of the care groups. Our testing identified that most topics listed under the key duties were discussed, but we did not see evidence of a quality and performance dashboard being presented, nor did we see updates on the Patient Experience or Citizen Engagement plans. **(Matter Arising 2)**

2.13 The quality framework requires each care group to have an assurance framework setting out how they will provide 'Service to Board' assurance in relation to quality and safety. As part of our fieldwork we requested the assurance frameworks from each of the care groups. We saw the Children & Families framework relating to the Maternity and Neonatal service and understand that this model is used at a care group level but did not see evidence of this. For DTPS we saw the Therapies Risk Escalation Framework, but no others from that care group. They were unable to provide an assurance framework that applies to the Care Group as a whole. **(Matter Arising 3)**

Conclusion:

2.14 The governance arrangements in place in each of the care groups that we sampled were broadly in line with the framework. However, there were some areas where the framework was not consistently applied. We have provided reasonable assurance opinion against this objective.

Objective 3: Care groups and clinical service groups have an annual quality work plan and relevant quality indicators to focus their delivery of SMART quality objectives. There is alignment to the Health Board's strategic quality goals.

2.15 The framework requires each care group and CSG to have an annual quality work plan. These work plans should have SMART objectives to ensure a targeted approach to improving quality. The framework refers to work plans capturing quality information to allow measurement and benchmarking of quality and outcomes of care.

2.16 We did not see a care group annual quality work plan in place for the two care groups that we sampled. Within the Children & Families care group we saw evidence of a quality improvement (work) plan for perinatal services, but we did not see plans for the two CSGs within the care group. We note that the perinatal plan did not incorporate SMART objectives.

2.17 Within the DTPS care group, there are four CSGs, but we were only provided with plans for the Pathology CSG. Each department within Pathology had plans of a standardised format, although the quality objectives listed did not incorporate SMART principals, other information was captured such as benefits to the service, benefits to the patient / service user, what the measurable benefit would be, the baseline measurement and the link to the Health Boards strategic goals. **(Matter Arising 4)**

Conclusion:

2.18 Whilst we saw good examples of quality work plans in some of the service areas that we tested, there was not a consistent approach across CSGs, and we did not

see quality work plans at a care group level. We have provided Limited assurance against this objective.

Objective 4: Monitoring and reporting within care groups and their CSGs is evident, using the 'always on'[1] approach.

2.19 Our testing confirmed that there was active monitoring and reporting of quality matters at both CSG and care group levels. Quality monitoring at the CSG level is through regular governance meetings. We note that the approach to monitoring not consistent between the two care groups that we tested. For example, for the Children & Families care group governance meetings held fortnightly with each meeting focusing on one CSG, while in the DTPS care group, governance meetings are monthly and cover all CSGs.

2.20 The governance meetings follow a similar agenda, which includes reviewing items such as concerns, incidents, HIW inspection outcomes, and patient safety notices. Tracker reports covering matters such as incidents, complaints, risks and claims, are also discussed at the governance meetings, and this information is used for reporting at QPSE care group meetings.

2.21 The information and reports received at the CSG governance meetings that we reviewed was timely and based on current data. However, the data presented at the April 2024 Children & Families QPSE meeting related to January and February, whereas the equivalent meeting for DTPS were reporting 'in month' data. **(Matter Arising 5)**

2.22 Our testing confirmed that highlight reports from care group QPSE meetings were reported at the Health Board's Quality and Safety committee. We also note that the committee receives a health board wide patient safety and quality dashboard.

Conclusion:

2.23 We saw evidence of on-going monitoring of quality matters, including the escalation between the various levels within the organisation. In some care groups, further work could be done to ensure the data and information reported on is more timely. We have provided substantial assurance against this objective.

[1] The Duty of Quality statutory guidance states: 'Always on' means that organisations collate, monitor and make information about the quality of their services readily available to their population and stakeholders, both within the organisation and externally.

Appendix A: Management Action Plan

Matter Arising 1: Terms of reference and attendance at the care group QPSE meetings (Operation)	**Potential Impact**
The QPSE Terms of Reference (ToR) for the Children & Families Care Group was due for review in October 2023, but at the time of our fieldwork this had not been done. The ToR set out the quoracy requirements as '*The meeting will be quorate if the chair (or deputy chair) is in attendance along with at least three Service Group representatives*'. We are unclear if this means there needs to be three representatives from each service group, or three of the care groups service areas need to be in attendance. This made confirming quoracy difficult, though we could confirm each service area was represented at the meeting. The ToR set out who should attend meetings. Our review of three sets of minutes for each care group identified: • Children & Families: 2/3 instances where the Head of Quality and Patient Safety for was not in attendance. All three meeting had more than 30 people in attendance, with most meetings lasting up to three hours. DTPS: The Head of Quality and Patient Safety did not attend the three QPSE that we reviewed. We understand that the meetings were at the same time as another care groups QPSE meeting. The ToRs are silent on the requirement for representatives to attended in their absence. • There was no finance representation at the meetings that we reviewed.	Unclear structures or responsibilities impacting flow of assurance from ward to Board.

Recommendations		**Priority**
1.1	Management within Children & Families care group should review and update the terms of reference for their QPSE meetings.	**Low**
1.2a	The quoracy arrangements for the QPSE meetings should be reviewed and made clearer. A review of attendees at the Children & Families QPSE meetings should take place to make efficient use of time, whilst also adhering to any quoracy requirements.	**Medium**

1.2b 1.2c	Where the Head of Quality and Patient Safety is unable to attend care group QPSE meetings, a representative should attend on their behalf. The ToRs should be updated to provide clarity on the need for representatives to attend meetings, if key members are unable to attend. It should be determined if finance colleagues are required to be in attendance at QPSE meetings. If it is felt they are not required to attend, the ToRs should be updated. However, if it is determined that finance representation is a requirement, care group management should remind their finance representatives of this requirement.	

Agreed Management Action		Target Date	Responsible Officer
1.1	We acknowledge the importance of having clear and up-to-date ToRs for our QPSE meetings. We agree that a review and update of these terms of reference is required, to ensure they align with current priorities and best practices of the Children's and Families Care Group. A thorough review of the existing QPSE meeting ToRs will be conducted. Any outdated elements or areas that require enhancement will be made to the ToRs. The ToRs will be reviewed on an annual basis.	31 December 2024	Care Group Director of Nursing & Midwifery
	We will conduct a thorough review of the existing ToRs and make the following updates:		
1.2a	Clarify the quoracy requirements, specifically defining how many representatives are needed from each service group/area for the meeting to be considered quorate.	30 November 2024	Care Group Director of Nursing & Midwifery
1.2b	Update the list of required attendees and specify the need for deputies (especially in relation to the Head of Q&S and deputy) to attend in their absence.	30 November 2024	Care Group Director of Nursing & Midwifery
1.2c	The QPSE Group will review whether finance colleagues are required to be in attendance at the QPSE meetings. If it is determined that finance representation is a requirement, the QPSE Chair will: • Remind finance representatives of the requirement to attend,	30 November 2024	Care Group Director of Nursing & Midwifery

	• Emphasise the importance of their participation, • Ensure finance colleagues understand their role within the QPSE meetings.		

Matter Arising 2: Content of QPSE meetings (Operation)	**Potential Impact**
The Quality and Safety framework provides a slide deck template for CSGs to report to care group QPSE meetings. While the slide deck format is used by in the DTPS care group, the Children & Families care group use a different structure. As such, we could not we see all areas included in the slide deck being covered. For example, we saw no reporting on risk registers. Furthermore, the ToRs for both care groups state that the group should be receiving quality and performance dashboards and receiving updates on the Patient Experience Plan and Citizen Engagement Plan. However, we could not evidence either care group being presented with a dashboard or updates on these plans at their last three meetings.	Inconsistent approaches to monitoring quality matters resulting in lack of awareness of potential issues.

	Recommendations	**Priority**
2.1	Management should ensure that care groups use the standard slide template provided by the framework. This includes incorporating sections for risk registers, key governance issues, and shared learning.	**Medium**
2.2	Some CSGs included additional information in their slide deck presentations, such as data on Learning from Event Reports (LFERs), PDR & mandatory training compliance rates and other performance data. If care group management consider this additional information to be beneficial, then consideration should be given to standardising this practice across CSGs and care groups. The slide deck template could be updated to include these sections, ensuring departments present this information in a consistent way.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
2.1	We acknowledge the importance of consistency and comprehensive reporting in our governance framework. The Corporate Quality & Safety team will review all Care Group QPSE slide templates and/or other methods of reporting, to ensure structures for reporting are consistent and in-line with the standard slide deck template within the Quality and Safety framework.	31 October 2024	Assistant Director Quality & Safety

	The Corporate Quality & Safety Team will review compliance of the slide templates on a bi-annual basis.		
2.2	The Corporate Quality & Safety Team will conduct a review of the additional information currently being included by some CSGs. This review will assess the value and relevance of any additional information and whether, for consistency, this should be included within the standard slide-deck (or other method of structure for reporting).	31 December 2024	Assistant Director Quality & Safety

Matter Arising 3: Care group assurance framework (Design)	**Potential Impact**
The quality framework requires care groups to have an assurance framework setting out how they will provide 'Service to Board' assurance in relation to quality and safety, following the four lines of defence model. During our fieldwork Children & Families provided an assurance framework specific to Maternity and Neonates. We understand that this format is used for the care group framework, but this was not provided. Similarly, we were not provided with an assurance framework for the DTPS care group. While we did not see evidence of a documented assurance framework for the care groups that we tested, we saw evidence of assurance structures within the care groups.	Unclear structures or responsibilities impacting flow of assurance from ward to Board.

	Recommendations	**Priority**
3.1	Management should ensure that all Care Groups have a documented assurance framework in place, setting out the assurance activities and structure of the CSGs and Care Group as a whole.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3.1	The Corporate Quality & Safety Team will: • conduct a detailed assessment of existing assurance frameworks within each Care Group to identify gaps and areas for improvement; • Develop a standardised assurance framework template that outlines key assurance activities and structures. This will include guidelines on documentation, reporting, and compliance requirements; • Establish a bi-annual monitoring and evaluation process to regularly review the effectiveness of the assurance frameworks. This will include periodic audits and feedback mechanisms to ensure continuous improvement.	30 November 2024	Assistant Director Quality & Safety

Matter Arising 4: Annual quality work plans (Operation)			**Potential Impact**
The Quality and Safety Framework requires care groups and CSGs to have annual quality work plans with SMART objectives to ensure a targeted approach to improving quality. We did not see annual quality work plans at a care group level, although we did see some CSG quality improvements plans, including for perinatal services and for each department within pathology. However, we noted the principles of SMART objectives had not been applied.			Lack of indicators or standards to assess the quality of services and outcomes.
Recommendations			**Priority**
4.1	The annual quality work plans developed by the pathology departments should be updated to include SMART objectives. The approach used by pathology should then be shared wider within the care group and to other care groups as a template for the development of annual quality plans as required by the Quality framework. Progress in implemented the care group level plans should be monitored via the care group QPSE meetings.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Pathology Department will update their Annual Quality Work Plan to include SMART objectives. Once the Pathology Department Annual Quality Work Plan has been updated, the revised plans will be shared at Care Group QPSE meetings. Templates and guidelines will be distributed to each Care Group QPSE group, who will complete an Annual Quality Work Plan (using SMART objectives). Each Care Group will ensure their QPSE Annual Quality Work Plan aligns with the Health Board's Annual Quality Work Plan. Care Groups will:	15 October 2024 31 December 2024*	Assistant Director Quality & Safety Care Group Nurse Directors

	• Ensure the QPSE Annual Quality Work Plan aligns with the Health Board's overarching Work Plan. • Add quality work plan updates as a standing agenda item at QPSE meetings; • Provide quarterly progress reports on SMART objectives; • Establish a process to escalate any objectives that are off-track; • Conduct an annual review of completed objectives and any lessons learned. * Although we would normally undertake this work immediately, due to the nature of the action a realistic timescale will be 31 December 2024.		

Matter Arising 5: Timely data presented at care group QPSE meeting (Operation)			**Potential Impact**
Within Children & Families and DTPS care groups, governance meetings are held with CSGs. Our review of the information and reports for these CSG meetings found they were timely and based on current data. However, we note that the reports presented at Children & Families care group QPSE meetings are not always timely. For instance, the data presented at the April QPSE meeting related to January and February, whereas the same DTPS care group QPSE meeting presented in-month data.			Poor decision making or actions not taken in a timely manner.
Recommendations			**Priority**
5.1	Management should review the reporting timeliness for Children & Families to ensure that the data presented is as current as possible to enable more accurate and timely data for decision making.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	The Children & Families Care Group will review of the current reporting processes to identify any delays in the reporting timeliness of data, to ensure it is as current as possible.	31 December 2024	Care Group Director of Nursing & Midwifery DTPS

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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Intelligence Led Organisation
Final Internal Audit Report

October 2024

Cwm Taf Morgannwg University Health Board

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

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

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Review reference:	CTM-2425-07
Report status:	Final
Fieldwork commencement:	7 June 2024
Fieldwork completion:	8 July 2024
Draft report issued:	26 September 2024
Management response received:	3 October 2024
Final report issued:	4 October 2024
Auditors:	Martyn Lewis IT Audit Manager
Executive sign-off:	Stuart Morris, Director of Digital
Distribution:	Andrew Nelson, Chief Information Officer
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 audit was to review the capabilities in place, from a people, process and technology perspective, for the Health Board to manage and transform its data to deliver appropriate and accurate intelligence to inform better decision making.

Overview

We have issued reasonable assurance on this area.

There is a data strategy in place as part of, and underpinning, the digital strategy, which makes clear the intent to move to being an intelligence led organisation. Management have considered the skills needed and increased resource provided to the information function. There is a data warehouse to provide information and the organisation is moving towards a Welsh data standard. Information products are used for decision making and the use of dashboards is monitored.

The key issues requiring management action are:

- Establishing a liaison arrangement to fully gauge information needs.
- Developing a data quality policy.
- Formalising a data governance framework for the Health Board as a whole.
- Provision of training on the use and interpretation of information.

Report Opinion

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

Assurance summary[1]

Objectives	Assurance
1 Strategy	Reasonable
2 Resources	Substantial
3 Tools & Technology	Substantial
4 Engagement	Reasonable
5 Data Quality	Reasonable
6 Data Governance	Reasonable
7 Decision Making	Reasonable

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Strategy	1	Operational	Medium
2	User needs	4	Operational	Medium
3	Data quality policy	5	Design	Medium
4	Awareness of data	6	Operational	Medium
5	Data governance framework	6	Operational	Medium
6	User skills	7	Operational	Medium

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation') a review of the capabilities in place, from a people, process and technology perspective, for the Health Board to manage and transform its data to deliver appropriate and accurate intelligence to inform better decisions has been undertaken.

1.2 In order to become an intelligence led organisation the Health Board must transform data into intelligence.

1.3 Data is a collection of facts which is raw and unorganised, information is a simplistic way of bringing data together and puts the data into context, and intelligence is knowledge or insights derived from information through analysis, synthesis and interpretation.

1.4 The potential risk considered in the review was the Health Board's strategic risk 6: Delivery of a digital and information infrastructure to support organisational transformation.

2. Detailed Audit Findings

Objective 1: An appropriate strategy should be in place to enable the organisation to become an intelligence-led organisation and to improve the coordination and use of its data to enable cross referencing and prevention of silos.

2.1 Data drives the use and development of digital applications and data forms part of the digital strategy, and is one of the themes within it. This is underpinned by a data programme which is closely linked to the national strategy and the National Data Resource (NDR). The NDR is a national aim to identify where data is, remove silos, and improve standardisation and use.

2.2 The Integrated Medium Term Plan (IMTP) for the Health Board has an 'enablers' section which includes digital. This shows the digital aims and themes, one of which is 'insights driven healthcare', the narrative states the aim as 'providing a platform to interrogate and analyse multi-source data'. As such, there is a strategic requirement to deliver the better use of information.

2.3 We note that reporting to the digital and data committee includes updates on digital progress and the ongoing work on business intelligence and analytics.

2.4 The delivery of the Health Board's digital strategy themes and IMTP is via the data programme, which forms part of the informatics work programme. This has a clear aim of creating a learning healthcare system which transforms data to knowledge in order to improve working practices on an ongoing basis. A number of the key workstreams within the informatics work programme relate to improved use of information and a drive to become an intelligence led organisation, these workstreams are:

- Software development;

- business intelligence;
- analytics;
- corporate reporting;
- data warehousing; and
- NDR.

2.5 The Digital Strategy and Informatics Work Programme only cover the items controlled by digital and digital data. There are areas and pools of data that sit outside of the Central Data / Information Team control. Some of these data pools are brought into central control for intelligence such as Workforce and Finance, although the detail and quality of the data varies, there remain areas which are not integrated into the intelligence system.

2.6 The intent for intelligence is for democratisation of data and analysis, with good quality data held in one place, controlled by the Central Data / Information Team and users able to analyse this as needed, based on individual skills.

2.7 Currently the data programme is not organisation wide, and the messaging associated with it may not be sufficient to fully break down silos. However we note that the Welsh Government have recently initiated a piece of work to update the Ministerial Statement of Intent on the Use of Data and AI in the NHS. As such the data and AI programme may benefit from a review following publication of the revised ministerial statement. We also note that there may be an upcoming refresh of the Digital Strategy, in which case the data aspects can be further refined and communicated. **Matter Arising 1**

Conclusion:

2.8 There is a clear framework for the Health Board to become an intelligence lead organisation, improve the coordination and use of its data, and enable cross referencing and prevention of silos. The framework does not fully cover the whole organisation, with data pools sitting outside the Central Data / Information department, however a revised ministerial statement along with a potential refresh of the Digital Strategy will offer the opportunity to refine and communicate the data and intelligence aims. Accordingly, we have provided **Reasonable Assurance** over this objective.

Objective 2: The Health Board should have sufficient resources to support an intelligence function, including financial and staff numbers and skills.

2.9 The Informatics work programme acknowledges the need for skills and sets out the required capabilities for the organisation and an assessment of the status of these capabilities at the time of our fieldwork. These are:

- analytics - clinical insights – noted as partially obtained;
- analytics - real time decision support – noted as not obtained;
- analytics - predictive decision support - noted as partially obtained;
- analytics - management info - noted as partially obtained;

- analytics - performance monitoring - noted as partially obtained;
- analytics - pop health info - noted as partially obtained; and
- enablement - information management - noted as partially obtained.

2.10 The Central Data / Information Team is responsible for providing information products for the organisation and contains the following teams:

- Corporate reporting;
- Business intelligence;
- Data warehouse;
- Data scientists; and
- Quantitative analysts.

2.11 There is a defined budget for information, and we note additional resource has been provided.

2.12 The Central Data / Information Team consists of people with skills in statistics, Operational Research, Data Science, Biostatistics, Epidemiology, software development, Data Management and is a separate discipline to the digital team.

2.13 From discussion with management we note that it is felt that the right skills are in place to deliver information products and the department includes skills related to: Qlik; Power BI, Python and R programming, FHIR, analytics and AI such as LLM and NLP. However, the number of staff means that not all information requests can be delivered in a timely way.

2.14 The development of these skills within the Central Data / Information Team is due to resource provided both for recruitment and for training, with training ongoing on open source models and Linux in order to meet future needs.

2.15 We note that a number of doctoral graduates from a data science background have been appointed in order to develop the analytic function and implement an appropriate data architecture, and time has been allocated to try new ways of analysing and interpreting health board data.

2.16 There is also close working with universities in order to gain access to maths skills and with other, third party organisations in order to access resources in order to meet the demand for information products.

Conclusion:

2.17 The skills required to deliver an intelligence function have been identified and staffing is in place, although we note that demand is higher than available resources. Additional resource has been provided and links have been developed with universities and other organisations in order to access skills. Accordingly, we have provided **Substantial Assurance** over this objective.

Objective 3: The Health Board should identify the most appropriate tools and technologies to fit their current and future needs. These tools should enable the

organisation to acquire, process, analyse, and use data from sources that produce increasing amounts of structured and unstructured data.

2.18 There has been consideration of the tools and technologies needed to provide intelligence and good quality data for the organisation. This is made clear within the Informatics Programme which notes the move to using FHIR (fast healthcare interoperability resources) within the health board architecture to ensure data interoperability (the ability of computer systems or software to exchange and make use of information).

2.19 The main underpinning tool for the delivery of information products is the data warehouse which is used to provide the data for reporting and is based on an SQL Server database.

2.20 Historically, the Qlik sense platform has been used for reporting, however reporting is transitioning onto Power BI. To date the Health Board has moved its information products onto Power BI without any loss of functionality.

2.21 We saw evidence of modelling information, and of some AI related tools such as NLP (natural language processing) and LLM (large language modelling), in order to provide intelligence and automation.

2.22 The National Data Resource / Local Data Resource (NDR/LDR) programme is also improving the use of technology for collating data and delivering intelligence. A recent IMTP update report noted that data acquisition methods are improving, with greater use of APIs (application programming interfaces) for passing of data between applications and the use of FHIR for direct feeds of data.

2.23 Management have considered the future needs of the Health Board and the use of FHIR ensures future integration with Wales and does not require specific applications for provision of analytics which enables the use of new tools in the future.

2.24 We note that there is an increasing move to using open source platforms for delivering digital services and intelligence. In order to meet this demand there has been training provided to staff on items such as Linux and we note that there is some use of open source analytics tools within the Central Data / Information Team.

Conclusion:

2.25 The tools in use within the Health Board are in flux. There is a move away from Qlik to Power BI within the Central Data / Information Team. The underlying data architecture is moving to FHIR which will enable greater interoperability in the future and training is being provided on open source tools to enable better use in the future. Accordingly, we have provided **Substantial Assurance** over this objective.

Objective 4: A process should be in place for identifying key stakeholders (internal and external) and their requirements, and translating these into deliverable intelligence products.

2.26 The Central Data / Information Team provides information to both internal and external stakeholders, these include corporate and clinical services, and Welsh Government and national bodies, along with hosted organisations. We note that there is clarity over the requirements from external stakeholders.

2.27 There is no process for formal liaison with internal stakeholders in order to identify intelligence needs, with each stakeholder making requests through various channels. We note that information is integrated into many ongoing programmes which enables identification of information / intelligence needs, however without a formal liaison approach activity may be reactive. **Matter Arising 2**

2.28 We note that there are more requests for information products (both dashboards /reports and modelling / analytics) than can be delivered within reasonable timescales, and so there is an assessment and prioritisation process in place.

2.29 Information requests are discussed by the Central Data / Information Team at a two weekly meeting, and priorities defined according to criteria including: seniority of request source; ease to produce; link to organisation priorities. We also note that information products are being moved from the Qlik platform to Power BI, and there is a prioritised plan for these products which also considers that level of use of the product.

2.30 The identification of the need for intelligence products such as modelling / analytics is from a variety of sources including: experience; links with programmes; executive requests; and IMTP requirements. Prioritisation of these can there for be difficult.

2.31 Once the need for information is confirmed, the development of the product follows a standard development process. The full need is defined with the developer in detailed discussions with the user in order to establish the true need / question. From this a formal scoping document is created and the product developed and subject to testing and iteration.

2.32 Information products are published and released to the relevant staff, with access controlled by Active Directory. We note that there is a Health Board wide available catalogue for users to see what information is available in order to avoid duplicated requests.

2.33 We reviewed a sample of information products to confirm that specification documents were in place. Our testing identified that specification documents were in place for newer products, with the outputs matching the user needs, although these were not available for older products.

Conclusion:

2.34 The Central Data / Information Team is aware of its key stakeholders and provides information and intelligence products to a variety of internal and external stakeholders. The development of the detailed requirement is undertaken in collaboration with the requester to ensure that user needs are met. We note that there is no formal business partner approach, partly due to the volume of requests, and this may make the service overly reactive and impact on prioritisation. Accordingly, we have provided **Reasonable Assurance** over this objective.

Objective 5: Appropriate data quality management arrangements should be in place, including a policy with clearly defined roles and responsibilities, a framework for data sharing and adequate controls for all systems of data collection.

2.35 There is a national Information Governance policy which contains a reference to data quality, noting its importance and staff responsibility. However, there is no data quality policy, or statement of requirements that make clear what good data quality looks like (the characteristics), and clearly mandates that staff must take care and ownership of data quality (responsibilities). **Matter Arising 3**

2.36 The Health Board has known issues with data quality due to historic causes, with the current application tools not set up to enable and enforce data quality standards. We understand that it is taking a variety of measures to resolve these matters including, developing a set of standard requirements for new systems of data capture and blocking those that do not meet standards, a coding improvement plan, bringing Bridgend patient administration system (PAS) into the main Cwm Taf PAS; and using of FHIR forms for data collection.

2.37 However there needs to be an appetite for improving data quality from the top down, and a lack of formal policy or statement does not explicitly show this. **Matter Arising 3**

2.38 The use of FHIR will enable a change on the use of the organisation's data and the Health Board is undertaking actions to embed and develop this with an aim to have data validation at source. The coding team have provided training to clinicians on the use of LHCForms (native FHIR forms which enable validation of the data at source) in order to improve data literacy and quality, and there is the ongoing development of e-forms to improve data quality.

2.39 The quality of data relies on the care taken by users when entering data. The Health Board has acknowledged within the risk register process and within the Central Data / Information Team that there are issues with data quality in some areas. There are issues with clinical coding in relation to poor quality information within notes, and there are problems with recruitment and retention. In order to improve this a new clinical coding strategy and improvement plan has been developed which includes automation and data capture at source to improve data quality.

2.40 Historically clinicians have not used their data which has contributed to poor data quality and so training has also included the use of data in order to enable clinicians to use their data and so ensure good quality data on input.

2.41 There has not been a full assessment of data maturity for the organisation, and so there is nothing that formally states where it is and where it wants to be together with an improvement plan. We note that there is assessment of data maturity within specific programmes, however the organisation as a whole does not show an awareness.

2.42 The use of FHIR will enable data collection and validation and so data quality enforcement. There is an intent to reuse data to reduce errors and improve

consistency. As an example, the Health Board is seeking to take data from the GP record to pre-populate forms and has purchased the appropriate FHIR connector for this.

2.43 In order to use the data collected within the Health Board to produce intelligence it has to be validated and a single agreed format for data items created in order to cross reference and combine information from multiple sources. This is provided within a data warehouse.

2.44 The Health Board's data warehouse is based on a SQL server database and is used for reporting and intelligence. We confirmed that there are data quality checks and reports for the flows of data in from different sources.

2.45 Data gets into the data warehouse by feeds, the development of new feeds being on request and requiring the mapping of source data to the warehouse data standard. We note that there is documentation for new feeds, with the old feeds not so well documented.

2.46 Data quality within source systems is reliant on the controls for those systems. That varies, but from our work in other areas there are controls in place to a greater or lesser extent.

2.47 Data is extracted from source systems, loaded into the warehouse and processed / transformed to create standardised data for use.

2.48 Currently the majority of data extracts use SSIS, (SQL server integration service) however the introduction of FHIR will enable better, direct connections as all new systems must be FHIR compatible.

2.49 Loading of data is monitored with reporting on failed feeds. There are data quality checks in place, both within feed scripts and as a separate job within the warehouse. These data quality checks ensure that data quality is maintained within the warehouse in order to provide quality information.

2.50 As part of the creation of information products there is consideration of including data quality measures in order to indicate to users the level of reliance that they can place on the information. However, our testing identified that the majority of information products do not need this for the use which they are intended. We note that one information product, patient flow, could benefit from a data quality indicator, and we were informed that, as part of the move into Power BI, this will be added.

2.51 The direction of travel for the organisation is of greater re-use of data and sharing of data within the organisation, within IG requirements. The Health Board is moving forward with a process for sharing information from the GP care record to the Health Board's systems.

Conclusion:

2.52 Although data quality is referred to within the IG policy, there is no Health Board policy or statement on data quality that defines good quality data and clearly states responsibilities. The Health Board has acknowledged data quality weaknesses, partly due to historical application provision, however it is working to improve this

and the move to FHIR, together with the link to the NDR, will improve data quality. The Health Board uses a data warehouse for provision of information and we note that there are data quality checks in place to ensure that the information held there is good. Accordingly, we have provided **Reasonable Assurance** over this objective.

Objective 6: The Health Board should be aware of where its data is and how it is aggregated and shared. Appropriate data governance should be in place to ensure that information remains accurate, consistent, timely and accessible. This should include metadata (i.e., data about data) management, security, privacy, data integration, data quality, and master data management.

2.53 The Health Board has an Information Asset Register (IAR) in order to comply with GDPR requirements which identifies information stores. At the time of our fieldwork management were reviewing the register as it needs to be updated. The review process includes asking departments to consider what information they hold. The IAR contains key information over what data is held, the department, the purpose and information on security. However, it does not contain key information about the data pool such as metadata, or the update mechanism and as such is not a full record of organisational data for use in intelligence. Although there is an awareness of information assets there is no structured awareness of data pools. **Matter Arising 4**

2.54 The Health Board has recognised a risk that the rollout of Office 365 can lead to an increase in data silos as users develop their own forms for data collection. It has also noted that the use of MS Forms does not meet data standards and has therefore blocked the use of forms for clinical information capture.

2.55 There is no formal Data Governance framework that sets out the requirements for control over data along with the responsibilities of users. We note that there is the basis of a framework, with various items in place such as the IG policy and IAR, the NIS regulations and the use of the FHIR standard. **Matter Arising 5**

2.56 Welsh Government has mandated data standards via Welsh Health Circulars, the Data Dictionary and Medical Records Standards and the Health Board has always adopted these. As such there is a defined data standard for the organisation, this is FHIR and so is consistent with the NDR and will enable full inter-functionality.

2.57 The Central Data / Information Team follow standards and good practice on information use and presentation with information products being consistent in look, filters and constraints always displayed and titles and axes labels displayed on charts with the use of dynamic labelling for some charts.

2.58 We note that as part of the move into Power BI, templates are being developed and the appearance of the products is being retained.

2.59 Our testing confirmed that there are data definitions for the information products with provides clarity over what is being presented and enables cross referencing. We also confirmed that there is standardisation of products, and graphs are always labelled. We identified that chart titles did not always change after filters, however the move to Power BI and the redevelopment of dashboards should resolve this.

2.60 We note that there are other departments within the Health Board that create information products, for example within Mental Health. The Head of Information provides professional guidance on this, however, at the time of our fieldwork, there is no remit to enforce good data governance across the wider Health Board. See **Matter Arising 5**

Conclusion:

2.61 The Health Board uses an IAR to track information assets in order to comply with IG requirements, and this identifies where information is held. Currently the IAR is being updated and omits key information about the data sources. A data standard for the organisation is being defined, and outputs from the information department are standardised and comply with good practice in terms of provision of information. Not all of the Health Board's information provision lies within the Central Data / Information Team and there is no remit to enforce data governance across the organisation. Accordingly, we have provided **Reasonable Assurance** over this objective.

Objective 7: Intelligence products are used to inform decision making. They should be designed with the appropriate flexibility of input parameters to allow consumers to narrow or broaden the focus of their analysis. This flexibility enables consumers to ask questions that might not have been anticipated during the initial development phase and supports adoption by empowering consumers with self-service capabilities.

2.62 The information products produced by the Central Data / Information Team enable a large amount of user interaction. Our testing confirmed that the dashboards and reports are tailorable and can be cut and filtered as the user needs in order to get specific information to aid decision making.

2.63 We note that user guides are in place for some information products to help users, this is more true for the newer products and as items are redeveloped for Power BI guides are being produced where appropriate.

2.64 The adoption and the use of information products is monitored using a dashboard that identifies the level of use of each product in terms of users, sessions and time used. There is also a report which identifies products that are not used in order to archive these. Our testing confirmed that the items that we tested were regularly used by an appropriate number of users.

2.65 The information provided from the Central Data / Information Team, (both modelling and dashboards) is used throughout the organisation. We surveyed a sample of staff to understand how they perceive the Health Boards use of data. While there was a limited response, the responses received identified that information was used for decision making, including adjusting current activity, and that information is useful, timely and relevant.

2.66 The responses identified an appetite for more intelligence with most respondents feeling that the organisation is not making use of its information, and a need for better analytics and modelling.

2.67 In order to effectively use intelligence and information tools, users within the organisation need to be comfortable working with information and understand core concepts in relation to the data and information provided. From our discussions we note that this is felt to be an area where skills across the organisation are lacking with gaps in data literacy and in the use of intelligence tools. This presents a risk to the Health Board that intelligence may not be fully used, or be used inappropriately if, for example, users do not understand the different between corelation and causation. **Matter Arising 6**

Conclusion:

2.68 Information products are used to inform decision making and the dashboards produced enable filtering and adjusting in order to tailor the information provided. We note that there is demand for greater intelligence provision, however skills in data use and understanding vary across the organisation and this may impact on the successful use of intelligence. Accordingly we have provided **Reasonable Assurance** over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Strategy (Operation)	Impact
Currently the data programme is not organisation wide, and the messaging associated with it may not be sufficient to fully break down silos. However we note that the Welsh Government have recently initiated a piece of work to update the Ministerial Statement of Intent on the Use of Data and AI in the NHS. As such the data and AI programme may benefit from a review following publication of the revised ministerial statement. We also note that there may be an upcoming refresh of the Digital Strategy, in which case the data aspects can be further refined and communicated.	Potential risk of: • poor quality intelligence.

Recommendations		Priority
1.1	The data and AI programme should be reviewed and if necessarily refreshed following the publication of the revised Ministerial Statement of Intent.	**Medium**
1.2	The Data and AI programme should be refreshed in the event that the Digital Strategy is updated. This should include an organisational wide perspective, noting that the Central Data / Information Team are the professional leads and the organisational aims to improve information use.	

Agreed Management Action		Target Date	Responsible Officer
1.1	The UHB will seek to contribute to the refresh of the Ministerial Statement of Intent on data and AI and the strategic and tactical refresh of the accompanying work programme.	December 2024	Director of Digital & Chief Information Officer
	We will ensure that the data strategy is refreshed at the appropriate time.	As applicable	Director of Digital & Chief Information Officer
	It is the intention of the UHB to develop a strategic position and plan for AI over the course of the next 6 months.	April 2025.	Director of Digital & Chief Information Officer

	In a rapidly developing environment the UHB will endeavour to ensure that our strategic and tactical approach to digital, data and AI, the EHR, patient portal, and other areas align through regular consideration and refresh of our strategic, tactical and operational decision making.	Continuous Improvement and Deployment	Director of Digital & Chief Information Officer

Matter Arising 2: Stakeholder Needs (Operational)			Impact
There is no process for formal liaison with (internal) stakeholders in order to identify intelligence needs, with each stakeholder making requests through various channels. We note that information is integrated into many ongoing programmes which enables identification of information / intelligence needs, however without a formal liaison approach activity may be very reactive.			Potential risk of: • Information needs for the health board are not met.
Recommendations			**Priority**
2.1	A formal process of liaison, taking a business partner approach should be considered, that links information to the service areas in order to pro-actively identify intelligence needs across the organisation.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	There is insufficient resource available to operationalise this requirement and the skills required by a care group are not held by every analyst. As such Lead analysts have been identified to individual care groups and corporate departments, which will co-exist with analysts taking responsibilities based on the skills required of the task requested.	Completed	Chief Information Officer

Matter Arising 3: Data Quality Policy (Design)	Impact
There is no data quality policy, or statement of requirements that make clear what good data quality looks like (the characteristics) and clearly mandates that staff must take care and ownership of data quality (responsibilities). We note that actions to improve data quality are underway, however there needs to be an appetite for improving data quality from the top down, and a lack of formal policy or statement does not explicitly show this.	Potential risk of: • Poor quality data leads to poor information.

Recommendations		Priority
3.1	A Data Quality Policy, or statement of intent should be developed that makes clear what good quality data looks like and its characteristic's along with clear expectations and responsibilities of staff.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	The UHB will develop and implement a data quality policy, recognising that we anticipate the real improvements to be made when the data becomes available to the staff members who initially made the record and staff members who would use the records to meet the requirements. This availability is dependent upon the open architecture and NDR programmes moving into rapid delivery phases.	January 2025	Chief Information Officer

Matter Arising 4: Awareness of data (Operational)			Impact
The IAR contains key information over what data is held, However it does not contain key information about the data pool such as metadata, update mechanism etc. as and such is not a full record of organisation data for use in intelligence. As such, although there is an awareness of information assets there is no structured awareness of data pools across the organisation.			Potential risk of: • Lack of awareness of data impacts on information provision
Recommendations			**Priority**
4.1	Consideration should be given to using the IAR process to fully identify data pools and expanding the information held within the IAR.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The UHB will establish a data catalogue in line with Welsh standards as part of a commissioned and funded element of the National Data Resource programme.	Started September 2024 – Completion c. March 2027 (part of NDR work plan discussions)	Chief Information Officer

Matter Arising 5: Data Governance Framework (Operational)			Impact
There is no formal Data Governance framework that sets out the requirements for control over data along with the responsibilities of users. We note that there is the basis of a framework, with various items in place such as the IG policy and IAR, the NIS regulations and the use of the FHIR standard. We have noted however that there are other departments within the health board who create information products. The Head of Information does provide professional guidance on this, however there is no remit to enforce good data governance across the wider health board			Potential risk of: • Poor quality intelligence
Recommendations			**Priority**
5.1	A Data Governance Framework for the organisation should be defined that sets out the requirements and responsibilities for the identification, aggregation, recording and use of data. This should include requirements for the presentation of information products that comply with good practice.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	A data governance framework complimentary to the data quality policy, and incorporating the numerous mandated requirements placed on the UHB will be developed and implemented.	January 2025	Chief Information Officer

Matter Arising 6: User Skills (Operational)			Impact
Our discussions noted skills gaps in relation to data literacy and in the use of intelligence tools. This presents a risk to the Health Board that intelligence may not be fully used, or be used inappropriately.			Potential risk of: • Inappropriate use of intelligence.
Recommendations			**Priority**
6.1	Training materials on data and its users should be provided, with targeted training provided to key staff tiers.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	The organisation will explore core competency training that is presently available across NHS and public sector Wales with the intention of incorporating this into the personal development approach of the organisation.	March 2025	Director of Digital & Executive Director for People

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Follow-up: Facilities Governance Arrangements

Final Internal Audit Report

October 2024

Cwm Taf Morgannwg University Health Board

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

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

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Review reference:	CTMUHB 2425- 27
Report status:	Final
Fieldwork commencement:	19 July 2024
Fieldwork completion:	29 August 2024
Draft report issued:	17 September 2024
Debrief meeting:	16 August 2024
Management response received:	27 September 2024
Final report issued:	7 October 2024
Auditors:	Emma Samways – Deputy Head of Internal Audit Jayne Gibbon – Audit Manager
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Distribution:	Jill Venables – Divisional Director of Facilities Claire Masters – Facilities Manager
Committee:	Audit and Risk Committee

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

Acknowledgement

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

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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

Our review followed up on the recommendations made in our previous facilities governance follow up audit. We have sought to ensure that for recommendations deemed to be implemented by management, suitable actions have been taken. We have also considered if adequate progress has been made against those recommendations that remain open.

Overview of findings

Management have made significant progress in addressing the recommendations and agreed actions detailed in the previous follow up audit report.

Of eight recommendations, six recommendations have been closed, including both high priority recommendations.

With regards to the one medium priority recommendation outstanding, whilst some progress had been made, further action is required. This recommendation relates to the receipt of 'invoices on hold' reports.

We have raised a low priority recommendation recommending an enhancement to the guidance in place concerning capturing information on retrospective orders and the retention of information.

Follow-up Report Classification

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected	

Progress Summary[1]

	Previous Matters Recommendations	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Procurement Process Training	Medium		Closed
2.2	Use of Retrospective Orders – Numbers & Guidance	Medium		Low
2.3	Use of Retrospective Orders – Oracle Update	Medium		Closed
2.4	Use of Retrospective Orders – retaining evidence	High		Closed
3	Invoices requiring competitive quotations	Medium		Closed

4	Monitoring Compliance with No PO no Pay process	Medium	⇔	Medium
5	Budget Holder Training	Low	⇧	Closed
6	Areas of Responsibility	High	⇧	Closed

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

1. Introduction

1.1 This second follow up review of facilities governance arrangements was completed in line with the 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original Facilities System audit report was finalised in June 2022 with an overall assurance rating of Limited Assurance. We undertook a follow up review in June 2023 to assess the progress that had been made in implementing the agreed management actions. While we confirmed that work had been carried out to implement some of the original recommendations, a number remained incomplete. As such, the assurance rating remained at Limited Assurance, with two high priority and six medium priority recommendations.

1.3 Following our follow up audit, the Facilities Management team developed an action plan to track progress against the implementation of the agreed actions. Progress against the action plan has been provided to the Audit and Risk Committee.

1.4 The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of and progress against the agreed management responses from the October 2023 Facilities Governance follow up audit.

1.5 The Executive lead for this review is the Chief Operating Officer.

2. Findings

2.1 There were eight recommendations to be followed up. The table below provides an overview of progress in implementing the previous internal audit recommendations.

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	2	-	-
Medium	5	3	1	1
Low	1	1	-	-
Total	**8**	**6**	**1**	**1**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**. Where action is ongoing we have re-assessed the priority rating for the recommendation and revised these where appropriate. Note that some recommendations made in our original audit, for example 2.1, had been implemented at the time of our first follow up review. Information in relation to those recommendations has not been included in this report.

2.3 With regards to the high and medium priority recommendations that have been closed:

- At the time of our fieldwork the procurement training compliance rate was at 95% for the facilities team, and processes have been implemented for the ongoing review of compliance.
- Significant progress has been made in reducing the number of retrospective orders raised. We note that greater use is now made of call off / open orders where appropriate.
- In relation to obtaining quotes and retaining evidence of this, our testing found that departments are complying with the requirements in place.
- Changes in the structure of the facilities department has meant budget responsibilities have been clarified to ensure that goods and services are charged to the correct budget.

2.4 We note that one recommendation, in relation to the requirement to update the notes tab and attach supporting documents to the Oracle procurement system for retrospective orders, is no longer applicable. We have confirmed that alternative mitigating controls have been introduced.

Appendix A: Management Action Plan

Previous Matter Arising 2: Use of retrospective orders (Operation)		
Our original audit identified a number of issues regarding the raising of retrospective orders that included failure to comply with approved guidance in place, not utilising call off / open orders, retrospective orders being raised inappropriately and lack of evidence to support the need for a retrospective order.		
Previous Recommendations		Previous Priority
2.2a	Management should continue to work with Procurement to review arrangements with suppliers where large numbers of retrospective orders continue to be used, with a view to using 'call off / open' orders instead (where practicable).	**Medium**
2.2b	In liaison with Procurement, clear guidance should be developed for when it may be acceptable to use 'call off / open' orders and the process staff need to follow to ensure appropriate controls are in place. The FCP should be updated accordingly.	
2.3	Management should clarify the access arrangements to the notes section in Oracle for requisitioning staff, in order for information to be captured on why a retrospective order has been used.	**Medium**
2.4	Management should remind staff of the requirement that documentation to support all orders should be retained. Consideration should be given to including information on the retention of documentation to support orders on the action cards. This information should align to any relevant information contained in the FCPs.	**High**

Previous Management Response		Target Date	Responsible Officer
2.2a	We will continue to work closely with Finance and Procurement colleagues to identify further opportunities for using call off orders instead of retrospective orders.	20/02/24	Wayne Lewis – Head of Technical Services
2.2b	We have developed and issued a new action card to remind staff of their responsibilities for attaching supporting information/documentation in respect to open/call orders and to provide information on the retention of information/documentation to support orders.		Jill Venables – Divisional Director of Facilities

	Although information cards have been designed there is no evidence that the cards are utilised and adhered to. A monitoring procedure will be added to Facilities Key Performance Indicators and will be monitored monthly.		
2.3	We have developed and issued a new action card to remind staff on how to access the notes section on Oracle reminding them of their responsibilities in relation to attaching and entering supporting information in respect of retrospective orders and providing the rationale for raising a retrospective order. Although staff have been advised, no monitoring has taken place. There is therefore no evidence that the procedures are being followed. This procedure will be added to the Facilities Key Performance Indicators and will be monitored monthly.	Completed 20/02/24	Wayne Lewis – Head of Technical Services Jill Venables – Divisional Director of Facilities
2.4	We have reminded staff of their responsibilities in relation to the requirement that supporting documentation to support all orders should be retained. Further work is required. These procedures require monitoring monthly to ensure compliance. All procedures will be added to the Facilities Key Performance Indicators and will be monitored monthly. An Action Plan Tracker will follow this report which will include specific actions, accountability and completion dates. The Tracker will be submitted in November 2023.	20/02/24	Wayne Lewis – Head of Technical Services Jill Venables – Divisional Director of Facilities Jill Venables – Divisional Director of Facilities
Current findings			**Residual Risk**
2.2a	Management have continued to work with Procurement colleagues to identify suppliers where there were high numbers of retrospective orders. Our analysis of data from April to June 2024 has established that improvements have been made, and there is a reduction in the percentage of orders being raised retrospectively. When the audit was first undertaken in 2021/22 the percentage of retrospective orders being raised was 20%. At the time of this follow up review the percentage had reduced to 9%. We undertook testing on a small sample of retrospective orders raised during the first three months of 2024/25 to assess their appropriateness. Of the five orders that we tested, one appeared to be inappropriate as an order should have been raised in advance. The matter was discussed with management who agreed with our finding.		N/A

	The Divisional Director of Facilities has again written to all Facilities department managers reminding them that retrospective orders should not be used. Furthermore, from our review of a sample of suppliers where retrospective orders had been raised, we note that for many of these suppliers, call off / open orders had since been raised for further costs that will be incurred during the year. **Conclusion:**. Action has been taken in line with recommendation and management response. We consider this agreed action of the matter arising to be **implemented.**	
2.2b	The department have developed a number of action cards setting out processes to be followed for purchasing goods and services. Action card 7 specifically outlines the process for raising purchase orders whether in advance or retrospectively. Our review of the action card identified that it does not explicitly include guidance for staff to follow with regards to recording why an order has been raised retrospectively, and also the requirement for retaining supporting documentation (including quotes) and ensuring that it is accessible. In addition to action cards, Financial Control Procedure (FCP) 13 relates to the Requisition of Goods and Services. Whilst the FCP has not been updated since our original audit, we are aware it is under review and finance colleagues have been made are aware of the concern that it does not contain information regarding the of the use of call / off open orders. **Conclusion:**. Work has been undertaken to implement action cards, though some further enhancements are needed. We consider this element of the matter arising to be **partially implemented.**	Incomplete audit trail to support the use of retrospective orders. Inconsistent approaches to ordering goods and services.
2.3	Following discussion with the Divisional Director of Facilities we agreed that the recommendation regarding updating the notes tab within Oracle to outline why a retrospective order was needed, was not practical. Instead, staff record the reason for raising the retrospective order when the requisition is generated. This reason will then be recorded on the order when it is generated. Management considers this to be a more practical solution. As we note in 2.2b, the relevant action card should be enhanced to include guidance in relation to this revised process. **Conclusion:** Whilst our recommendation has not been implemented, alternative action has been taken. As such, we consider this matter arising as **superseded.** The residual aspect in relation to updating the action card has been reported under 2.2.	N/A
2.4	Following discussion with the Divisional Director of Facilities we note that attaching copies of supporting documentation within Oracle is not practical, instead documentation will be retained within the department. We	N/A

	undertook testing in relation to sample of orders where it was believed quotes were needed. In all cases management were able to provide the required supporting information, which is an indication that Department Heads are ensuring that documentation is saved and filed for future access. As we note above, at the time of our fieldwork, action card 7 did not contain detailed information in relation to the retention of supporting documentation. **Conclusion:** Whilst our recommendation has not been implemented, alternative action has been taken. As such we consider this matter arising as **superseded**, with the residual aspect in relation to updating the action card reported under 2.2.	
New Recommendation		**Priority**
2.2	The action cards developed by Facilities could be enhanced to include: • the requirement for staff to record the reasons for the retrospective order within the 'description' box when raising the requisition. • the requirement for approving managers to file/save any relevant supporting documentation, including evidence of quotes, appropriately and in a location that can be accessed by other members of the department.	**Low**

Management Response		**Target Date**	**Responsible Officer**
2.2	The need to update the action cards to reflect the process to be followed for retrospective orders is no longer required due to changes in operating practices: • Staff have been informed that they are not permitted to place retrospective orders. Retrospective orders will only be placed in an emergency (outbreak etc.) Only the Director of Facilities or the Performance and Governance Lead, in the absence of the Director, can place a retrospective order, and only in an emergency. Supporting documentation will be given when raising the requisition and the Executive Director of Finance will be informed. • The facilities directorate is currently going through a re-structure. A Band 5 procurement manager will be recruited to manage all orders and procurement issues. Unit managers will place orders with the procurement manager. The	N/A	N/A

	procurement manager will place all orders on the system/ Catalogue and Oracle. This will negate the need for others to raise orders. **Audit comment:** We acknowledge the revised approach mitigates against the potential risk.		

Previous Matter Arising 4: Monitoring compliance with the No PO No Pay process (Operation)			
Our previous audit work identified that supplementary reports and support was being provided by procurement in relation to invoices on hold reports.			
Follow Up Recommendation			Previous Priority
4	The level of ongoing additional support provided by procurement to Facilities should be reviewed with an aim to reducing it over time as more Facilities staff complete training. Facilities staff should remind suppliers that queries should be directed through 'Action Point' in the first instance, and not directly with the department.		**Medium**
Previous Management Response		Target Date	Responsible Officer
4	We have requested the reinstatement of the 'invoices on hold' reports with an agreed frequency from procurement. Reports are generated and distributed.	07/10/23	Wayne Lewis – Head of Technical Services
Current findings			**Residual Risk**
4	We were advised that due to resource issues, the Procurement Department have been unable to issue 'invoices on hold' (IOH) reports to departments for a number of months. As such, Facilities Management were not aware of any significant issues regarding invoices on hold. However, as part of our fieldwork we obtained a copy of the latest IOH report for Facilities. Our review of the report identified over 1,600 'holds' listed. While 88% of the 'holds' were made in 2024, approximately 50 invoices had been on hold since 2022. **Conclusion:** Invoice on hold reports are not routinely received by the Facilities department, meaning action is not proactively taken to resolve issues. We consider this recommendation to be **not implemented**.		Delay in Health Board paying suppliers on time.
New Recommendations			**Priority**
4	Management should liaise with the Procurement Department resume the regular receipt of the Invoices on Hold reports. Once received it should be ensured that queries are reviewed and resolved as soon as possible.		**Medium**

Management Response		Target Date	Responsible Officer
4	Liaison with the procurement department takes place during monthly SLT meetings and Facilities & Procurement Compliance meetings. We have raised the lack of receipt of invoice on hold reports with the procurement lead. This data will now be provided monthly to the Performance Governance lead who will disseminate the relevant parts of the report to the various facilities departments. The department leads will be present at the Facilities & Procurement Compliance meetings where there will be scrutiny of the reports and managers held to account on the actions they have taken to resolve the hold issues. The SLT meetings will have a higher-level overview of facilities as a whole, but focus on hotspot departments if required. The first SLT meeting where invoice on hold data will be presented is due to take place on 03/10/24. At the current time there are just over 1,000 invoices on hold that the facilities team are responsible for actioning. Nearly 200 of these relate to a specific supplier that we intentionally put on hold due to hygiene risks and concerns with quality of supply.	October 2024	Performance Governance lead

Appendix B: Previous Matters Arising Now Closed

Previous Matter Arising 1: Procurement Process Training (Operation)		
Follow Up Recommendation		Original Priority
Management should ensure that staff who are yet to attend training sessions identified as a requirement for their role, do so as soon as practicable.		**Medium**
Management Response	Target Date	Responsible Officer
A change in the Facilities Structure was implemented in September 2023. The hub and non-hub services have now merged into one service. The ILG Service Managers are no longer accountable for Facilities services. Leadership is new and facilities services are under review. Training records will be amalgamated. Any employees who have missed the training will receive the recommended training. A total of 77% have completed Qlik Finance system training and 66% have completed P2P Procurement training. Further training will be arranged.	20/02/24	Claire Masters – Quality Assurance, Performance and Compliance Jill Venables – Divisional Director of Facilities
Current findings		
A central record is in place for all Facilities staff that notes training requirements and when training is undertaken. The record is reviewed regularly, and action taken where it is identified that staff have not attended the required training. The record shows that 95% (74/78) of required staff have completed P2P Procurement training.		
Conclusion		
Additional training has been provided and compliance continues to be monitored. We consider this matter arising to be **implemented**.		

Previous Matter Arising 3: Invoices requiring competitive quotations (Operation)		
Previous Recommendation		Previous Priority
Management should ensure that staff are reminded that documentation to support all orders, including the evidence of quotes, is retained and accessible. Management should ensure that staff who have not had refresher training, receive this as soon as practically possible. Management should also consider enhancing the action card prompts that have been developed to remind staff of the quotes and tender thresholds, while ensuring they align to FCPs.		**Medium**
Previous Management Response	Target Date	Responsible Officer
We have reminded staff that documentation to support all orders, including the evidence of quotes, is retained and accessible. We have developed and issued an action card reminding staff and management of the guidance in relation to the requirement of obtaining three quotes where expenditure for the goods and services to be procured will exceed £5k, or where tenders are required.	Completed	Wayne Lewis – Head of Technical Services
Current findings		
A series of action cards have been developed. 'Action Card 9: Obtaining a Quote' sets out specific guidance that Facilities staff must follow where expenditure will exceed £5k. The guidance is in line with the information detailed in Financial Control Procedure 13 Requisitioning of Goods and Services. We tested a sample of orders/invoices where expenditure exceeded £5k. The results of our testing confirmed that, when applicable, the guidance had been complied with.		
Conclusion		
Action cards are in place to guide staff and testing confirmed adherence to the required process. We consider this matter arising to be **implemented**.		

Previous Matter Arising 5: Budget holder training (Operation)		
Previous Recommendation		Previous Priority
Management to ensure that outstanding staff receive QlikView training as soon as practicable.		**Low**
Previous Management Response	Target Date	Responsible Officer
Additional training sessions will be arranged with Finance colleagues to ensure that the staff who require the training receive it and training records are updated accordingly.	07/10/2023	Claire Masters – Quality Assurance, Performance and Compliance.
Current findings		
A central record in place for facilities staff that notes training requirements and when training is undertaken. The record is reviewed regularly, and action taken where it is identified that staff have not attended the required training. The record shows that 88% (22/25) of required staff have completed QlikView finance training.		
Conclusion		
Additional training has been provided and compliance continues to be monitored. We consider this matter arising to be **implemented**.		

Previous Matter Arising 6: Areas of responsibility (Operation)		
Previous Recommendation		Previous Priority
Management should review and clarify purchasing and budgetary arrangements and responsibilities for Central Facilities Hub and ensure that they align to the Health Board's revised Operational Structure.		**High**
Previous Management Response	Target Date	Responsible Officer
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 areas are significantly overspent. Further control measures need to be determined, implemented and monitored.	03/10/2023	Jill Venables – Divisional Director of Facilities
Current findings		
The budgetary responsibility for facilities is now more clearly defined. The Divisional Director of Facilities has overall budgetary responsibility and delegated budget managers have responsibility for individual departments. There is a hierarchy in place for the approval of expenditure/requisitions that is in line with budgetary responsibility and the delegated limits for approvers are in line with the Health Board's Scheme of Delegation.		
Conclusion		
Budget responsibilities are clearly set out. We consider this matter arising to be **implemented**.		

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

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

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

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

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

Date issued: October 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.	We are scheduled to present the Audit of Accounts Addendum Report to the Audit and Risk Committee on 17 October.	October 2024
Audit of the 2023-24 Charitable	Executive Director of Finance	To provide an audit opinion on the 2023-24	We are scheduled to commence the audit in November 2024.	Certification is scheduled for January 2025.

Funds Annual Report and Accounts		Annual Report and Accounts.		

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	December 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	Part 2 – Fieldwork Underway	December 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		of patients from hospital to help improve patient flow (Part 1). We are also reviewing progress being made in managing unscheduled care demand by helping patients access 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	December 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	December 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
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 care, meet demand, and improve productivity and efficiency.	Scoping	To be confirmed
All-Wales thematic review of planned care	Chief Operating Officer	This work follows on from the national report on tackling the planned care backlog 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

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
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.	Fieldwork underway	December 2024
Review of Eye Care Services	Chief Operating Officer	This work will assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs. The work will also seek an update from the Health Board on its progress in addressing previous audit recommendations arising from the review of follow up outpatient appointments, particularly in the context of ophthalmology patients.	Scoping	To be confirmed

Other relevant publications

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

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

Title	Publication Date
NHS Wales Data tool and press release	August 2024
Community Pharmacy Data Matching Pilot	May 2024

Additional information

7 We have published our proposed fee scales for 2025-26 as part of a consultation that concluded in September 2024. The fee scales proposed an uplift of 1.8% on average across Wales.

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