Audit & Risk Committee

Thu 22 February 2024, 10:15 - 12:15

Virtual Via Teams

Agenda

10:15 - 10:20
5 min

1. PRELIMINARY MATTERS

Information

1.1. Welcome & Introductions

Patsy Roseblade, Chair

1.2. Apologies for Absence

Information *Patsy Roseblade, Chair*

1.3. Declarations of Interest

Information *Patsy Roseblade, Chair*

10:20 - 10:25
5 min

2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes of the Meeting held on 19 December 2024

Decision *Patsy Roseblade, Chair*

2.1.1 Unconfirmed Minutes 19.12.23 ARC 22 February 2024 v3.pdf (13 pages)

2.1.2. Unconfirmed Minutes from the In Committee Meeting held on 19 December 2023

Decision *Patsy Roseblade, Chai*

2.1.2 Unconfirmed IC Minutes 19.12.23 ARC 22 February 2024.pdf (3 pages)

2.1.3. Audit & Risk Committee Annual Cycle of Business 2024-25

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

2.1.3a Annual Cycle of Business Cover Report ARC 22 February 2024.pdf (4 pages)
2.1.3b Appendix 1 - Annual Cycle of Business ARC 22 February 2024.pdf (4 pages)

2.2. FOR NOTING

2.2.1. Annual Committee Self Effectiveness Survey Outcome & Improvement Plan

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

Deferred - This item will now be received at the April 2024 meeting

2.2.2. Committee Forward Work Plan

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

2.2.2 Audit & Risk Committee Forward Work Plan ARC 22 February 2024.pdf (2 pages)

10:25 - 10:30
5 min

3. MAIN AGENDA

3.1. Audit & Risk Committee Action Log

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

- 3.1 Audit & Risk Committee Action Log ARC 22 February 2024.pdf (4 pages)

3.2. Matters Arising not contained within the Action Log

Discussion *Patsy Roseblade, Chair*

10:30 - 11:15
45 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

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

- 4.1a Local Counter Fraud Update Report ARC 22 February 2024.pdf (3 pages)
- 4.1b Local Counter Fraud Update Report ARC 22 February 2024.pdf (3 pages)
- 4.1c Appendix 1 - Proactive Exercise Report - Impersonating a Medical Practitioner.pdf (11 pages)
- 4.1d Appendix 2 -Counter Fraud Investigations Update ARC 22 February 2024.pdf (13 pages)

4.1.1. National Fraud Initiatives Progress and Outcomes

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

- 4.1.1 National Fraud Initiative Progress and Outcomes ARC 22 February 2024.pdf (6 pages)

4.2. Procurements & Scheme of Delegation Report

Discussion *Sally May, Executive Director of Finance & Procurement*

- 4.2 Procurement and Scheme of Delegation ARC 22 February 2024.pdf (10 pages)

4.3. Losses and Special Payments Report

Discussion *Sally May, Executive Director of Finance & Procurement*

- 4.3 Losses Special Payments Report to Dec 2023 ARC 22 February 2024.docx (9 pages)
- 4.3a Losses and special payments Report Appendices Dec 23 ARC 22 February 2024.xlsx (9 pages)

4.4. National Commissioning review and the establishment of the new NHS Wales Joint Commissioning Committee - Progress Report

Discussion *Samia Edmonds, Programme Manager*

- 4.4a Progress on Establishing the NHS Wales Joint Commissioning Committee ARC 22 February 2024.pdf (6 pages)
- 4.4b NCP Risk Log v8 15 02 24 ARC 22 February 2024.pdf (13 pages)

11:15 - 12:00
45 min

5. IMPROVING CARE

5.1. Organisational Risk Register

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

- 5.1a - Org Risk Register Cover Paper - ARC 22 February 2024.docx (8 pages)
- 5.1b - App 1 - Org RR Jan 24 - ARC 22 February 2024.xlsx (9 pages)

5.2. Audit Recommendations Tracker

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

- 5.2a Audit Recommendations Tracker Cover Report ARC February 2024 - V5.docx (7 pages)
- 5.2b App 1-Audit & Risk Committee 22.02.2024_Audit Trackers_Final v3.xlsx (37 pages)

5.3. INTERNAL AUDIT

5.3.1. Internal Audit Progress Report

Discussion *Paul Dalton, Head of Internal Audit*

- 5.3.1 IA CTM -Progress report 22 February 2024.pdf (10 pages)

5.3.2. IA report - 4 Hour Emergency Department Performance Reporting (Limited)

Discussion *Internal Audit*

- 5.3.2 IA report - 4 Hour Emergency Department Performance Reporting (Limited) ARC 22 February 2024.pdf (26 pages)

5.3.3. IA Report - IT Service Management

Discussion *Internal Audit*

- 5.3.3 IT Service Management - IA Final Report ARC 22 February 2024.pdf (19 pages)

5.3.4. IA Report - Facilities Governance follow up - Progress Update on Action Plan

Discussion *Gethin Hughes, Chief Operating Officer*

- 5.3.4a Facilities Governance Follow Up Review ARC 22 February 2024final.docx (4 pages)
- 5.3.4b Facilities Governance Follow Up Audit Tracker ARC 22 February 2024.xlsx (11 pages)

5.4. AUDIT WALES

5.4.1. Audit Wales Audit & Risk Committee Update

Discussion *Sara Utley, Audit Wales*

- 5.4.1 CTMUHB February 2024 AW Audit Update ARC 22 February 2024.pdf (12 pages)

5.4.2. Annual Audit Report 2023

Information *Audit Wales*

- 5.4.2 Annual Audit Report 2023 ARC 22 February 2024.pdf (26 pages)

5.4.3. Audit Wales Letter - NHS – Audit of Accounts 2023-24 and Fees

Information *Audit Wales*

- 5.4.3 Audit Wales Letter - NHS – Audit of Accounts 2023-24 and Fees (W) ARC 22 February 2024 (2).pdf (10 pages)
- 5.4.3a Audit Wales Letter - NHS – Audit of Accounts 2023-24 and Fees (E) ARC 22 February 2024.pdf (10 pages)

12:00 - 12:10
10 min

6. CLOSE OF BUSINESS

Patsy Roseblade, Chair

6.1. Any Other Urgent Business

Discussion *Patsy Roseblade, Chair*

6.2. How Did we do in this Meeting

Discussion *Patsy Roseblade, Chair*

6.3. Highlight Report to Board

Discussion *Patsy Roseblade, Chair*

12:10 - 12:15
5 min

7. PRIVATE/IN COMMITTEE SESSION

Information *Patsy Roseblade, Chair*

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

- Organisational Risk Register - Business Sensitive Risks
- Financial Control Procedure - Medical Variable Pay Reports - Summary of Authorised Breaches
- Audit Recommendations Tracker

12:15 - 12:15
0 min

8. DATE AND TIME OF NEXT MEETING - THURSDAY 18 APRIL 2024 AT 2:30PM

Agenda Item Number:

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

Audit and Risk Committee held on 19 December 2023 as a virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Sally May	Executive Director of Finance & Procurement
Dom Hurford	Executive Medical Director
Paul Dalton	NWSSP- Internal Audit & Assurance
Emma Samways	NWSSP- Internal Audit & Assurance
Eifion Jones	NWSSP- Internal Audit & Assurance
Matthew Evans	Head of Local Counter Fraud Services
Mark Jones	Audit Wales
Sara Utley	Audit Wales
Darren Griffiths	Audit Wales
Owen James	Head of Corporate Finance
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Head of Corporate Governance & Board Business
Claire Brown	Head of Quality Assurance and Compliance (Observing)
Kelly Eddington	Quality Assurance & Compliance Officer (Observing)
Kathrine Davies	Corporate Governance Manager (Secretariat)

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

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

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

1.2 Apologies for Absence

Apologies have been received from:

- Gareth Watts, Director of Corporate Governance/Board Secretary
- Carolyn Donoghue, Independent Member
- Geraint Hopkins, Independent Member

1.3 Declarations of Interest

There were no interests to declare.

2. CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on 24 October 2023

The Chair apologised to Members that the minutes were late being published which was due to a query in relation to the wording in respect of the JAG accreditation and endoscopy waiting time issues. The Chair advised that the minute would be amended to reflect that at the last meeting it had been requested that the JAG Accreditation would be taken to the Quality & Safety Committee with regard to the quality & safety aspect and for assurance purposes, the Audit & Risk Committee would receive a further report at their meeting to be held in June 2024 if Members were content.

Resolution: The Minutes were **APPROVED** subject to the above amendment.

2.1.2 Unconfirmed Minutes of the In Committee Meeting held on 24 October 2023

Resolution: The Minutes were **APPROVED.**

2.2 FOR NOTING

2.2.1 Audit & Risk Committee Annual Cycle of Business 2024-25

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

2.2.2 Audit & Risk Committee Forward Work Programme

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

2.2.3 Declarations of Interest and Gifts & Hospitality Report

Resolution The Declarations of Interest and Gifts Hospitality Report was **NOTED.**

2.2.4 Clinical Audit Report

Resolution The Clinical Audit Report was **NOTED.**

3. MAIN AGENDA

3.1 Audit & Risk Committee Action Log

The Committee reviewed the Action Log and noted the following updates:

C. Hamblyn referred to Action 5.2.3 Medical Rostering Report and advised that an update would be provided under agenda item 5.2.3 Medical Rostering.

C. Hamblyn referred to Action 4.1.1 National Fraud Initiative Progress and Outcomes, and informed the Committee that a Bi-Annual Update would be presented to the February 2024 meeting.

P. Roseblade referred to responses to be taken outside of the meeting via email and advised that it would be helpful if there was a robust process of monitoring these and suggested that they could be kept on Admin Control in order that Members could refresh their memories, if required. C. Hamblyn advised that the Corporate Governance Team do keep a log within their files but agreed that the Team would be happy to do this moving forward for future meetings if everyone was in agreement.

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

Action: Transfer any email responses taken outside of Committee to Admin Control for future meetings.

3.2 Matters Arising not Contained within the Action Log

There were no matters arising.

4. SUSTAINING OUR FUTURE

4.1 Local Counter Fraud Report

M. Evans presented Members with the report and provided detail on tasks and actions undertaken with the four strategic counter fraud work areas.

K. Palmer queried how the Health Board were performing in terms of the data. M. Evans advised that the Health Board were about average in comparison to other Health Boards and performing well in areas around

risk and pro-active work, which was a good position to be in following the Covid pandemic.

I. Wells referred to the case referral rate which was increasing yearly with a big increase being seen in 2023 and queried if there was any reason for this. M. Evans advised that they were seeing a trend in cases coming in across Wales and added that there had been a decrease in 2021 which then led to a recovery of referral figures in 2022. M Evans advised that it was also important to note that with the average across Wales some of the smaller organisations had high figures as well and added that he was happy to explore some benchmarking around this.

S. May, in response, advised that the higher referral rate was positive, in that it suggested that we are promoting a fraud aware culture.

The Chair referred to page 3 of the report and an issue involving overlapping shifts and queried whether the report that would be presented to the February 2024 meeting would include an indication of whether those shifts were paid for twice. M. Evans advised that the Team were reviewing the data and trying to collate all of this together across Health Boards to ensure that the shifts had been verified with National Insurance numbers.

M. Evans advised that a large proportion of those shifts had not been filtered out and had not been paid which could be due to agencies not keeping accurate records. The Team were currently confirming the invoices of who had been paid and would provide further information and clarity with regard to this for the February 2024 meeting.

The Chair, in response to the above, queried if any patient harm had occurred as a result of someone working within the Health Board who did not have the required experience or qualifications and whether Workforce had improved their processes and procedures so that this was far less likely to occur in the future. M. Evans advised that he was not aware of any patient harm with regard to this particular case and that the Team would have been made aware of any patient harm issues, if any, as part of the investigation.

The Chair referred to the overpayment of prescriptions and asked if the Post Payment Verification team had been part of this work. M. Evans advised that both Post Payment Verification and Counter Fraud Services Wales were both involved in the investigations.

Resolution:

The report was **NOTED.**

4.2 **Procurement & Scheme of Delegation Report**

S. May presented Members with the report and highlighted the position on procurement matters for the period 01.10.23 to 30.11.23, and provided an update regarding Purchase to Pay and achievement of the Public Sector Payment Policy target to the end of October 2023.

The Chair referred to the graph on page 6 and commented that it was pleasing to see the work that had been undertaken in relation to the reduction in no Purchase Order (PO) no pay invoices on hold.

Resolution — The Committee **NOTED** the report and **ENDORSED** the Updated Scheme of Delegation for **BOARD APPROVAL.**

4.3 Losses and Special Payments Report

S. May presented Members with the report that provided an update to the Committee on the Losses and Special Payments made by the Health Board for the period 1 August 2023 to 31 October 2023.

The Chair referred to the GP Indemnity and queried whether there was any indication that Welsh Government would continue to fully fund this. S. May advised that they had not received any indication on this at the present time.

D. Hurford, in response to the above, advised that they were continuing to do this in England and did not envisage this being a problem. He added that this was a UK wide issue.

Resolution — The Committee:

NOTED the losses and special payments made for the period 1 August 2023 to 31 October 2023, and;

NOTED the increase in the Medical Negligence provision due to increase in number and value of claims highlighted in Table 1 of the report and the consequent overspend on net claim expenditure and the impact of this on the in-year revenue position

5. IMPROVING CARE

5.1 Organisational Risk Register

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

The Chair advised that K. Palmer had raised a question in advance of the meeting which was as follows:

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

The response was as follows:

I have attached the report which was presented to the Improving Care Board on the 18 October 2023 and the Creating Health Board on the 5 December 2023 for your information. Both Strategy Boards have provided approval and support to progress to Full Business Case and we are aiming to work this up by the end of January 2024. I would be more than happy to pick up a conversation around the need for the children's weight management service with you and get your advice/support for the Business Case.

The Chair sought confirmation that K. Palmer was happy with the response and that it had been confirmed that this would be considered as part of the planning process for 2024. K. Palmer confirmed that she was content with the response, however, was surprised that there was not a service for young people and children and a prioritisation question that required consideration.

K. Palmer referred to the risk training and queried how many staff were being trained and intended to be trained in the future. C. Hamblyn advised that this was not part of the statutory and mandatory training, but sessions targeted for all staff who undertake risk assessments and in terms of priority they were focusing on the Care Groups where the risks were not as robust.

C. Hamblyn confirmed that they were getting a good mix of attendance from clinical and non-clinical staff and were carrying out specific targeted sessions, for example, Accident and Emergency. She added that they did also rely on intelligence with colleagues to help target key staff.

The Chair referred to paragraph 3.2 and the changes to the risk on Emergency Department overcrowding and commented that the Committee had previously had this discussion but it was important to keep this valid and perhaps a different way in approaching issues was required.

The Chair commented that it was pleasing to see the increases in improvements with mitigations and actions and that it was clear to see the significant amount of work that had been undertaken in comparison to previous years and thanked the team for their work. C. Hamblyn confirmed that she would feed this back and added that it was important to note that the amount of risk interaction on a daily basis was now completely different to a couple of years ago.

Resolution: The Committee **NOTED** the report.

5.2 Audit Recommendations Tracker

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

K. Palmer made some observations on the report and referred to the outstanding actions that were overdue and queried whether they had been reviewed and assessed for any common themes and trends. She commented that some of the dates were optimistic and referred to the Patient Pathway action which was due to be completed by January 2024 and the Facilities Central Hub overspend and also advised that were no reference numbers on the Tracker so it was difficult to cross reference.

In response, C. Hamblyn advised that the team were reviewing the Tracker and looking to implement a new system which included looking at themes and trends and formatting in terms of referencing and this would be picked up on the next item on the agenda on the Audit Tracker Automation Update.

K. Palmer queried if the review would pick up on the question she had raised on the dates and whether people actually did own their recommendations and dates. S. May advised that there had been some push back from Teams in terms of some of the recommendations and how clearly they were being framed. She added that usually they were quite wide ranging actions, however, it was felt that Internal Audit could be more specific on the actions which would discussed further with Internal Audit colleagues

In response, C. Hamblyn advised that the Team were looking to develop this and had linked in with Internal and External Audit colleagues to ensure recommendations being made were more specific and provided further clarity.

S. Utley confirmed that Audit Wales held regular meetings with the team to go through outstanding recommendations which included a cleansing process, a sense check and discussions on timescales and this was quite similar across all Health Boards.

E. Samways advised that Internal Audit always request Managers to be realistic in terms of target dates and they were trying to educate them with regard to setting sensible timeframes.

S May followed up on K. Palmer's comments relating to the Facilities Central Hub overspend and provided assurance that they had been subjected to a number of targeted audits and there was now refreshed leadership in place within the department. She advised that the over spend was starting to decrease and was moving in the right direction. She highlighted that it had also been agreed at the October 2023 ARC meeting that a clear update on progress against recommendations would be provided by the Service Director at the February 2024 meeting.

I Wells referred to the table on page 3 of the report where he had observed that there were a number of implementation dates which had now passed with not many actions on target, and queried whether there was a reason

for this. S. May advised that from a finance perspective, it included some of the capital areas, the vast majority of which were with regard to Sunnyside which had been temporarily put on hold as a project. S. May confirmed that Sunnyside had now had the funding confirmed and that progress should start to improve.

E. Walters confirmed that she had received a late update to the Tracker from Procurement on the recommendations and would add this to the Tracker and re-upload for Members to review progress.

K. Palmer referred back to the Patient Pathway Limited Audit Assurance Audit which had a number of outstanding actions and sought assurance that the deadline of January 2024 would be met. C. Hamblyn advised that if actions were not being met and Members were not sufficiently assured the relevant Executive Lead could be asked to attend to provide further assurance.

In response, E. Samways advised that they would be following up on this Audit at their meeting with the Team tomorrow and a further audit report would be presented to the Committee in the new year on whether those recommendations would be met.

The Chair confirmed the process with Internal Audit reports and confirmed that if there were two subsequent 'Limited' audit reports the Committee would ask that the responsible Executive Lead attends the Committee to provide assurance.

P. Dalton suggested that he would be happy to discuss and explain the processes with K. Palmer as a new member of the Committee outside the meeting

Resolution:

The Committee **NOTED** the report and the assurances provided particularly in relation to closed recommendations.

Action:

To re-upload the updated Audit Tracker to Admin Control for Members to review.

5.3 Audit Tracker Automation Update – Verbal Update

C. Hamblyn provided a verbal update on the work being undertaken by the newly appointed Quality and Assurance team with regard to the changes being implemented to the Audit Tracker.

C. Hamblyn advised that the team were looking at an automated system rather than the current manual system for the audit tracker recommendations. She advised that all inspections had been inputted into the system and that the Team were also developing a dashboard for the Committee with themes and trends and taking on board feedback from the Committee which would be shared for comment once developed.

P. Dalton offered his support and advised he would be happy to meet with the Quality and Assurance Team if they so wished.

The Chair commented that it was good that the team were observing the meeting today so they could see the scrutiny that had taken place.

Resolution: The Committee **NOTED** the verbal update.

5.2.2 Consultant Job Planning

D. Hurford provided the Audit & Risk Committee with an update on the progress in relation to job planning.

The Chair referred to the non-consultant rate card and queried whether that reached the Welsh Government cap. D. Hurford confirmed that it did and that it also matched the Aneurin Bevan UHB rate card which was above the Welsh Government card. He advised that there were also plans to put in place a National rate card which had not been implemented as yet.

Resolution**:** The report was **NOTED.**

5.2.3 Medical Rostering Progress Report

D. Hurford presented the report that provided an update to the Committee on the progress achieved in relation to the audit report on Medical Rostering.

The Chair referred to the health roster system and queried whether there were any implications for the Workforce Team in regards to using different systems. D. Hurford advised that previously some Emergency Departments used different systems, however, now that the Care Groups were in place and moving specialties across the Emergency Departments they were being managed in the same way and was less of an issue. He added that there were specific reasons for pushing for annualised sessions which were much easier to manage than the health roster system.

The Chair queried whether the rostering systems purchased involved anaesthetics. D. Hurford advised that he would have to look into this and respond back outside of the meeting.

Resolution: The report was **NOTED.**

Action: To review whether the rostering systems purchased involved anaesthetics outside of the meeting.

5.3 INTERNAL AUDIT

5.3.1 Internal Audit Progress Report

P. Dalton presented Members with the report that provided the Committee with the current position of the work undertaken by Internal Audit as at 11 December 2023.

K. Palmer sought assurance as to whether Internal Audit were confident that they would achieve completion of the audits by the end of the year. P. Dalton advised that the Team were aiming to, however, he advised that the position could change as the year progresses.

The Chair commented that the report turnaround was currently at 56%, which was an improvement compared to what was reported previously at the Health Board meeting in November 2023.

C. Hamblyn advised that the Compliance and Assurance team would be closely monitoring the timely submission of management responses. She also advised that the Team were developing a Governance Dashboard that would be presented to the Executive Leadership Group weekly to highlight the timeliness of management response submissions to help focus on improvement.

The reported was **NOTED.**

Resolution:

5.3.2 Internal Audit Review – Arrangements for Financial Savings 2022/2023

P. Dalton presented Members with the report and highlighted assurance that there were effective arrangements in place to support the achievement of the 2023/24 savings targets, including work carried out as part of the value and effectiveness enabling schemes.

The Committee were advised that the report was split into three components in terms of assurance which was as follows:

- Centralised processes for determining savings targets, disseminating and monitoring – Substantial assurance
- Care Group processes for allocating targets, identifying, planning and monitoring schemes – Limited assurance
- Enabling schemes governance structures, work plans and monitoring arrangements – Reasonable assurance;

K. Palmer sought an update on progress with the Care Groups in identifying savings. S. May advised that at Month 8 the health board were forecasting breakeven and some of that included the improved positions within the Care Groups and other elements in relation to centrally retained funds and an improvement towards the bottom line. She added that there was still a significant way to go and confirmed that there was a planned national audit by Audit Wales on cost efficiencies due to commence this week.

The Chair referred to recommendation 1 on the audit which was deemed as low priority and had been challenged by the responsible officer, and queried where this would sit on the audit tracker moving forward. P. Dalton advised that with regard to this audit they had talked about engagement

with the team and was a good example of where they had undertaken deep dives into this matter. He added that it had been quite a challenging audit and the narrative stated that these were areas for management consideration only and added that he would not expect for the recommendations to be entered on to the audit tracker.

The Committee discussed this matter and were assured with the response and due to no action being required from the team agreed that the Audit recommendation would not be entered onto the audit tracker.

C. Hamblyn suggested that a section could be added to Internal Audit reports to identify a simple yes or no to whether the review needed to be added to the tracker and a section for audit to comment. P. Dalton advised that they did previously have something similar to this where they would an audit comment in to state that they were happy with the action suggested by management.

Resolution The Committee **NOTED** the report.

5.3.3 Internal Audit Review – Deprivation of Liberty Safeguards

E. Samways presented the Deprivation of Liberty Safeguards (DoLS) Final Report that had received a Reasonable assurance rating.

Resolution The report was **NOTED.**

5.3.4 Internal Audit Review PCH Quality – Site Supervisor Role

E. Jones presented the PCH Redevelopment Programme Final Report that had received a Substantial assurance rating.

Resolution The report was **NOTED.**

5.3.5 Internal Audit – PCH Validation of Management Actions

E. Jones presented the PCH Validation of Management Actions report that had received a substantial assurance rating.

Members were advised that all recommendations had now been completed and closed.

The Chair congratulated the team on completing the work to the satisfaction of Internal Audit and asked that her thanks on behalf of the Committee be relayed back to the team.

Resolution The report was **NOTED.**

5.4 AUDIT WALES

5.4.1 Audit Wales Audit & Risk Committee Update

S. Utley and M. Jones provided the Committee with an update on the current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.

Resolution

The report was **NOTED.**

5.4.2 **Structured Assessment 2023**

S. Utley presented the report that sets out the findings from the Auditor General's 2023 structured assessment work at Cwm Taf Morgannwg University Health Board.

S. Utley advised that the review overall had been really positive and demonstrated that the organisation had good planning arrangements in place and strength in its Executive leadership. The report had recognised the capacity issues within the Corporate Governance team, who despite of this, had continued to undertake 'business as usual' activities. She extended her thanks to the Health Board and the Governance Team for their support with this work.

K. Palmer congratulated everyone and commented that it demonstrated that there was a really good Executive team in place with a strong governance structure underneath it.

C. Hamblyn thanked Audit Wales for working with the Team on this and provided assurance to the Committee that this had gone through a robust clearance and would now be presented to the Public Board in January 2024. She advised that the management response had been agreed by each Executive lead, and that there were some January dates within it which could be implemented sooner due to additional capacity.

The Chair thanked the team and commented that the improvements visibly be seen considering the past history.

Resolution

The report was **NOTED.**

5.5 **Audit & Risk Committee Annual Self-Effectiveness Assessment – Verbal Update**

C. Hamblyn reminded members that the Committee Annual Self-Effectiveness Survey was now open and encouraged members to participate in the survey which would enable the Committee to reflect on how they were working and to take learning from the evaluation. She advised that this would be presented to the February 2024 meeting.

The Committee **NOTED** the update.

6. **CLOSE OUT BUSINESS**

6.1 **Any other Business**

There was no other business to report.

6.2 How did we do

The Committee Chair advised that if Committee Members had any comments to raise as to how the meeting went today, then they could share these with herself and the Head of Corporate Governance outside the meeting and in particular from K. Palmer as a new Member of the Committee and Quality and Assurance team who had been observing the meeting.

6.3 Highlight Report to Board

The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.

7. PRIVATE/IN COMMITTEE SESSION

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

- Cyber Security Risks
- Financial Control Procedure – Medical Variable Pay

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

Agenda Item Number: 2.1.2

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

Audit and Risk In Committee held on 19 December 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Dom Hurford	Medical Director
Sally May	Executive Director of Finance & Procurement
Paul Dalton	NWSSP- Internal Audit and Assurance
Emma Samways	NWSSP- Internal Audit and Assurance
Matthew Evans	All Wales Post Payment Verification Manager
Sara Utley	Audit Wales
Mark Jones	Audit Wales
Sally May	Executive Director of Finance & Procurement
Owen James	Head of Corporate Finance
Cally Hamblyn	Assistant Director of Governance and Risk
Kathrine Davies	Corporate Governance Manager (Secretariat)

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

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

1.2 Apologies for Absence

Apologies have been received from:

- Geraint Hopkins – Independent Member
- Gareth Watts – Director of Corporate Governance & Board Secretary

2. MAIN AGENDA

2.1 Financial Control Procedure – Medical Variable Pay – Summary of Authorised Breaches

D. Hurford presented the report that outlined the process for the monitoring, verification and payment of Additional Duty Hours and agency locum spend.

The report provided a summary of all authorised breaches for each Care Group relating to quarter 1 August – 31 October 2023 and provided a breakdown for each Care Group of the hourly rate and length of placement.

P. Roseblade referred to the summary of authorised breaches for medical variable pay and queried whether primary care was captured, particularly managed practices. D. Hurford advised that the practices were independent so were not captured. He advised that he could provide an update on the managed practices via the Care Group report to the next meeting.

Resolution: The Committee **NOTED** the report.

Action: To provide an update on the summary of the authorised breaches for medical variable pay with regard to the Primary Care managed practices for the February 2024 meeting via the Care Group Report.

2.2 Audit Wales – Audit of Accounts Addendum

M Jones presented the addendum to the Audit of Accounts Report that was presented to the Audit and Risk Committee on 26 July 2023. The report sets out the recommendations arising from the audit of the 2022-23 annual report and accounts and provided an update on the progress made against the last year's recommendations.

Resolution: The Committee **NOTED** the report

2.3 Organisational Risk Register – Cyber Security Risks

C Hamblyn presented the report drawing attention to the risks that were business sensitive and therefore captured within the private Committee session for discussion.

Resolution: The Committee **NOTED** the report.

3. ANY OTHER BUSINESS

There were no urgent matters raised.

4. DATE AND TIME OF NEXT MEETING THURSDAY 22 FEBRUARY 2024

Agenda Item
2.1.3

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
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 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	

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

5. Recommendation

5.1 The Audit & Risk Committee are asked to **APPROVE** the Annual Cycle of Business.

6. Next Steps

6.1 There are no next steps required.

Audit & Risk Committee

Cycle of Business

(1st January 2024 – 31st December 2024)

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

The Cycle of Business covers the period 1st January 2024 to 31st December 2024.

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

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

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

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

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

Audit & Risk Committee Cycle of Business (1st January 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				🏳				🏳				🏳
Clinical Audit Annual Plan	Medical Director	Annually				🏳								
Clinical Audit Annual Report	Medical Director	Annually												🏳
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		🏳		🏳		🏳		🏳		🏳		🏳
Annual Financial Accounts	Director of Finance	Annually						🏳 Draft	🏳 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		🏳		🏳		🏳		🏳		🏳		🏳

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														
WHSSC Internal Audit Recommendations Tracker	WHSSC Director of Finance	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
WHSSC Corporate Risk Assurance Framework including the risk register.	WHSSC Committee Secretary/Head of Corporate Services	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
WHSSC Governance Statement	WHSSC Committee Secretary/Head of Corporate Services	Annually						⚑						
EASC Risk Register	Chief Ambulance Services Commissioner	All regular meetings		⚑		⚑		⚑		⚑		⚑		⚑
EASC Governance Statement	Chief Ambulance Services Commissioner	Annually						⚑						
WHSSC & EASC Annual Accounts	WHSSC/EASC	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		⚑						⚑				

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**
Action from December 2023 Meeting	Additional Item	National Fraud Initiative Progress and Outcomes Bi-Annual Update.	Head of Local Counter Fraud Investigations	22 February 2024 – **On agenda**
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – PCH Financial	Internal Audit	18 April 2024
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Controlled Drugs	Internal Audit	18 April 2024
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Patient Pathway Follow Up	Internal Audit	18 April 2024
Proposed approach suggested by the Director of Corporate Governance	Additional Item	Endoscopy JAG Accreditation Closure report - Progress and Associated Risk Mitigation	Chief Operating Officer	13 February 2023 – Deferred to 19 April 2023 as per action log update. Deferred to August 2023 as per action log update. Verbal Update received at the August 2023 meeting. Written progress report to

				be presented to the meeting being held on 24 October 2023. Agreement given by the Chair outside the meeting for a report to be presented to the Committee in **June 2024.**

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)
4.1.1	21/06/2023	National Fraud Initiative Progress and Outcomes - Future reports to include an opening paragraph which explained the purpose of the national fraud initiative and what the process means for the Health Board	Head of Local Counter Fraud	Next report due February 2024	**In progress** The Head of Local Counter Fraud has suggested that the Committee receives bi-annual updates on this matter, with the next report to be presented to the February 2024 Audit & Risk Committee. **On Agenda February 24.**
5.2	21/06/2023	Audit Recommendations Tracker - Lead officers to be asked for rationale to be provided as to why they were proposing a change to the implementation date.	Head of Corporate Governance & Board Business	16 August 2023 Now October 2023 **Now December 2023**	**In Progress** Rationale for changes to implementation dates has been captured against some updates provided. Work will continue to ensure rationale is provided for all future updates.
4.4	24/10/2023	Changes to the Welsh Risk Pool Agreement - Report to be shared with the Planning, Performance & Finance Committee for information only.	Head of Corporate Governance & Board Business	27 February 2024	**In progress** This report has been shared with the Committee Secretariat for the Planning, Performance & Finance Committee for

					inclusion on the February 2024 agenda. **On Agenda.**

Completed Actions					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action (as at date papers where circulated)**
5.3.2	19/04/2023	Medical Rostering Progress Report – The next update report should report on progress towards a board-wide medical rostering policy underpinned by a single IT system with the aim of providing a single reliable source of information regarding the deployment of the medical workforce. Medics Rostering Policy to be presented to the People & Culture Committee for formal approval.	Medical Director	October 2023 **Now December 2023**	**Completed** Report presented to the December 2023 meeting.
5.2	19/12/23	**Audit Recommendations Tracker**	Head of Corporate Governance	December 2023	**Completed** Tracker re-loaded on to Admin Control.

		To re-upload the updated Audit Tracker to Admin Control for Members to review.	& Board Business		
3.1	19/12/23	**Action Log** Transfer any email responses taken outside of Committee to Admin Control for future meetings.	Assistant Director of Governance & Risk	22 February 2024	**Complete** Email responses to questions ahead of meeting or managed outside of Committee are now logged on a tracker within the Corporate Governance Team and added to Admincontrol within the meeting folder where appropriate.
5.2.3	19/12/23	**Medical Rostering Report** To review whether the rostering systems purchased involved anaesthetics outside of the meeting.	Medical Director	22 February 2024	**Completed** The Anaesthetic department processes are currently undergoing, along with job planning and establishment, a deep dive analysis. The CLW system (which CTM Anaesthetic departments use) is used widely across the UK for Anaesthetic rostering and as such is a robust and reliable system. The deep dive is incorporating how leave and sessions are allocated to provide assurance to the

					Planned Care group. It will continue to be used but the ground rules will be clarified so all three anaesthetic groups follow the exact same processes when using the CLW roster system. This will take a period of time and relies on the introduction of a pan-Health Board Operations Manager and Clinical Director for Anaesthetics
2.1	19/12/23	**Financial Control Procedure – Medical Variable Pay – Summary of Authorised Breaches** To provide an update on the summary of the authorised breaches for medical variable pay with regard to the Primary Care managed practices for the February 2024 meeting via the Care Group Report.	Medical Director	22 February 2024	**Complete** Update contained within report for February 24 meeting.

Agenda Item
4.1

Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

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

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

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

4. Assessment

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

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

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

5. Recommendation

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

6. Next Steps

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

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 22 February 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	44
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.	118	77
Prevent and Deter Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	130	153
Hold to Account Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	320	237
TOTAL	616	512

4. STRATEGIC GOVERNANCE

UK Parliament has passed the Economic Crime and Corporate Transparency Act 2023 which subsequently received Royal Assent in October 2023. The intent of this new legislation is to establish wide ranging reforms to tackle economic crime and improve transparency over corporate entities. The Act will bring in amendments to Proceeds of Crime Act 2002 confiscation and civil recovery powers primarily aimed at cryptocurrency as well as strengthening of anti-money laundering powers.

The Act has also introduced a new offence of 'Failure to Prevent Fraud' this is where a relevant body is guilty of an offence if, in a financial year of the body a person who is associated with the body commits a fraud offence intending to benefit that body or persons connected with the body.

The Home Office have now issued draft guidance which is being widely consulted on in Wales via Welsh Government. The draft guidance has been shared with NHS Wales bodies for comment and a review is currently taking place.

5. INFORM AND INVOLVE

A Spring Newsletter has been developed and is due to be issued. This edition highlights the successful prosecution following a CFS Wales investigation of a Cwm Taf Morgannwg UHB Locum Consultant has was sentenced to 12 months in prison, suspended for 2 years and ordered to pay £6,149 in prosecution costs. £44,035.09 was also paid back to the Health Board.

6. PREVENT AND DETER

The Counter Fraud Team have completed work for the proactive exercise around the Fraud Prevention Notice issued relating to impersonating a medical professional. A findings paper is at Appendix 1 to this report.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 to this report. A summary of basic investigation KPI data is presented at outset of the appendix.
Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table.
The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries.
A table of Closed Cases is also presented to review outcomes of investigations.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

COUNTER FRAUD, BRIBERY & CORRUPTION

Proactive Exercise

Impersonating a Medical Practitioner

February 2024

Executive Summary

In response to a risk identified via received referrals for investigation and an NHS Counter Fraud Authority issues Fraud Prevention Notice the Local Counter Fraud Team (LCFT) have undertaken an exercise to explore the current procedure around engaging and managing agency workers (primarily nursing staff both registered and unregistered) within Cwm Taf Morgannwg University Health Board (CTMUHB) utilising additional data from Health Boards across Wales.

This report has been written with consideration to the following documents:

- People 25 – Staff Bank and Agency Worker Policy.
- WOD 19 – Roster Policy, expired 09/05/21.
- The All Wales - Contract Specification for the Supply of Registered Agency Nurses, Midwives and Health Visitors, Healthcare Assistants and Operating Department Practitioners to Health Boards and Trusts in Wales, hereafter referred to as the Contract Specification.

In order to establish the Health Board's compliance with these policies and the level of risk to CTM UHB service users, engagement and support was sought from colleagues in different departments across the Health Board and Local Counter Fraud Specialist (LCFS) colleagues across all Health Boards in Wales.

Introduction and Background

Cwm Taf Morgannwg University Health Board contract out their Counter Fraud services to Swansea Bay University Health Board (SBUHB). There are two LCFS staff solely responsible for CTM UHB Counter Fraud work. Both LCFS officers have insight to emerging fraud, specific cases and risks identified, across both Health Board areas.

The LCFS officers also receive information, alerts and notices from other LCFS colleagues across Wales.

The Counter Fraud Authority (CFA) in England provide a consolidated database of known and emerging fraud risks, that are disseminated across England and Wales via Fraud Prevention Notices (FPN). The CFA also provide guidance for LCFS staff to assess the Health Boards robustness in their processes to minimise the risk potential.

Instances have been found within CTM UHB where individual agency staff, booked as Health Care Assistants (HCA's) have sent an unknown third party in their place to cover their CTM UHB shift. On these occasions the third party persons did not gain access to the wards, patients or other staff and the shifts were not paid out. These incidents have been investigated and whilst no criminal outcome was deemed appropriate, the agency workers concerned were reported to the relevant agencies, in order that the appropriate action could be taken with regard to the incidents. The CTM UHB Bank/Agency department work closely with agencies to ensure the integrity of all Agency Workers placed within the Health Board.

A further instance found an agency worker had been booked, worked and paid, in respect of 4 back to back shifts over two consecutive days, across two different hospital sites. Two day shifts were completed at one site and two night shifts at another site. The agency worker had registered with two separate agencies to enable the placements and neither agency was aware that the worker had been placed on shifts by the other company. This matter was investigated by the LCFT, it was found there was insufficient evidence to prove that anyone other than the booked agency worker had attended and completed the booked shifts, making criminal action inappropriate in this instance. The agency worker remains available for placement at CTM UHB via agencies.

In addition, SB UHB are currently dealing with an incident whereby a HCA had registered with an agency and a night shift was booked for them to work in a secure NHS healthcare facility. Due to the nature of the facility, ID badges are held securely until the completion of the shift. Upon returning the ID badge to the agency worker, the photograph on the badge fell off, revealing that the badge had been issued to a person other than that which had worked the shift. The person made off and their identity was unknown. The case is ongoing with SB UHB.

The CFA have recently circulated a FPN that evidences there is a similar problem in other Health Boards/Trusts across England and Wales, in one instance an agency nurse booked onto hundreds of shifts but sent multiple unknown persons to the various locations to undertake the work.

Once these unidentified parties leave our hospital sites, there is little, to no chance, of identifying who has attended the placement, in order to bring them to account

Scope of Exercise

This exercise was undertaken to establish:

- The policies and processes in place.
- Booking of agency staff, whether via the Health Roster or by other means.
- Identification of the individual upon attendance at the booked location.
- Orientation of the agency worker once at the booked location.
- The process for raising concerns, in any capacity, regarding agency staff.
- The assurance that payment of the shift booked, was valid, based on attendance and completion of the shift, undertaken by the correctly identified person.
- Managers at the booked location being aware of their role in supervising agency staff and completing the relevant records.
- Data analysis of agency shifts between all Health Boards across Wales, to identify agency staff booking multiple shifts for the same date and time.

Method

Strategic Governance

The Contract Specification for the supply of agency staff was obtained – this outlines matters such as recruitment procedures, placement procedures, hourly rates of pay, Agency Workers obligations, booking arrangements and uniform, to name but a few.

The Staff Bank and Agency Worker Policy for CTM UHB, along with the NHS Wales Agency Worker Placement checklist and the Ward Induction checklist were also obtained, for reference.

In addition, The Roster Policy for CTM UHB has been obtained, this sets out the process for filling empty shifts and specifies where Agency Workers fit in to the cycle of securing additional staff at times when staffing levels are under pressure.

Relevant Systems

Allocate software is utilised by the Health Board for management of booking and payment of agency staff –

- Health Roster (used for the production of rosters and enables unfilled shifts to be identified for bank / agency fill).
- Bank Staff (e-system used by the Bank Office Team and approved on-contract agencies to fill shifts).

Data Matching Exercise

All Health Boards across Wales were informed of the exercise being undertaken by the LCFS at CTM UHB. A request was made for the following Health Boards to provide data for all shifts, worked and paid for Agency Workers, between 01/12/22 and 31/05/23:

- Aneurin Bevan UHB (AB UHB)
- Cardiff & Vale UHB (C&V UHB)
- Swansea Bay UHB (SB UHB)
- Hywel Dda UHB (HD UHB)
- Betsi Cadwaladr UHB (BC UHB)
- Cwm Taf Morgannwg UHB (CTM UHB)

No request was made to Powys Teaching Health Board or Welsh Ambulance Services NHS Trust, as these were deemed outliers for the scope of this exercise, by the nature of services provided by them.

The shifts were then analysed to identify instances whereby there was overlap of shift dates and times for the same individual. The intent was to provide evidence as to the extent, if at all, of agency staff booking multiple shifts across different Health Boards or within the same Health Board, for the same dates and times. The results would provide an indication if possible unknown third parties were in attendance at our sites, in place of the registered Agency Worker.

Ward level processes

Contact was made with the Executive Director of Nursing, Midwifery and Patient Care, along with the Executive Director for People, to inform them of the exercise and a proposal to carry out visits at the three acute hospital sites, to determine the procedures being undertaken at ground level on the wards. Permission was obtained for the visits, as this encroached on the medical workplace, staff and patients.

Dates were appointed for the visits to be carried out at the three sites, for the purposes of anonymity, hospital sites will be referred to as site 1, 2 and 3.
The purpose of the visits was to discuss with Ward Managers/Senior Nurses the process they undertook in the following areas:

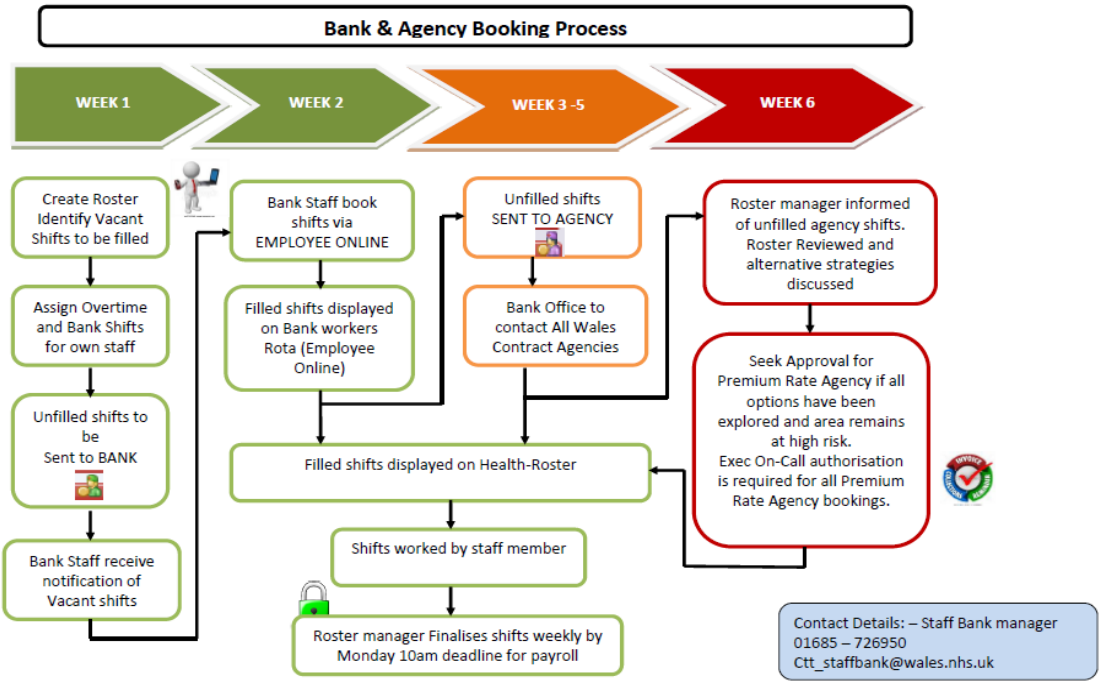
1. Booking of Agency Workers
2. Identification of the agency worker upon attendance.
3. Induction/orientation at the workplace location.
4. Completion of the necessary documentation and its return to the Bank/Agency department for collation.
5. Process for verification of staff attendance and finalisation of shift, for payment to the agency, upon satisfactory completion of the shift.
6. The process for escalation of concerns.
7. Any issues or concerns there were around Agency Workers and their placements within CTM UHB.

Visits were also made to the Patient Flow Team to determine how they fit in to the process for engagement of Agency Workers.

Findings

It should be noted that as of October 2023, CTM UHB has made the decision to not book Agency Workers to supplement gaps in HCA roles. A business case must be submitted in instances where business areas require Agency Worker HCA's, Senior Management will decide whether to grant permission on a case by case basis.

The order of engagement of additional nursing resources as defined in the CTM UHB Roster Policy is:



Data Analysis

Data analysis sample test undertaken between AB UHB, C&V UHB and CTM UHB for dates of proposed visits to the three acute sites in CTM UHB.

- Data analysis of all pre-booked agency shifts found two Agency Workers both had overlapping shifts between AB UHB and CTM UHB, where shifts had been booked for the same date and time, but across different Health Boards.
- Of special concern was, one of the Agency Workers, was booked to work in Parc Prison, Bridgend at the same time they were booked to work at AB UHB.
- The matter was escalated to CTM UHB Staff Bank Manager, who ascertained that both Agency Worker bookings, for the CTM UHB shift placements, were made direct with the Ward/Department, a procedure that is discouraged.
- The agencies concerned were notified by the Staff Bank Manager.
- The Managers for the Department/Wards in both Health Boards were notified of the overlap.
- Counter Fraud provided guidance to the Managers in question for both CTM UHB and AB UHB, should staff attend both the booked placements. With advice around contacting the local police force to attend and identify the persons present.
- Further investigation of the overlapped shifts, after the date of shift had passed, found that one shift for each of the agency workers had been cancelled by their respective agencies prior to the shift date, with no overlap occurring.
- Analysis was carried out on both these agency workers shifts, for the past 12 months to determine if there had been any previous overlaps, none was found.

Data supplied by all other Health Boards across Wales

The 6 monthly data, 01/12/22 to 31/05/23, supplied by all other Health Boards across Wales, has been analysed for overlap of shifts and any other concerns that this may highlight.

Initial analysis has found that persons signing up to multiple agencies appear to be using variations of their names, adding or missing out middle names, using double barrelled surnames but also singular surnames. This allows them to be set up on the Health Roster as two separate people, allocated two different employee numbers, thus allowing a workaround of the Working Time Directive parameter that is inbuilt to the Health Roster system.

Ward Visits

Counter Fraud Team site visits to, Prince Charles, Princess of Wales and Royal Glamorgan Hospitals

The LCFT attended all the three acute sites within CTM UHB, with visits to some of the wards.

The following queries were made with Ward Managers/Senior Nurse on duty –

1. Were agency staff booked via the Heath Roster or off Roster direct with agency staff?
2. Upon attendance what were the means of identification of the agency worker, specifically, was the ID badge checked?
3. How the attendance was recorded, by use of signing in a timesheet or by other means?
4. Was an induction carried out if the agency worker had not attended the ward previously?
5. Was the induction form completed and returned to the Bank/Agency department?
6. Who would finalise the attendance of the shift within the Health Roster for payment of the shift?
7. What were the checking process for attendance of the shift prior to finalising the shift for payment?
8. Who would they escalate concerns to?
9. Comments on the effectiveness of agency staff?

10 wards were visited across the 3 acute sites in CTM UHB. The wards were picked at random, avoiding areas such as A&E, Maternity and ITU areas.
One Ward Manager was responsible for two wards, therefore the responses for these two have been recorded the same. One out of the 10 wards visited, had removed all agency staff from its supply, following submission of a risk assessment and agreement

by Senior Management, this was a direct result of an incident that had occurred. As a result the responses are only relevant to 9 of the 10 wards visited.

The majority of wards used the Health Roster system to secure agency staff bookings. There were a number who used Whatsapp message groups, of known reliable staff that they would notify when shifts were available, in order to book specific staff. Many of the staff in charge of the wards that were approached, stated they would keep a list of agency staff who had worked on the ward previously and who they would welcome back.

All staff approached confirmed they would not take bookings directly with the Ward, bookings were managed through the Health Roster.

All wards would check ID badges upon arrival of staff, however 1 stated it would only check if staff were unknown to them.
During the visit to one ward, the ID badge of an Agency Worker currently on duty, had not been checked. This was a direct result of the busyness of the ward at the time, the Ward Manager hoped to check the ID before end of the shift.

Some wards would ask for the Agency/Health Roster booking reference number in addition to checking the ID badge.

The majority of the wards used a book to record staff signing in for duty, 2 of the wards use the number of staff on duty to determine who was present, based on the staff recorded on the roster for that particular shift.

One ward was found to carry out the formal induction, with completion of the Induction Template form. The remainder of the wards visited carried out either:
An induction style process.
or
A walk around for Agency Workers to orientate themselves with the location
One ward would only carry out an induction if the agency worker was not known to the ward staff.
No Induction Template form was completed in all these instances.

In the one instance where an Induction Template form had been completed by ward staff this was not returned to the Bank/Agency dept. as directed in the Staff Bank Policy.

It is a requirement that an Induction Template form be completed where an induction is carried out with an Agency Worker and that form be returned to the Bank/Agency dept.

For purposes of finalisation of the shift, to enable payment and in order to have assurance around attendance, hours worked and agency worker completion of the shift. 6 wards would use the details recorded in the, sign in book, 2 would use the numbers worked on the shift for the allocated date, with one of these also requiring a

copy of the timesheet, the 1 remaining ward used the timesheet completed at end of shift.

All staff indicated that the Nurse in Charge on duty at the time of either, the shift or finalisation of the shift, would finalise the shift within the e-billing system, built in to the Health Roster.

Shifts within CTM UHB are paid via the E-billing system built into the Health Roster system. Every Tuesday and Thursday a payment run is activated which captures shifts that have been finalised for the preceding 3 week period. Any finalised outside of this parameter need submission of an invoice to secure payment.

Staff on all wards confirmed that concerns would be raised to the Ward Manager in the first instance, the Site Manager or Bed Manager, if out of hours and of a nature that required escalation. The Bank/Agency department would be notified of any issues concerning Agency Workers by all wards.

During discussions ward staff raised some issues in respect of their experience with agency colleagues' behaviour and performance and these have been shared with the relevant ward leadership and with People Services.

Patient Flow Team process.

Bed Managers sit under the structure of the Patient Flow Teams (PFT). The term 'patient flow' refers to the ability of healthcare systems to manage patients effectively and with minimal delays as they move through stages of care.

Bed Managers as part of the PFT are responsible for ensuring that there are beds available for patients, as required, in the appropriate areas, suited to their medical needs. There are generally 2 staff by day and 1 by night, on duty in the acute sites.

Where a staffing shortage is highlighted across the Hospital, the PFT will firstly, reallocate staff on duty if this is possible. If this is not possible, bank staff will be called upon and where there is still a shortfall Agency Workers will be engaged.

No identity check is carried out of the Agency Worker upon reporting to the PFT/Bed Managers, this requirement is the expectation of the Ward Manager/Nurse in Charge as is the Induction.

Data Matching Exercise

A total of 196154 shifts across the participating Health Boards were analysed. Analysis was undertaken by way of allocation of a reference to each shift to enable matching. The allocated reference was a combination of worker first name, last name and date of shift.

These references were then matched to provide instances where the same name worked shifts on the same date. Further analysis was then undertaken on this matched dataset to verify start and finish times to identify any overlap of these shifts. Overlap for this purpose includes any amount of overlapping start/finish time and not necessarily the entire shift.

Instances where a matched overlap of name, date and times were identified these were termed high risk for further interrogation. The data was separated out between shift overlaps within a Health Board and shift overlaps across different Health Boards.

The data across different Health Boards identified a total of 999 shifts as high risk following the initial data matching, of those 264 shifts cross matched between CTM UHB and other Health Boards as overlapping. Overlapping data within individual Health Boards identified a total of 296 shifts as high risk, of those, 70 shifts were found to be overlapping within CTM UHB itself.

These high risk shifts were then scrutinised further using payment system data. Further data interrogation sought to clarify that the matched names were the same individuals using National Insurance Numbers and that each of these shifts had been paid in this name.

979 shifts across the participating Health Boards have been identified as having been paid for the same individual with an overlap of date and times of those shifts, 240 shifts identified in this context at CTM UHB.

There is not enough evidence to suggest that all of the shifts identified are a result of fraudulent activity particularly an unknown third party attending to work a shift booked in the name of another registered agency worker. The opposing reasons could be inaccurate recording leading to inaccurate invoicing.

The LCFS will now engage with the Nurse Bank Team and Agencies to seek further clarity around the identified shifts. The range of resulting action from these further enquiries in relation to individual shifts will be no further action, seeking repayment of the shift, and/or criminal investigation in the most serious instances of multiple occurrences.

Conclusion

The issue of engaging Agency Workers will always be susceptible to fraud given that there is no sharing of information between agency companies and/or no cross-matching of data held by each individual company. In addition there is nothing at Health Board level which allows the sharing of agency worker data, specifically prior to the date of shift to prevent booking of overlapping shifts.

It is evident from the staff working within CTM UHB that there are some excellent Agency Workers available, who provide a high standard of support to our substantive staff in caring for our patients.

This exercise has determined the following:

A number of performance issues or concerns were raised by ward staff in relation to some agency colleagues. Any performance issues or concerns regarding any agency worker should be reported and managed via the provisions of the contract specification and non-compliance reported to Bank/Agency Team.

Ghost booking is being undertaken by some agencies, evidenced by the fact that differently named Agency Workers are reporting for duty, in comparison to that which is named on the Health Roster and where there has been no notification of any cancellation of the original worker. This is contrary to the Contract Specification. Instances of this nature should be reported to the Bank/Agency department at CTM UHB.

Inductions are not being carried out as per the Contract Specification and Bank Staff Policy or where they are, they are not being recorded on the relevant Staff Induction form. These forms need to be completed when an agency worker first presents to complete a shift on a new ward. Forms should then be returned to the Bank/Agency Department. Inductions include verification of ID documents to confirm individual has attended is the same worker booked to the shift. Recording of inductions provides assurance that Agency Workers are familiar with their surroundings, the processes and procedures expected whilst at the booked location, along with the expectations of them during the shift as well as introducing directive and detective controls around identifying Workers who have attended.

The Contract Specification clearly sets out the uniform requirements for Agency Workers. They should attend in the uniform for the relevant agency that they are engaged by, for the shift in question. Former substantive staff wearing CTM UHB uniform whilst undertaking agency shifts should not be permitted and should be reported to the Bank/Agency department at CTM UHB. Along with ID checks agency specific uniform is a fraud preventive control in identifying the correct individual has presented to complete a shift.

The data matching exercise has led to identification of a significant number of agency shifts paid where there is an overlap of individual staff attending to cover those shifts. The primary controls to combat agency fraud of this nature are centred around the booking and payment systems themselves, as well as ward level controls, with ward staff acting as ‘gatekeeper’ to agency staff attending and completing shifts. This exercise has identified issues within this ecosystem of controls which lead directly to an increased risk of fraud due to increased likelihood.

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Item 4.1 – Appendix 2

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 2023/24
16	1	38

Case Rates

Referrals Received 2023/24	Cases Under Investigation for Over 12 Months
45	1

Sanctions/Outcomes

Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	3	2

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	The subject in this case has entered a not guilty plea to 9 counts of dishonesty offences relating to deceit around gaining employment in the NHS. Trial preparation hearings have been set and trial is expected to be in June 2024. There has been press interest in this case with TV and print media coverage. Further interest anticipated at trial. A communication plan was in place and continues to be maintained with support from the Health Board's Communications Dept and NHS CFA Communications Team. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC are awaiting outcome of criminal case.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/23/01232	27/06/2023	False Overtime	Allegation received that staff are not completing overtime hours or not attending at all and claiming full day overtime payments. Allegation states that supervisors are aware of this. Enquiries are ongoing but made more difficult by allegation that managers are aware of and allow conduct limiting investigative approaches. A senior manager contact has been identified and approached in efforts to progress investigation. Following discussions it is unlikely that evidence will be available to enable continuation of criminal investigation. A wider review is underway in this area and these concerns will feed into that.
INV/23/01588	01/08/2023	Timesheet Fraud	Information received following concerns established during disciplinary process. Allegation that staff member has not been completing contracted hours and is in deficit. Enquiries have sought data of Outlook account, IT logins, system logins, and ESR. This has been measured against fob data to established working hours. Enquiries have established a small deficit which would not be proportionate to seek prosecution. Findings have been shared with disciplinary process which is proceeding with investigation phase concluded. Disciplinary process is ongoing and case will remain open to capture resolution given advanced stage of that process.

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. A meeting has been held with Prescribing Services to gain their view on allegation. Prescribing data was reviewed in line dispensing contractors guidance and in conjunction with Prescribing Services. A full case review is to be completed to assess investigation strategy.
INV/23/2885	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 will be approached to discuss upon receipt of secondary employer information

Open Cases			
Reference Number	Date Opened	Allegation	Status
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.
INV/24/00067	09/01/2024	Prescription Fraud	Allegation that Pharmacy contractor has been receiving fake prescriptions, not dispensing any items and then claiming reimbursement. Primary Care Prescribing Services colleagues have been contacted for advice and input. Claims data for the contractor has been gathered and is being analysed.
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 underway to corroborate allegation.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00220	29/01/2024	Fraudulently Obtaining Controlled Drugs	The partner of a patient currently serving a custodial sentence in prison, has been obtaining repeat prescriptions from the GP in the name of the patient, for controlled drugs (gabapentin), for a 6 month period, when the patient has been prescribed this medication through the prison. GP has been engaged as initial enquiries seek to corroborate allegation.
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 underway to corroborate allegation with requests for information made to supplying agency.
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 underway to corroborate allegation with requests for information made to supplying agency.

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. Further enquiries underway to assess how firm existing job plan arrangements are for this consultant.
INV/24/00267	02/02/2024	NHS Patient Selling Prescribed Medication	A Patient is alleged to be selling medication prescribed to her by the GP. Medication is food supplements with relatively high resale value. The patient has appeared to text the GP practice by mistake offering her products for sale. Text message records to the GP Practice have been gathered. LCFS to engage GP Practice for further background information around the prescribing.
INV/24/00290	06/02/2024	Theft	Information received from the Fraud and Corruption Reporting line that a steals items from the stock cupboard including antibiotics, pain killers and adhesive remover. Referral states that subject submits stock orders for items. Enquiries underway to corroborate allegation.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00022	04/01/2024	Optical Outlet Claiming NHS Voucher Payments When Not on The GOC Register	Allegation that an Optical Outlet is dispensing spectacles to under 16s and accepts NHS optical vouchers. The owner does not appear on the GOC register. Primary Care Contract Support Manager has been engaged for advice and support on this investigation. Enquiries ongoing to clarify the contractual position of the Outlet.
INV/24/00026	08/01/2024	Safeguarding Issue	Allegation received by Counter Fraud Authority England as that private social housing entity are attending the address of a vulnerable individual with previous self harm episodes asking medical questions and claiming to work for the individual's GP and Mental Health Team at Kier Hardie Health Park. No NHS fraud has been established but clear safeguarding concerns in this matter. LCFS are engaging with subject's GP and council services to raise and pass on concerns.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/23/02142	29/09/2023	Recruitment Fraud	Allegation received via Fraud and Corruption Reporting Line that an applicant failed to declare an ongoing investigaiton at employer at point of application. Subject was traced as being successfully appointed at another NHS Health Board. Given that the subject did not successfully gain employment with Cwm Taf Morgannwg UHB and therefore no loss was realised investigation is better placed with other Health Board. An approach was made to seek transfer of investigation which has now taken effect.
INV/23/02268	11/10/2023	Overpayment of Salary	A former staff member continued to be paid for a period of 16 months following leaving Health Board employment. This resulted in a gross overpayment of £14k. Enquiries established that this matter was known in August 2022 at which point payments were suspended. The referral to Counter Fraud did not take place until over a year later. The investigation could not clarify this timeline and actions taken. Given the lack of clarity and time passed before referral this would have the effect of undermining any potential prosecution and the matter was referred back for normal recovery processes to take effect.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/23/02269	11/10/2023	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Staff member alleged to be absent due to sickness but providing the same services fulfilled in substantive NHS role within their own private clinic. Investigation could not establish any evidence that private clinic work was undertaken during sickness absence.
INV/23/02802	11/12/2023	Forged Fitness for Work Certificate	Allegation that member of staff has submitted a fitness for work certificate covering a period of sickness where the dates appeared to have been altered with handwritten entry. Enquiries were undertaken with the issuing GP Practice who confirmed that it is their procedure not to alter via handwriting fitness for work certificates. The subject then submitted a new fitness for work certificate covering the period of sickness the Health Board required evidence for therefore there has been no loss the Health Board and no Fraud Act offence completed.
INV/23/02862	14/12/2023	Patient Selling Medication	Information received from the Fraud and Corruption Reporting line that a patient has been selling prescribed medication. The LCFS engaged with Police via the Drugs Liaison Officer who added information to Police intelligence systems and also arranged for inclusion on Police Daily intel document for Supervisors and officers for that area.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			Without corroborating information the Police are limited in scope of potential actions.
INV/23/02884	18/12/2023	Timesheet Fraud	Information received from the Fraud and Corruption Reporting line that a staff member has not been completing contracted hours. Timesheets were scrutinised and subject's management spoken with. No evidence to substantiate there was any wrong doing on the part of the subject on dates given within the allegation was established.
INV/23/02935	03/01/2024	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Information received from the Fraud and Corruption Reporting line that a staff member was seen to be working at residential address whilst sick as their car was outside properties. Enquiries sought to contact the source to clarify what they had witnessed with particular interest in what work had been witnessed being carried out. Source was established to be anonymous however. Information was shared with People Services for consideration. The allegation was put to the subject who denied working whilst sick. No further evidence could be established to substantiate allegation and no disciplinary action was undertaken.
INV/24/00066	09/01/2024	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Allegation received from People Services contact that a staff member has been working while absent due to sickness from substantive role.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			Allegation has been put to the subject as part of the disciplinary process and subject has admitted to working over the Christmas period at due to financial reasons. The disciplinary process is proceeding and given low value of fraud is took primacy in this instance. A disciplinary fast track process was undertaken and a verbal warning issued. Proceeding with criminal investigation and potential criminal action has been assessed as being disproportionate in the context of the circumstances.

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National Fraud Initiative

Progress and Outcomes

Matched Datasets Background

Payroll to Payroll

To identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time.

The criteria for a match are a person having one full-time post plus at least one other post elsewhere.

Payroll to Creditors

The match identifies instances where an employee and creditor are linked by the same bank account (report 80) or the same address (report 81) to identify employees with interests in companies with which your organisation is trading.

This may indicate potential undeclared interests and possible procurement corruption or where a member of staff has set up a creditor with their own bank details in order to receive payments they are not entitled to.

Duplicate Creditors by Credit Reference

Duplicates identified in this match suggest poor creditor management as the system has permitted a creditor reference to be used more than once.

Duplicate Creditors by Creditor Name

To identify instances where the same supplier has been set up with more than one reference number on the system thus increasing the potential for creditors to obscure fraudulent activity.

Duplicate Creditors by Address Detail

To identify multiple creditors operating at the same address. These may represent simple errors, where the same creditor may have been set up twice using a slightly different spelling, for example LIMITED and LTD, or an attempt to obscure fraudulent activity.

Duplicate Creditors by Bank Account Number

This output shows where the same bank account details appear on more than one record. Of particular interest is where the same bank details are shown against suppliers with different names. These may indicate where a supplier has changed trading name but the standing data has not been updated to reflect this or there are links between companies with different trading names.

Duplicate Records by Reference, Amount and Creditor Reference

This match highlights possible duplicate payments in excess of £500 that may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

Duplicate Records by Invoice Amount and Creditor Reference

This match highlights possible duplicate payments in excess of £1,000 that may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff. There are likely to be more matches than in report 707 as this report does not require the invoice reference field to match.

VAT Overpaid

This report identifies instances where VAT may have been overpaid. This is based on the information provided within the NFI invoice history data submission and the output includes the level and scale of overpaid VAT. The VAT amount is compared to a calculated maximum VAT of 20%, the maximum VAT rate in the payment period covered by the NFI exercise.

Duplicate Records by Supplier Invoice Number and Invoice Amount but Different Creditor Reference and Name

This match highlights possible duplicate payments for the same goods/services but to creditors with different reference numbers, which may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

Duplicate Records by Postcode, Invoice Date and Invoice Amount but Different Creditor Reference and Supplier Invoice Number

This match highlights possible duplicate payments for the same goods/services but to creditors with different reference numbers, which may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

Procurement - Payroll to Companies House (Director)

To identify potential undeclared interests that have given a pecuniary advantage. To do this we have matched your payroll data to companies house information and then to your creditors data.

The reports are split between those highlighting employees who appear to be registered directors of companies that the employing body has traded with (Report 750) and those where the employees address appears to have links to the company directors or the company (Report 752).

Report ID	Report Title	Responsible Lead	Total Matches	Status	Closed Matches	Further Enquiries	Matches Outstanding
65	Payroll to Payroll	Counter Fraud	2	Opened	2	0	0
66	Payroll to Payroll		189	Opened	167	22	0
67.1	Payroll to Payroll - Phone Number		9	Not Opened	0	0	9
67.2	Payroll to Payroll - Email Address		1	Opened	1	0	0
68.1	Payroll to Payroll - Phone Number		14	Opened	10	3	1
68.2	Payroll to Payroll - Email Address		1	Opened	1	0	0
78	Payroll to Pensions	Pensions/Counter Fraud	130	Not Opened	0	0	130
80	Payroll to Creditors	Counter Fraud	12	Not Opened	0	0	12
81	Payroll to Creditors		8	Not Opened	0	0	8
700	Duplicate creditors by creditor reference	NWSSP -Accounts Payable	1080	Not Opened	0	0	1080
701	Duplicate creditors by creditor name		2	Not Opened	0	0	2
702	Duplicate creditors by address detail		56	Not Opened	0	0	56
703	Duplicate creditors by bank account number		102	Not Opened	0	0	102

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

Agenda Item
4.2

Audit & Risk Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James - Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

1.1 Procurement Matters

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

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

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

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

d) Summary of contracts over £500,000

e) Free of charge services

f) Retrospective orders and non-receipting areas

g) Consultancy contracts

h) No PO No Pay summary

This report provides details of any such transactions within the period 01.12.23 to 31.01.24

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 2023-24.

1.3 Scheme of Delegation and Financial Control Procedures

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

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

2. Specific Matters for Consideration

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.12.23 to 31.01.24.

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 01.12.23 to 31.01.24

Table A – Single Tender Actions 01.12.23 to 31.01.24

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1705	Rev	Catering	Repair and replacement of evaporation coil for the blast freezer	Cool Therm	£36,291	(c)	20.12.23
1710	Cap	CDAT	Fibroscan430 + with XL+ probe Ultrasonic Liver Elastography	Echosens	£90,800	(c)	25.01.24

1712	Rev	ICT	Maintenance of existing telephony system	Netcall Technology Ltd	£24,948	(c)	19.01.24
1713	Rev	Estates	Maintenance of various water pressurisation Units, Booster Sets and Vessels in line with "Pressure Systems Safety Regulations 2000.	Aquatronic Group Management Ltd	£46,279	(b)	30.01.24
1714	Rev	Estates	Annual maintenance to our Nurse Call System and associated equipment at PCH, RGH, YCR, YCC and KHHP.	Wandsworth Group Ltd	£98,400	(c)	20.01.24
1715	Cap	Estates	Upgrade and replace the remaining obsolete Trend controllers	Building Control Maintenance Ltd	£113,776	(b)	23.01.24

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 -

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1707	Rev	NCCU	The Royal College of Psychiatrists membership	Royal College of Psychiatrists	£123,000	(c)	24.01.24

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

There were no contracts requiring Ministerial approval for this period

Reference	Title	Supplier	Value	Date Approval Received
N/A	N/A	N/A	N/A	N/A

d) Summary of contracts awarded over £500,000

Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. Below is a retrospective summary of contracts awarded between 01.12.23 to 31.01.24:

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

Reference	Title	Supplier	Value	Date Approval Received
N/A	N/A	N/A	N/A	N/A

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 01.12.23 to 31.12.24:

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

f) Retrospective orders and non-receipting areas

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

Supplier	Areas	Number of retro orders	Value of retro orders	Comments
Blue Arrow	533918_RGH HOSP ADMI 544063_LLW DOM TOP B 544053_MAIN CPU TREORCHY	52	£73,100	Agency Staff
MXF PROPERTIES V LTD	559152_KH Admin Blk2 533121_New Tynewydd Surgery	31	£6,910	
BOC LTD	555100 PCH PHARMACY 533044_DENTAL BRIDGEND CLINIC 534131_POW DERMATOLOGY UNIT (WARD 17)	28	£13,920	Medical Gases

g) Consultancy Contracts

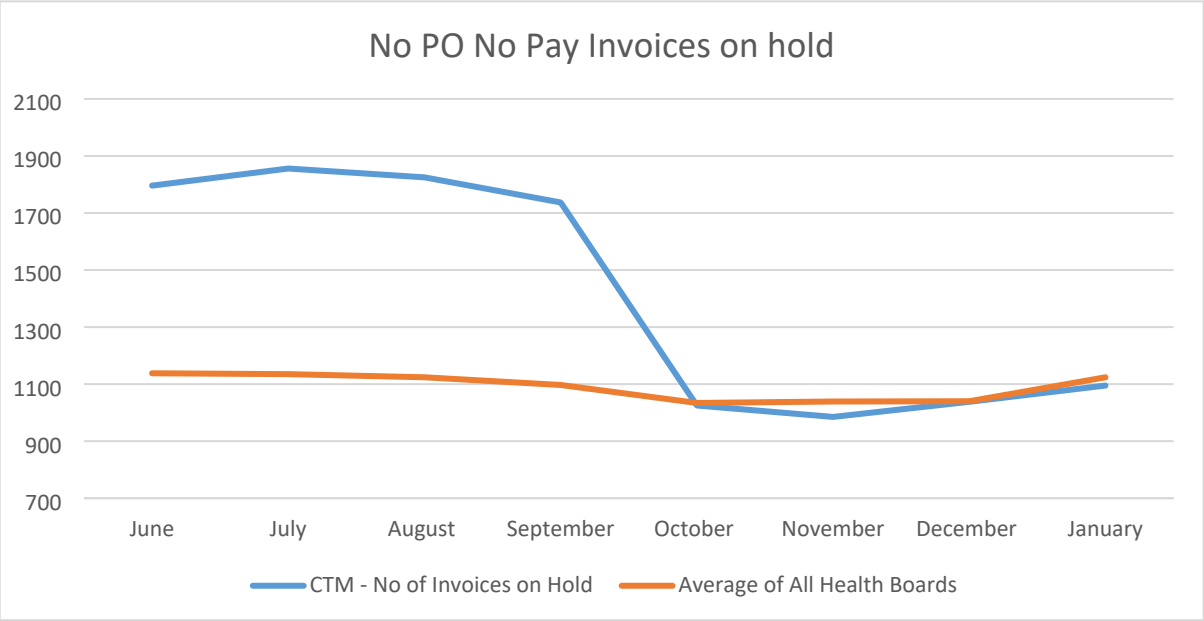
Below is a table detailing consultancy contracts that have been awarded between 01.12.23 to 31.01.24

Reference	Title	Supplier	Value	Date Awarded
RFA1196	Dementia Services Pathway Review	North of England Commissioning Support	£100,000	18.12.23
RFA1203	Extension of Architectural and Design Support to the Llantrisant health Park	Strides Treglowan	£286,300	08.01.24
RFA1204	Extension of Engineering to	Hydrock	£562,581	08.01.24

	the Llantrisant Health Park both Civil and Structural and M&E			
RFA1210	Extension of PMO Support to the Llantrisant health Park	Archus Ltd	£112,440	24.01.24

h) No PO No Pay Summary

Below shows the trend of number of No PO No Pay holds over the past 8 months.



2.2 Purchase to Pay (P2P)

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

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 9 2023-24 achieving 97.5% (value 95.6%).

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-23	15,571	38,586,322	16,298	43,991,964	95.5	96.0
May-23	23,465	69,816,166	23,924	76,960,512	98.1	97.9
Jun-23	22,974	35,244,677	23,533	39,126,216	97.6	95.2
Jul-23	31,044	54,058,760	31,830	56,526,210	97.5	95.6
Aug-23	18,381	34,149,207	18,973	36,983,288	96.9	92.3
Sep-23	19,722	46,960,932	20,740	51,217,771	95.1	91.7
Oct-23	22,915	39,801,116	23,334	41,882,427	98.2	95.0
Nov-23	23,410	47,800,063	23,727	49,377,365	98.7	96.8
Dec-23	15,337	38,211,080	15,501	38,750,462	98.9	98.6
YTD	**192,870**	**404,680,564**	**135,349**	**423,406,822**	**97.5**	**95.6**

The NHS invoice position continues to be challenging and shows that 80.8% (number) and 94.6% (value) of invoices were paid within 30 days to month 9 2023-24.

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

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

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

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

3. Key Risks / Matters for Escalation

3.1 While there has been an improvement in recent months the level of No PO No Pay Holds remains a concern, this is particularly having an

impact on the PSPP percentage for payment of NHS invoices. It is important that directorates raise POs in a timely manner in order for efficient payment of invoices. Finance and Procurement teams continue to engage with appropriate officers to communicate the importance of the No PO No Pay 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))*	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? /*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

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

5. Recommendation

5.1 The Audit & Risk Committee is asked to:

NOTE the position on procurement matters for the period 01.12.23 to 31.01.24;

NOTE the update regarding Purchase to Pay and achievement of PSPP target to period of 2023/24;

Agenda Item
4.3

Audit & Risk Committee

Losses and Special Payments 01.11.23 to 31.12.23

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Daxa Varsani – Financial Accountant
Cyflwynydd yr Adroddiad / Report Presenter	Sally May - Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

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

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

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

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

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

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

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

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

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

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

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

2. Specific Matters for Consideration

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

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

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

a) Provision and Creditors as at 31 December 2023

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

Table 1

	31.12.23	31.10.23	31.03.23	31.03.22	31.03.21
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	92,859	92,048	72,198	65,127	86,029
Redress Medical Negligence claims/costs	484	419	385	235	269
GP Indemnity (Note 1)	134	113	0	0	0
Personal Injury claims/costs	794	646	701	611	436
Recoverable from Welsh Risk Pool	(101,213)	(100,323)	(83,623)	(93,074)	(114,863)
Net claim provision	**(6,942)**	**(7,097)**	**(10,339)**	**(27,101)**	**(28,129)**
Permanent Injury Benefit	4,252	4,162	4,077	6,201	6,320
Net Provision	**(2,690)**	**(2,935)**	**(6,262)**	**(20,900)**	**(21,809)**
Number of live cases on the Losses Register					
	31.12.23	**31.10.23**	**31.03.23**	**31.03.22**	**31.03.21**
Medical Negligence claims	343	340	334	299	309
Redress Medical Negligence claims	250	251	230	213	168
GP Indemnity claims	25	21	18	7	0
Personal Injury claims	105	115	129	113	110

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

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

b) Expenditure incurred for the year to 31 December 23

This is shown in table 2 below, together with equivalent figures for the last three complete financial years and last reporting period to the Audit & Risk Committee (31.10.2023).

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

Table 2

	Year to	Year to	Year ended	Year ended	Year ended
	31.12.23	**31.10.23**	**31.03.23**	**31.03.22**	**31.03.21**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	25,647	23,237	17,386	1,945	13,110
Redress Medical Negligence claims/costs	254	217	711	170	305
GP Indemnity	141	117	6	1	0
Personal Injury claims/costs	617	391	822	772	316
Recoverable from Welsh Risk Pool	(24,870)	(22,482)	(16,858)	(1,210)	(12,449)
Net claim expenditure (Note 1)	**1,789**	**1,480**	**2,067**	**1,678**	**1,282**
Permanent Injury Benefit	402	312	(1,707)	286	470
Other	140	126	1,427	570	609
Total Net expenditure	**2,331**	**1,918**	**1,787**	**2,534**	**2,361**

Note 1: The annual budget for net claim expenditure for 2023-24 is £1,785k (year to date £1,339k), actual expenditure for the year to date is £1,480k, therefore an overspend of £450k to December 2023. This overspend has a direct impact on the in-year position of the health board.

c) Cash Write-Offs made for the period 1 November 2023 to the 31 December 2023

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

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

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

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

Table 3

Cash write-offs made during 23/24

	01.11.23 - 31.12.23 £000	Previous Months	Total 2023-24 £000
Medical Negligence (Appendix 1)			
Claims	1,307	2,218	3,525
Costs	225	796	1,021
Defence Fees	67	373	440
Medical Negligence Totals	1,599	3,387	4,986
Redress Medical Negligence (Appendix 2)			
Claims	-33	107	74
Costs	3	29	32
Defence Fees	3	46	49
Redress Medical Negligence Totals	-27	182	155
GP Indemnity (Appendix 3)			
Defence Fees	2	5	7
GP Indemnity Totals	2	5	7
Personal Injury (Appendix 4)			
Claims	0	152	152
Costs	50	220	270
Defence Fees	28	75	103
Personal Injury Totals	78	447	525
Permanent Injury Benefit (Appendix 5)	0	227	227
Permanent Injury Benefit Totals	0	227	227
Other (Appendix 6)			
Ex-Gratia	15	97	112
Debt Write Off	2	0	2
WRP Penalty Charge	0	17	17
Ombudsman	0	9	9
Employment Matter/Other	-3	3	0
Other Totals	14	126	140
Total	1,666	4,374	6,040
Recovered from Welsh Risk Pool	(1,497)	(5,782)	(7,279)
Net Cash Write-Off	169	(1,408)	(1,239)

WRP Risk Sharing Agreement

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

As reported previously, WRP forecast £26.5m of overspend for 23/24; CTM share being £3.5m. This has been included in the Health Boards Forecast.

3. Key Risks / Matters for Escalation

As highlighted in Table 2 section 2.3 there has been an increase in net claims expenditure during 2023/24 which is giving a year to date overspend of £450k. This is charged to the Patient Care & Safety revenue position.

4. Assessment

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

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

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

	the level of provision within the balance sheet for potential future payments.

5. Recommendation

5.1 The Audit & Risk Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 November 2023 to 31 December 2023.
- **NOTE** the WRP forecast overspend and the CTM share of overspend; which has been incorporated into the LHB's annual forecast.
- **NOTE** the overspend on net claim expenditure and the impact of this on the in-year revenue position highlighted in Table 2. This expenditure is charged to the Patient Care & Safety revenue position.

6. Next Steps

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

Medical Negligence Payments 01/11/2023 - 31/12/2023							Appendix 1
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
10RYLMN0014	0	1	0	0	1	108	109
12RYLMN0004	0	0	300	0	300	177	477
12RYLMN0035	0	1	0	0	1	1,383	1,384
13RYLMN0096	0	0	600	0	600	150	750
15RYLMN0049	0	2	17	0	19	398	417
15RYLMN0106	0	0	0	0	0	121	122
15RYLMN0109	0	0	0	-0	-0	25	25
15RYLMN0199	0	4	0	0	4	5	9
16RYLMN0098	0	0	0	-46	-46	71	25
18RYLMN0029	5	0	0	0	5	1	6
18RYLMN0068	0	0	0	-260	-260	285	25
18RYLMN0085	0	3	0	0	3	221	224
18RYLMN0106	0	0	0	0	0	19	20
20RYLMN0005	0	0	0	-376	-376	401	25
20RYLMN0033	0	3	0	0	3	17	20
20RYLMN0035	0	0	0	-3	-3	28	25
20RYLMN0037	0	9	0	0	9	807	817
20RYLMN0099	25	0	40	0	65	9	74
20RYLMN0109	0	2	0	0	2	242	244
20RYLMN0116	-8	0	0	0	-8	431	423
20RYLMN0125	0	0	105	0	105	11	116
20RYLMN0170	0	1	0	0	1	11	12
21RYLMN0019	0	0	0	-418	-418	443	25
21RYLMN0023	10	0	0	0	10	9	19
21RYLMN0024	0	0	0	-166	-166	191	25
21RYLMN0033	0	3	0	0	3	8	11
21RYLMN0034	0	0	0	0	0	5	5
21RYLMN0080	-16	2	0	0	-14	77	63
21RYLMN0098	10	0	0	0	10	73	83
21RYLMN0149	0	1	0	0	1	2	3
22RYLMN0007	75	1	0	0	76	62	139
22RYLMN0039	0	0	25	0	25	3	28
22RYLMN0040	0	1	0	0	1	70	71
22RYLMN0154	0	0	-50	0	-50	54	4
22RYLMN0164	0	1	0	0	1	2	2
22RYLMN0165	0	0	0	0	0	5	5
22RYLMN0174	30	0	17	0	47	7	54
22RYLMN0182	0	0	0	0	0	9	10
22RYLMN0190	0	3	28	0	30	0	30
22RYLMN0195	0	1	0	0	1	2	3
23RYLMN0042	0	1	0	0	1	2	3
23RYLMN0044	0	1	0	0	1	57	58
23RYLMN0061	0	0	12	0	12	3	15
23RYLMN0069	0	0	0	0	0	1	1
23RYLMN0073	0	2	0	0	2	3	4
23RYLMN0079	0	0	120	0	120	6	126
23RYLMN0094	0	3	0	0	3	2	4

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
23RYLMN0119	0	3	0	0	3	1	4
23RYLMN0124	0	2	0	0	2	0	2
23RYLMN0125	15	0	0	0	15	65	80
23RYLMN0139	0	2	0	0	2	0	2
23RYLMN0143	0	0	0	0	0	8	8
23RYLMN0156	21	0	65	0	86	0	86
23RYLMN0157	8	0	13	0	21	0	21
23RYLMN0158	49	1	0	0	51	31	82
23RYLMN0177	0	0	5	0	5	0	5
23RYLMN0180	0	2	0	0	2	6	8
23RYLMN0197	0	1	0	0	1	2	2
23RYLMN0202	0	0	11	0	11	4	16
23RYLMN0220	0	1	0	0	1	0	1
23RYLMN0239	0	7	0	0	7	4	11
24RYLMN0051	0	1	0	0	1	0	1
24RYLMN0069	0	2	0	0	2	0	2
Total 01/11/2023 - 31/12/2023	**225**	**67**	**1,307**	**- 1,269**	**330**		
Total						**6,139**	**6,469**

Redress Payments 01/11/2023 - 31/12/2023							Appendix 2
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLMN0124	0	0	7	0	7	35	42
19RYLMN0109	0	0	0	-8	-8	9	2
19RYLMN0114	0	0	0	-1	-1	1	0
20RYLMN0079	0	0	0	-4	-4	6	2
20RYLMN0082	0	0	-3	0	-3	4	1
20RYLMN0147	0	0	2	0	2	0	2
20RYLMN0176	0	0	0	-19	-19	19	1
20RYLMN0189	0	0	0	-6	-6	6	0
20RYLMN0191	0	0	-8	0	-8	0	-8
20RYLMN0206	0	0	0	-5	-5	7	2
21RYLMN0037	2	0	1	0	3	2	5
21RYLMN0069	0	0	3	0	3	5	7
22RYLMN0018	0	0	0	-1	-1	1	0
22RYLMN0026	0	2	0	0	2	12	14
22RYLMN0032	0	0	0	-27	-27	28	2
22RYLMN0081	0	0	0	-4	-4	4	0
22RYLMN0119	0	0	-2	0	-2	2	0
23RYLMN0020	0	0	-1	0	-1	1	0
23RYLMN0026	0	0	0	-20	-20	21	2
23RYLMN0059	0	0	-1	0	-1	1	0
23RYLMN0090	0	0	-11	0	-11	11	0
23RYLMN0108	0	0	-22	0	-22	22	0
23RYLMN0167	0	0	-2	0	-2	0	-2
23RYLMN0173	0	0	1	0	1	0	1
23RYLMN0189	2	0	3	0	4	0	4
24RYLMN0026	0	0	0	0	0	0	0
24RYLMN0086	0	1	0	0	1	0	1
Total 01/11/2023 - 31/12/2023	**3**	**3**	**- 33**	**- 92**	**- 119**		
Total						**195**	**75**

GP Indemnity Payments 01/11/2023 - 31/12/2023							Appendix 3
Case Reference	**Costs £000**	**Defence Fee £000**	**Claims £000**	**WRP reimbursement £000**	**Total £000**	**Previous Write Offs £000**	**Cumulative £000**
23RYLMN0210	0	1	0	0	1	0	1
23RYLMN0233	0	2	0	0	2	3	4
Total 01/11/2023 - 31/12/2023	**-**	**2**	**-**	**-**	**2**		
Total						**3**	**5**

Personal Injury Payments 01/11/2023 - 31/12/2023							Appendix 4
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLPI0020	0	0	0	-124	-124	149	25
19RYLPI0030	10	0	0	0	10	10	20
20RYLPI0043	0	0	0	-3	-3	28	25
21RYLPI0005	0	2	0	0	2	0	2
21RYLPI0008	0	1	0	0	1	0	1
21RYLPI0009	0	0	0	-9	-9	34	25
21RYLPI0020	0	4	0	0	4	9	13
21RYLPI0041	0	1	0	0	1	2	2
22RYLPI0002	0	1	0	0	1	2	2
22RYLPI0007	0	0	0	0	0	12	13
22RYLPI0014	0	1	0	0	1	9	9
22RYLPI0016	0	0	0	0	0	1	1
22RYLPI0017	0	0	0	0	0	1	1
22RYLPI0020	0	0	0	0	0	1	2
22RYLPI0022	0	0	0	0	0	2	2
22RYLPI0026	0	0	0	0	0	1	2
22RYLPI0027	0	0	0	0	0	1	1
22RYLPI0031	0	0	0	0	0	1	1
22RYLPI0035	40	1	0	0	41	13	53
22RYLPI0036	0	0	0	0	0	1	1
22RYLPI0039	0	0	0	0	0	1	1
22RYLPI0041	0	0	0	0	0	22	22
22RYLPI0043	0	1	0	0	1	1	2
22RYLPI0044	0	1	0	0	1	2	3
23RYLPI0003	0	1	0	0	1	1	2
23RYLPI0005	0	0	0	0	0	2	2
23RYLPI0006	0	1	0	0	1	24	25
23RYLPI0007	0	1	0	0	1	7	8
23RYLPI0008	0	0	0	0	0	1	1
23RYLPI0009	0	0	0	0	0	4	4
23RYLPI0014	0	0	0	0	0	1	1
23RYLPI0019	0	0	0	0	0	1	1
23RYLPI0027	0	0	0	0	0	4	4
23RYLPI0029	0	0	0	0	0	2	2
23RYLPI0032	0	0	0	0	0	1	1
23RYLPI0039	0	0	0	0	0	1	1
23RYLPI0040	0	1	0	0	1	1	2
23RYLPI0042	0	0	0	0	0	0	1
23RYLPI0046	0	0	0	0	0	0	1
23RYLPI0047	0	1	0	0	1	0	1
23RYLPI0051	0	0	0	0	0	0	1
23RYLPI0052	0	0	0	0	0	1	1
24RYLPI0001	0	0	0	0	0	0	1
24RYLPI0002	0	1	0	0	1	0	1
24RYLPI0003	0	0	0	0	0	0	1
24RYLPI0004	0	1	0	0	1	0	1
24RYLPI0005	0	0	0	0	0	0	1

24RYLPI0006	0	0	0	0	0	0	1
24RYLPI0008	0	0	0	0	0	0	0
24RYLPI0009	0	0	0	0	0	0	0
24RYLPI0010	0	0	0	0	0	0	0
24RYLPI0011	0	0	0	0	0	0	0
24RYLPI0014	0	1	0	0	1	0	1
24RYLPI0015	0	0	0	0	0	0	0
24RYLPI0016	0	1	0	0	1	0	1
24RYLPI0017	0	0	0	0	0	0	0
Total 01/11/2023 - 31/12/2023	**50**	**28**	**-**	**- 136**	**- 58**		
Total						**355**	**297**

Permanent Injury Benefit 01/11/2023 - 31/12/2023

Appendix 5

Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	0	253	253
02RVEPI0001	0	73	73
02RVEPI0003	0	185	185
02RVEPI0004	0	127	127
03RRSPI0020	0	903	903
03RVEPI0028	0	275	275
04RRSPI0009	0	246	246
04RRSPI0024	0	172	172
05RRSPI0020	0	85	85
05RRSPI0021	0	204	204
05RVEPI0033	0	312	312
05RVEPI0034	0	92	92
08RVEPI0009	0	203	203
10RYLPI0070	0	115	115
11RYLPI0065	0	266	266
12RYLPI0059	0	81	81
13RYLPI0020	0	42	42
13RYLPI0050	0	156	156
98RVEPI0005	0	7	7
19RYLPI0022	0	353	353
20RYLPI0032	0	49	49
20RYLPI0033	0	21	21
20RYLPI0034	0	33	33
20RYLPI0035	0	97	97
20RYLPI0036	0	67	67
20RYLPI0037	0	23	23
20RYLPI0038	0	54	54
20RYLPI0039	0	41	41
20RYLPI0040	0	102	102
20RYLPI0041	0	68	68
20RYLPI0042	0	33	33
Total 01/11/2023 - 31/12/2023	**0**		
Total		**4,736**	**4,736**

Note-

Other Payments 01/11/2023 - 31/12/2023			Appendix 6
Case Reference	**Type**	**Details**	**Amount £000**
24RYLEG0144	Ex-Gratia	Retirement Vouchers	0.27
24RYLEG0145	Ex-Gratia	Retirement Vouchers	0.32
24RYLEG0146	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0147	Ex-Gratia	Retirement Vouchers	0.46
24RYLEG0148	Ex-Gratia	Retirement Vouchers	0.42
24RYLEG0149	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0150	Ex-Gratia	Retirement Vouchers	0.23
24RYLEG0151	Ex-Gratia	Retirement Vouchers	0.28
24RYLEG0152	Ex-Gratia	Retirement Vouchers	0.40
24RYLEG0153	Ex-Gratia	Retirement Vouchers	0.25
24RYLEG0154	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0155	Ex-Gratia	Retirement Vouchers	0.30
24RYLEG0156	Ex-Gratia	Retirement Vouchers	0.30
24RYLEG0157	Ex-Gratia	Retirement Vouchers	0.32
24RYLEG0158	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0159	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0160	Ex-Gratia	Retirement Vouchers	0.44
24RYLEG0161	Ex-Gratia	Retirement Vouchers	0.37
24RYLEG0162	Ex-Gratia	Retirement Vouchers	0.30
24RYLEG0163	Ex-Gratia	Retirement Vouchers	0.30
24RYLEG0164	Ex-Gratia	Retirement Vouchers	0.35
24RYLEG0165	Ex-Gratia	Retirement Vouchers	0.36
24RYLEG0166	Ex-Gratia	Retirement Vouchers	0.40
24RYLEG0167	Ex-Gratia	Retirement Vouchers	0.28
24RYLEG0168	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0169	Ex-Gratia	Retirement Vouchers	0.31
24RYLEG0170	Ex-Gratia	Retirement Vouchers	0.36
24RYLEG0171	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0172	Ex-Gratia	Retirement Vouchers	0.21
24RYLEG0173	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0174	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0175	Ex-Gratia	Retirement Vouchers	0.26
24RYLEG0176	Ex-Gratia	Retirement Vouchers	0.34
24RYLEG0177	Ex-Gratia	Retirement Vouchers	0.36
24RYLEG0178	Ex-Gratia	Retirement Vouchers	0.39
24RYLEG0179	Ex-Gratia	Retirement Vouchers	0.38
24RYLEG0180	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0181	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0182	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0183	Ex-Gratia	Retirement Vouchers	0.39
24RYLEG0184	Ex-Gratia	Retirement Vouchers	0.26
24RYLEG0185	Ex-Gratia	Retirement Vouchers	0.26
24RYLEG0186	Ex-Gratia	Retirement Vouchers	0.22
24RYLEG0187	Ex-Gratia	Retirement Vouchers	0.33
24RYLEG0188	Ex-Gratia	Retirement Vouchers	0.20
24RYLEG0189	Ex-Gratia	Retirement Vouchers	0.31
24RYLEG0190	Ex-Gratia	Retirement Vouchers	0.37

24RYLEG0191	Ex-Gratia	Retirement Vouchers	0.34
23RYLEG0055	Ex-Gratia	Retirement Vouchers	0.40
23RYLEG0182	Ex-Gratia	Bramble clearing	0.38
24RYLBD0001	Bad Debt write off	Invoice 11779	0.34
24RYLBD0002	Bad Debt write off	Invoice 83890	0.44
24RYLBD0003	Bad Debt write off	Invoice 21872	0.28
24RYLBD0004	Bad Debt write off	Invoice 106486	0.05
24RYLBD0005	Bad Debt write off	Invoice 100216	0.63
24RYLBD0006	Bad Debt write off	Invoice 3574	0.51
24RYLBD0007	Bad Debt write off	Invoice 90323	0.06
24RYLLC0004	Penalty	NHS Pensions Agency - Additional Pension Charge - Adjustment	-3.00
Total 01/11/2023 - 31/12/2023			**14.28**

Agenda Item
4.4

Audit & Risk Committee

Progress on Establishing the NHS Wales Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Samia Edmonds Director of Planning, Welsh Government
Cyflwynydd yr Adroddiad / Report Presenter	Samia Edmonds Director of Planning, Welsh Government
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**
National Commissioning Oversight Board & National Commissioning Implementation Board	Click or tap to enter a date.	Both Boards meet monthly with representation across NHS Wales to oversee implementation of the new Joint Commissioning Committee

Acronyms / Glossary of Terms	
EASC	Emergency Ambulance Services Committee
JCC	Joint Commissioning Committee
NCCU	National Collaborative Commissioning Unit
SARC	Sexual Assault Referral Centres
WHSSC	Welsh Health Specialised Services Committee

1. Situation /Background

1.1 This paper is intended to update the Cwm Taf Morgannwg Audit and Risk Committee on progress to establishing the NHS Wales Joint Commissioning Committee (JCC), as hosted by Cwm Taf Morgannwg University Health Board. The Audit and Risk Committee is asked to note the progress.

1.2 An independent review was conducted in early 2023 to reflect upon the experiences of the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), which also includes the National Collaborative Commissioning Unit (NCCU), and to further build upon national commissioning arrangements.

1.3 The review found that whilst there is good evidence of evolution and growing maturity in both WHSSC and EASC, there remain gaps and potentially lost opportunities in the current national commissioning arrangements in Wales. In particular, the review found scope to improve and strengthen decision making and accountability arrangements.

In summary, the independent review recommendations made are:

- WHSSC, EASC and NCCU should be combined to form a single Joint Commissioning Committee. This would simplify and streamline the current arrangements. It would also create one central point of NHS commissioning expertise in Wales.
- This new Joint Commissioning Committee should be given a new name to highlight that it is a new Committee rather than just a merger of existing bodies.
- The term "specialist" [or "specialised"] should not be used in any new name, but the scope and responsibilities of the service should be defined.
- The new Joint Commissioning Committee should take on an expert supportive role to health boards in developing Regional and Inter Health Board commissioning. This would help build commissioning capacity across the health system in Wales.
- The new Joint Commissioning Committee should be responsible for commissioning the 111 service. This could provide a model for managing other commissioned services within NHS Wales going forward.
- The current hosting agreement should be retained but would need to be reviewed after the new Joint Commissioning Committee is established. (This single, new Joint Commissioning Committee would

be hosted by Cwm Taf Morgannwg UHB as the UHB is the current host and employer for the two existing Joint Commissioning Committees).

- There is currently a lack of Public Health input around population needs assessment etc. and this should be remedied in line with the requirement in the Memorandum of Agreement.
- An organisational development programme should be put in place, including a behaviour framework. This would help ensure the new Joint Commissioning Committee create its own identity.
- The establishment of strengthened governance arrangements for the Joint Commissioning Committee, as set out in further detail in the report.

1.4 Whilst the commissioning of 111 services was not explicitly included in the initial scope of the review, this falls under the opportunities that were explored as part of the horizon scanning. It was subsequently agreed that elements of the 111 service, call handling and clinical advice hubs would transition into the new JCC.

1.5 In addition, Sexual Assault Referral Centres (SARC) commissioning will also become the remit of the JCC.

2. Specific Matters for Consideration

2.1 The new JCC will be established on 1st April 2024. The following progress has been made towards establishing the JCC.

- The new name and branding for the NHS Wales Joint Commissioning Committee/Cyd-bwyllgor Comisiynu GIG Cymru is in place.
- The JCC membership and structure has been agreed as reflected in the NHS Wales Joint Commissioning (Wales) Directions 2024 and the NHS Wales Joint Commissioning (Wales) Regulations 2024.
- The Directions came into force on the 07 February and the Regulations were laid before the Senedd on the 09 February.
- Work is well underway on the supporting governance requirements, including standing orders, standing financial orders, the scheme of delegation and arrangements for managing potential conflicts of interest. An accountability framework is also being developed, with input from a range of stakeholders and experts in this field.
- Recruitment has commenced for the Chair and Lay Members (the advert closed on 12 January with interviews scheduled to take place over the coming weeks). In accordance with the agreed structure appointments will be made to one Independent Chair and three Lay members.
- The supporting Tier 1 and Tier 2 management structure has also been agreed. The Organisational Change Policy (OCP) Consultation was launched on 08 February and will run until 08 March. T1 and T2 job descriptions have been drafted as part of the OCP process and will

be shared on the dedicated staff Teams channel for all affected staff to view in the coming days.

- Welsh Government has confirmed that the Tier 1 Officer of the Joint Commissioning Team will hold Accountable Officer status for certain elements of their role, namely the propriety and regularity for public finances delegated to them by the Health Boards. This does not impact on the accountability of the Chief Executives of the seven Local Health Boards with regard to the planning, securing and commissioning of those services for their respective populations. The Tier 1 officer will also remain accountable, as an employee, to the host in respect of ensuring adherence to all relevant legislation, policies and procedures. This is intended to strengthen and further clarify accountabilities.
  Some concerns have however been raised regarding how this could impact on the ability of the CEO of CTM UHB to discharge his Accountable Officer responsibilities as Chief Executive of the Host Body. Work is underway to ensure the Accountable Officer Memorandum, Interface Agreement between the two Accountable Officers and the Hosting Agreement provides the required safeguards to ensure clarity.
- A BETA SharePoint (intranet) site has been built for the JCC and will have a soft launch at the end of February. A public facing website (internet) is under development and will be ready to go live by 01 April.
- A benefits realisation paper is being formulated and this will continue as part of the organisational development programme for the JCC. The overarching aim remains that by bringing teams and functions together, health boards in Wales will have a central source of experience and expertise for all national commissioning, building on and strengthening existing arrangements.

3. Key Risks / Matters for Escalation

3.1 Good progress has been made and the programme remains broadly on track. The programme continues to review the programme plan and risk register on a monthly basis. The latest risk register is attached for awareness.

3.2 However, it is unlikely that the recruitment for the Tier 1 and Tier 2 posts will have concluded by 01 April and the Oversight Board has advised that a transition plan will be developed by Welsh Government. This will ensure business continuity during early 2024-25, whilst the OCP process is being concluded. The principle of minimal disruption remains as one of the underpinning and guiding principles, recognising though that there will be some change. The Oversight Board next meets on 6 March at which an update on the transition plan will be provided.

3.3 The latest risk register is attached for awareness.

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)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Choose an item. If more than one applies please list below: The creation of the JCC is intended to have a positive impact against all the domains of quality.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Outcome:	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	Legal advice has been sought on all aspects of the programme.	
Enw da / Reputational	Yes (Include further detail below)	
	The governance framework which will support the establishment of the JCC will further mitigate the risks to CTM as the host body.	
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 and Risk Committee is asked to note the progress on establishing the NHS Wales Joint Commissioning Committee

6. Next Steps

6.1 The WG National Commissioning Oversight Board (which includes representation from the Chair and CEO of CTM) will continue to oversee the implementation of the new JCC by 1 April 2024.

National Commissioning Implementation Programme - Risk Log

Risk Ref	Domain	Summary Description of Risk	Owner
NCIP/01	Comms & Engagement	Staff not receiving consistent and timely information leading to misinformation being circulated and disengagement	LL
NCIP/02	Workforce (People)	Uncertainty of TUPE transfer of people from 111 and SARC	KW
NCIP/03	Function and Form	Lack of timely agreement on functions of new Joint Committee (JC)	KP
NCIP/04	Function and Form	Lack of timely agreement on form of new JC	KP
NCIP/05	Function and Form	Delay in agreeing name for new JC through Ministerial Approval (MA) process. Name required for setting up new bank account and for the OCP process	KP
NCIP/06	Function and Form	Delay in seeking MA to proceed with recruitment of Chair for the new JC	SE
NCIP/07	Programme	Capacity of nominated programme support team staff to deliver the programme activities in addition to their daily duties and responsibilities	KP
NCIP/08	Programme	Slippage to programme timelines to ensure the establishment of a new JC by 1st April 2024	KP
NCIP/09	Governance	Timescales for WG to deliver the new governance documentation required to ensure the establishment of a new JC by 1st April 2024, and for HBs to approve delegated authority	SE

NCIP/10	Finance	Delay in agreeing full scope of 111 commissioning elements for transfer into the new JC	KP
NCIP/11	Function and Form	The new integrated call handling platform (SALUS) that was in the process of being brought in has been abandoned and a piece of work is now underway to procure an alternative, which might potentially overlap with the transfer of the 111 call handling service	KP
NCIP/12		Whilst the voting of independent NOMs for the new JCC was there to bring in the balance of decision making, there would be a transitional period for new, potentially inexperienced NOMs to get up to speed in their new roles. This could be a risk recognising the critical nature of some of the impending service decisions that the JCC will be required to make.	SE
NCIP/13		Lack of timely agreement on T1/T2 structure and their roles and responsibilities will delay the OCP process beyond the point of being able to secure posts in place by 1 April 2024	SE/KP
NCIP/14		Restrictions related to the OCP which affect recruitment, staff on FTCs, and create organisational uncertainty could lead to a high level of vacancies in key posts on 1st April 2024	SE/KP
NCIP/15	Service	That the WAST 111 solution (CAS) is end of life at contract expiry in May 2024 and requires replacement prior to this date. This presents a constrained timeframe in which to procure and safely implement a fit for purpose replacement solution. This delivery may overlap with the transition to JCC	WAST
KEY:		**KEY (RAG):**	
LL - Lee Leyshon KW - Karen Wright		Low Score 0 - 9 Moderate Score 10 - 19	

KP - Karen Preece

High Score 20 - 25

Date Risk Identified	Inherent Risk		Overall Risk Factor
	Likelihood of the Risk Occurring 1 (Low) 5 (High)	Impact if the Risk Occurs 1 (Low) 5 (High)	
18.08.2023	5	4	20
05.09.2023	5	3	15
18.08.2023	5	5	25
18.08.2023	5	5	25
08.08.2023	5	5	25
18.08.2023	5	5	25
08.08.2023	5	5	25
08.08.2023	5	5	25
08.08.2023	5	5	25

08.08.2023	5	4	20
19.09.2023	5	1	5
07.11.2023	4	4	16
06.12.2023	5	5	25
19.12.2023	5	5	25
19.09.2023	5	3	15

Mitigating Measures	Date Mitigating Actions Put in Place	Residual Risk	
		Likelihood of the Risk Occurring 1 (Low) 5 (High)	Impact if the Risk Occurs 1 (Low) 5 (High)
Development of FAQ Monthly circulation of staff bulletins and joint staff meetings Up to date complete staff distribution list	30.08.2023	2	4
Clarification being sought. Confirmation needed by November 2023 at the very latest to ensure sufficient time to following TUPE process	05.09.2023	2	3
Early engagement and discussion with Implementation Group and Implementation Board for consideration at October Oversight Board	12.09.2023	3	5
Early engagement and discussion with Implementation Group and Implementation Board for consideration at November Oversight Board	03.10.2023	3	5
Suite of potential names shared with Welsh Government SRO to send up to the Minister in late September/early October for MA	16.08.2023	2	5
3 months built into programme timelines, dependent on approval of Form at Oversight Board in November	06.09.2023	2	5
Fortnightly monitoring by the Programme Director of actions due for completion. Support meetings in place and ad hoc meetings established as required where risks of slippage are identified	16.08.2023	3	5
Programme of activities and timelines developed for each work stream Fortnightly monitoring by the programme support team of actions due for completion Scrutiny and escalation process of all risks built into the programme structure	16.08.2023	3	5
4 months built into programme timelines, dependent on approval of Form at Oversight Board in November	06.09.2023	3	5

Expedite through process to Implementation Board and Oversight Board if unable to agree	06.09.2023	2	4
Following the Salus Contract Exit, focus on financial implications of incumbent and replacement solutions. LHB Adastra 3 year contract renewal completed in Nov 2023. 111 Programme funded Year 1 licence and maintenance costs. WAST CAS replacement business case and costs approved by Interim 111 Board in Dec 2023. WG remain appraised of current position and funding requirement.	19.09.2023	5	1
Mitigating actions identified as Induction and Orientation Programme for Chair and Lay Members Legacy Statements will provide background to the key decisions outstanding and the required action Support and the provision of robust information to inform decision making will be provided to all Joint Committee Members		2	4
Transition Plan under development for Qtr. 1 2024/25. Extended People workstream established, to meet twice in January to consider and agree titles and portfolios of T1/T2 posts. Revised OCP timeline in place. Interim arrangements may need to be agreed i.e. 'Acting Into' posts from 1 April 2024.	19.12.2023	5	4
No mitigating actions identified		5	5
WAST Business Case approved by Interim 111 Board in Dec 2023 identifying preferred supplier and solution. Letter of approval issued noting caveats incl. all capital defined in business case and ongoing revenue within limits of existing resource allocations. Implementation activity now commenced in readiness for April 2024 launch. WAST to update regularly on progress and risk.	28.11.2023	5	3

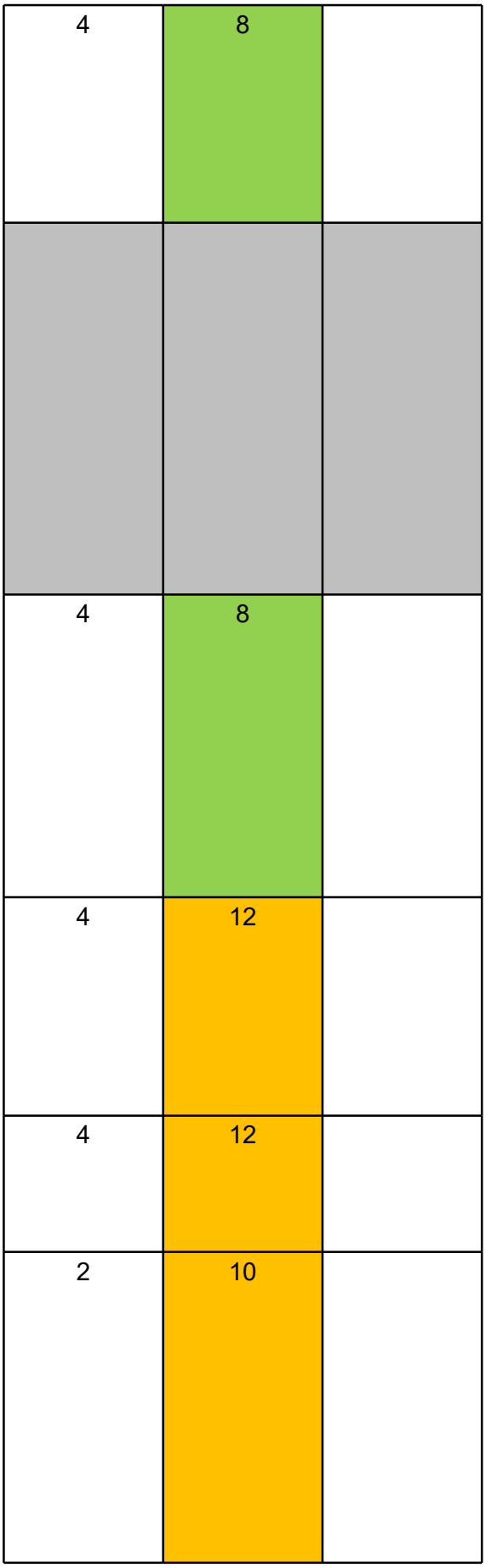
Overall Risk Factor	Further Actions Required/Current Status	Residual Risk	
		Likelihood of the Risk Occurring 1 (Low) 5 (High)	Impact if the Risk Occurs 1 (Low) 5 (High)
8	FAQ developed and shared, continually updated Staff bulletins being issued and monthly joint staff meetings taking place Teams channel established to support two-way communication	1	4
6	SARC Update to be presented to IB and OB in December 23 identifying any staff issues	2	3
15	Functions agreed and signed off by Oversight Board, Ministerial Approval (MA) given.	1	5
15	Form of new JCC agreed sufficient to enable the drafting of legislation which has commenced. MA given.	1	5
10	Name agreed	1	4
10	Form of new JCC agreed sufficient to enable the drafting of legislation which has commenced. MA given.	1	5
15	On track Additional HR support secured to run the OCP process and comms and engagement work Residual risk continues in terms of the capacity of staff	3	5
15	Recruitment of new Chair and Lay Members has commenced. Adverts gone live 12/12/23	3	5
15	On track Drafting of legislation commenced Drafting of SOs and SFIs etc. commenced	2	5

8	£10.3m resource allocation (plus 3.67% uplift) agreed with Welsh Government with formal letter being received. Service model stable and workforce numbers agreed with WAST. Transition plan will be worked through given the one remaining risk linked to CAS replacement.	2	4
5	Propose risk closure owing to replacement solutions identified and in place for LHB (Adastra) and WAST solution being implemented. New Risk NCIP/15 created to track WAST replacement solution to delivery in April 2024.	5	2
8	Develop Induction and Orientation Programme for Chair and Lay Members Ensure Legacy Statements, when developed provide background to the key decisions outstanding and the required action Governance Framework once developed will ensure the provision of robust information to inform decision making will be provided to all Joint Committee Members	2	4
20	Transitional Plan under development for Qtr 1 2024/25 - update to be provided to Overisight Board 06/03/24 T1/T2 titles and portfolios agreed. OCP consultation launched 08/02 - 08/03 Interim arrangements will form part of the Transitional Plan	3	4
25	Vacancies have been considered and released as appropriate FTCs have been given notice to end with the option to be extended following completion of the OCP process	3	4
15	WAST currently implementing the new solution and report status as "On Track"	5	2

Overall Risk Factor	Status	Further Actions Required/Current Status	Residu Likelihood of the Risk Occurring 1 (Low) 5 (High)
4		No further actions identified	1
6		No staff to be transferred. Legacy statement drafted and transitional plan being developed to support the transfer post April 24	1
5	Closed		
5	Closed		
4	Closed		
5	Closed		
15		Programme on track. All workstreams operating effectively and majority of project activities completed. Programme Director and Project Manager leaving (20/02 and 14/03 respectively) Alternative arrangements in place for PD. Arrangements to replace PM to be agreed	2
15		Sufficient applications received. Shortlisting taking place 14/02. Interviews to take place w/c 26/02. On track to appoint by 01/04	2
10		Directions came into force 7/02, Regulations laid 9/02 Further drafting of Governance Framework documentation for review at Implementation Board 20/02	1

8		No further actions identified	2
10	Closed		
8		No further actions identified	2
12		No further actions identified	3
12		No further actions identified	3
10		No further actions identified	5

al Risk Impact if the Risk Occurs 1 (Low) 5 (High)	Overall Risk Factor	Status
4	4	
2	2	Closed
3	6	
5	10	
5	5	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Agenda Item
5.1

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
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 / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	December 2023	RISKS REVIEWED
Operational Management Board / Offline via Email	December 2023	ENDORSED NEW RISKS FOR ELG
Executive Leadership Group (ELG)	15th January 2024	EXECUTIVE SIGN OFF RECEIVED
Quality & Safety Committee	23rd January 2024	ASSIGNED RISKS REVIEWED
People & Culture Committee	7th February 2024	ASSIGNED RISKS REVIEWED
Digital & Data Committee	21st February 2024	ASSIGNED RISKS REVIEWED

Acronyms / Glossary of Terms	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

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

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 9th January 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

2.4 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.

2.5 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

2.5 To date **589** members of staff trained to date since training commenced in 2021.

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

2.7 Feedback on the training continues to be positive, please see below:

- 21 attendees have provided formal feedback (using the URL Code for the Evaluation Form) from the November 2023, December 2023 and January 2024 sessions. 76% provided a score of 5/5 in terms of content of the session and the remaining 24% provided a score of 4/5.

- 100% of the 21 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.

- 95% of the 21 attendees said they felt more confident to escalate a risk through the organisation.

- Some of the comments received through evaluation have been included below:

  "Good delivery of training session, presenter knowledgeable of session contents and professional in delivery of contents. Helpful links and ongoing support offer. Organisational changes impact on new/revised way of working, well defined and explained in the risk management session, would highly recommend staff to attend training session".

  "Engaging session, presented the subject matter in a way that was easy to understand, good use of examples and taking us through a live risk was helpful. Enjoyable session helped by a good presentation style".

  "Really clear explanation of risk and Datix. Will get my team on training ASAP".

  "I feel more confident that I know who to contact for support escalating a risk even if I don't necessarily feel more confident doing it independently".

  "Find Datix very difficult to use. However this session helped clarify why it's important to record risk and went someway to demystifying how to do it. Still feel the legacy system will be a challenge but worth persevering with."

Once For Wales – New Datix Risk Module

2.8 The implementation of the new Datix Risk Module has been delayed. The Assistant Director of Governance & Risk represents the Health Board on the All Wales Task and Finish Group and is contributing to the developments and improvements sought from the opportunity to develop a new module.

2.9 The Once-for-Wales Programme Management Board met in December 2023, and they took the decision to extend the current Datix contract by a further three years which will take the Health Board up to the end of November 2027. A timeframe as to when the new OFW risk module will be achieved is awaited. In the meantime, there is a pilot of the new system underway in another Health Board whose feedback is eagerly awaited.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Central Function - Medical Directorate

- **Datix Risk ID 5640 – Potential Junior Doctors Industrial Action.** New risk escalated in December 2023. Risk score of 20.

Mental Health & Learning Disabilities Care

- **Datix Risk ID 5646 – The Impact of "Right Care Right Person" approach.** Escalated in December 2023. Risk score of 16.

3.2 CHANGES TO RISKs

a) Risks where the risk rating INCREASED during the period

Nil on this reporting period.

b) Risks where the risk rating DECREASED during the period

Diagnostics, Therapies, Pharmacy and Specialties Care Group

- **Datix Risk ID 2713 – "Backlog of Reporting Radiology Examinations".** Risk reviewed in November 2023. Risk reduced from 20 to 16 due to additional funding secured, non-recurrent until end of March 2024, to be used for outsourcing reports.

Facilities Directorate

- **Datix Risk ID 4348 - Compliance to the PUWER (Provision and Use of Work Equipment) Regs 1998, MHRA compliance, Wales**

Duty of Quality Statutory 2023. Risk reviewed and likelihood score reduced to a score of 3 as function have reviewed outstanding Planned and Reactive Jobs. General reduction and downward trend noted of outstanding backlog of jobs. The risk will remain on the Facilities Risk Register as risks not completely mitigated and therefore target score not yet reached.

Central Function – Finance

- **Datix Risk ID 5425 – Failure to achieve financial balance in 2023-2024.** The £8m stretch target has been allocated to Care Groups and their latest forecasts (post M7) are forecasting a £5m improvement compared to their M6 forecasts. The Health Board's Month 8 Finance report is now forecasting that the Health Board will achieve the break-even Control Total set by WG for 23/24. In response to this update the likelihood of this risk being realised has been reduced, however, in recognition of the continuing pressures and challenges the target score has not yet been achieved.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Diagnostics, Therapies, Pharmacy and Specialties Care Group

- **Datix Risk ID 4798 – Staffing levels do not meet standards for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital**. Following a review of this risk in December 2023 the target score had been reached and the risk has now been closed. Speech and Language Therapy (SLT) staff are now in post across all three critical care units. Gaps between current staffing levels and Guidelines for the Provision of Intensive Care Services (GPICS) standards remain for Physiotherapy, Occupational Therapy and SLT, however no clinical incidents or concerns are being reported. However, a gap remains in relation to funding of Dietetics for Princess of Wales, with clinical incidents being reported and a new risk is being developed (Risk ID 5658, which is being considered for escalation to the Organisational Risk Register).

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

Consequence						
	5			4253 3337 4768 3993 4887 4080	4664 5276	
	4				4337 3008 4906 4809 4753 3131 4671 5477 4908 5404 5579 4152 3133 4752 4922 4417 5374 5254 4907 5602 5646 5427 2713	4491 4071 4103 4841 4827 4780 3826 1133 5590 5640 4632 5462
	3					3638 4732 4699 4928 4650 4672 4691 2808 5040
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 **Matters to Note / Notified emerging risks**

- The Assistant Director of Transformation is currently developing a new risk for escalation relating to the "Community Brain Injury Service in Bridgend", the risk development is still progressing and is yet to be escalated to the organisational risk register.

- Diagnostics, Therapies, Pharmacy and Specialties Care Group have identified a new risk for approval relating to the "Lack of Dietetic service provision to Princess of Wales Critical Care", this is expected to be captured in the next iteration of the organisational risk register in March 2024, once agreed by the Operational Management Board.

- Datix Risk ID 5642 Adult Weight Management Service is being reviewed to consider incorporating the any additional risk areas identified relating to compliance with National Institute of Clinical Excellence (NICE) guidance and it is anticipated that these updates will be reflected in the March iteration of the organisational risk register as appropriate.

- Primary Care and Community Care Group have identified a new risk for approval relating to the "Palliative Medicine Staffing Merthyr Cynon", this is expected to be captured in the next iteration of the organisational risk register in March 2024, once agreed by the Operational Management Board.

- The Facilities Directorate have identified a new risk for approval relating to "Fire doors in staff residential accommodation across organisation are non-compliant to the Regulatory Reform Fire Order 2005". This is expected to be captured in the next iteration of the organisational risk register in March 2024, once agreed by the Operational Management Board.

4. IMPACT ASSESSMENT

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

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	5640	Executive Medical Director	Medical Directorate	Medical Directorate Manager	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential Junior Doctors Industrial Action	If...the NHS Wales Junior Doctors take industrial action related to a dispute over pay erosion between 15th-18th January 2024 Then...there will be significant disruption on clinical services and planned and unscheduled care provision will likely be impacted. Resulting in...the quality of the care and services provided to patients and service users being affected in terms of access to services and compliance with performance and delivery objectives. This includes an impact on waiting list times for surgery and outpatients increasing, and patients being unable to access some health care services.	This is a national issue and decisions on any pay increases are out of CTM's control. A decision on strike action has been confirmed for 15th-18th January 2024. There will be no derogation agreed ahead of the proposed strike unless the health board has offered BMA agreed rates to the doctors Consultants/SAS doctors in some cases will be asked and negotiated with to cover gaps in service. National group in place which includes group of senior colleagues who are agreeing process around pay rates for "acting down"	Process to be agreed with BMA for derogation decisions on day of strike with clear info on the information UHB's will have to provide. BMA have stated they will turn these around in 30-60 minutes CTM working group taking place regularly HB can switch pre-existing locum hours around with agreement, however, locums have already cancelled their shifts Planning and preparation with contingency plans for all affected service will be taken. With these measures in place the consequence score will reduce to 3, with a target score of 15.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C4xL5	C3xL5	New risk escalated January 2024	04.12.2023	05.01.2024	15.1.2024 & 12.2.2024
3	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	**IF**: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. **THEN** patients will not receive the necessary imaging **RESULTING IN** delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Update January 2024 Risk reviewed at the end of November 2023. Weekly meeting regionally, engaged with pharmacy Royal Glamorgan Hospital (RGC), dispensing training arranged at RGH with support from Cardiff and Vale clinical scientist, ARSAC license in place, reviewing Delegated Authorised Guideline (DAG) (under radiation protection legislation)for authorising and reporting. USC patients currently being seen in POW as most clinically vulnerable. Will continue to review on a weekly basis. Potential backlog for non USC work. Next review scheduled for mid-January 2024. Update 9th January 2024 - Update 9.1.24: New Service Level Agreement (SLA) required with Swansea Bay, currently in progress. All CTM patients being scanned at Princess of Wales Hospital (POW). Score remains the same,	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	9.1.2024	9.2.2024
4	5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update January 2024 - This risk was discussed at the LIMS Programme Board on the 9th January 2024. The outcome of the discussion was to retain the risk on the Organisational Risk Register as the risk priority remains high due to reporting issues across all Health Boards. Local build is going well although there are risks in terms of resources. Paper submitted to ELG requesting resource within the department to support the implementation for the next two years. Risk score remains unchanged at present.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	09.01.2024	09.02.2024
5	4780	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Patient Handling Training	If there are no Trainers available to provide patient handling training Then all new starters need to be on restricted duties. Organisational compliance is affected. Training response to Incidents such as W156305 cannot be achieved. Manual Handling Training staff resource is not sufficient for new HB. Current establishment of two Trainers to approx. 7000 patient handling staff makes compliance with regulatory requirements unachievable. Resulting in breach of Health & Safety Law, particularly MHOR 1992, LOLER 1998, PUWER 1998, H&S at Work Act. Non-compliance with Organisational mandatory training requirements. Enforcement action from the HSE.	Two Band 3 Training Assistants continue to deliver Inanimate Load Handling Training so staff groups such as Admin & Clerical are not at risk. The current Training Post for Bridgend is vacant, new Trainer commencing employment 31st August 2021. Trainer in post at Tontegis on LTS (Long Covid). Manual Handling Advisor picking up training where possible which is impacting on their ability to function within their role.	Update January 2024 -All funding now approved for these additional posts and all posts are in the various stages of recruitment. Risk score will be reviewed in February.	Health Safety & Fire Sub Committee	20	C4 x L5	4 C2xL2	↔	06.08.2021	02.01.2024	29.02.2024
6	4827	Executive Director for People	Central Support Function -Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Lack of Lead for Face Fit Training along with Face Fit Trainers	If the organisation fails to appoint and provide a fully qualified face fit testing lead and suitable number of Face Fit Testers. Then there is a potential for staff to be exposed to airborne viruses e.g. Covid, flu, etc.; Resulting in lack of assurance that the risk is being adequately managed at a local and Board level further resulting in a high risk of prosecution by the Health and Safety Executive.	Departmental Trainers have been trained but not in the numbers required by the organisation. Many of those trained during the first phase has now returned to substantive posts and are unable to undertake this role. Also may now be out of compliance for annual review of practice. Single H&S Coordinator is taking up this role on a part-time basis but this is inadequate for the requirements due to the commitments of his substantive post and the demands/size of the organisation. Departmental trainers are in post across the organisation but not all are able to fulfil this role either due to returning to busy substantive roles or being out of compliance of their annual review. Despite posts being added to Trac, it has become apparent that there is no funding available in the UHB to support this work. Discussions are underway between the Director for People and the Deputy Director of Nursing. No clear plan available to address this risk currently.	Update January 2024 - Business case approved but not for the full funding. Two fit testers and lead roles have been advertised and due to close middle January 2024. Risk score ill be reviewed in February.	Health Safety & Fire Sub Committee	20	C4xL5	9 C3xL3	↔	01.02.2021	02.01.2024	29.02.2024
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 January 2024 - due to ongoing pressures risk reviewed and score and mitigation remains unchanged. The following updates are however noted in terms of the Six Goals Plan: 1. Capital work underway in Prince Charles Hospital for Same Day Emergency Care (SDEC) unit completion. This timeframe has moved to February due to contracting delays. 2. Acute frailty established in Princess of Wales Hospital and Royal Glamorgan Hospital, recruitment completed for service in Prince Charles Hospital awaiting start dates. Deputy Medical Director (Acute Services) to meet with Care of The Elderly (COTE) Teams to establish progress. 3. Navigation hub screening calls from nursing homes and pulling proactively from WAST stac (Ambulance demand) .Pilot phase completed and successful, Navigation hub used as business as usual. Next steps are to develop ticket to ride model and expand to residential homes. Also exploring opportunities to work with WAST with Advanced Paramedics being incorporated as part of the navigation hub MDT. Next review: 22.2.2024	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	22.01.2024	22.02.2024
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 January 2024 - Further work undertaken in streaming the Haematuria pathway. Work undertaken with Bowel screening Wales. Next review 5.2.2024.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	05.01.2024	05.02.2024

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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	Next Review Date
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: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews Update January 2024 - risk mitigation reviewed with no change or further updates. Next review 5.2.2024.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	05.01.2024	05.02.2024
10	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 January 2024 - New governance arrangements will provide a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • Operational Group established, first meeting held in September 2023 with a focus on the performance and actions for improvement. • Consultant recruitment still problematic and as such alternative options being explored re SAS doctors to provide an increased level of robustness. • Brainomix implementation continues led by Stroke Consultant. • The USC SMT have had further engagement with colleagues from CAV in developing options towards a regional solution for stroke services. These would involve significant service change and potential for investment – options will follow a regional piece of work. • Directorate teams exploring feasibility of developing further stroke ANP roles. Review undertaken of the historical action plan aligned to the stroke strategy group where many of these actions have been closed. Risk Remains 20, C4 C5 Review date 28/02/2024.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	05.1.2024	28.02.2024
11	5462	Executive Director of Therapies and Health Sciences.	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update January 2024 Last review 15.12.23 next review 11.03.23 Current actions are the monitoring of capacity and demand alongside pathway redesign. Mitigations via provision of an interim offer of a level 2 service have been fully explored. 1300 people remain on the waiting list. There was a 47% response rate to the partial booking letters sent in November. If this trend continues, estimated waiting time will reduce from 6 years to under 3 years. Initial findings from evaluation of pathway redesign (group interventions) will be completed in Quarter 4, from which further capacity mapping will take place.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	15.12.2023	11.03.2024
12	4664	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	Captured in private session of the Committee due to business sensitivities.										
13	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 January 2024 - Unscheduled Care Senior Management Team reviewed risk, a review is to be undertaken of the ambulatory SOP relating to fit2sit and the potential to expand ambulatory footprint at the Princess of Wales site. This is being explored with the clinical team. • The operational capital group meeting held 18th October advising that they have been successful in obtaining WG funding for RGH nurse call bell and emergency call system within Ambulatory Emergency Care Unit (AECU), a complete ward refurbishment to ward 19 RGH and a scoping exercise to expand the RGH ED footprint. This will improve patient experience within these departments. • This remains an ongoing risk for all 3 sites and will be reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With the recent onsite of winter pressures, risk rating to remain at 20. C4, likelihood 5. New review date 28/02/2024.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	05.1.2024	28.02.2024
14	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update January 2024 - Senior Management Team risk reviewed, nurse establishment review continues in RGH Emergency Department (ED), invest to save paper submitted for RGH ED nursing staff. Awaiting outcome, Health Care Support Workers will be submitted next and can then to look to reduce. Risk rating remains C4 & L5, risk score 20. Review date 28/02/2024.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	20	C4xL5	8 (C4xL2)	↔	20.02.2014	05.1.2024	28.02.2024
15	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.	The Health Board will gather and analyse available data to further understand the issues and impact The Health Board will explore options to manage the need in a different way. Risk likelihood assessment: Initial data gathering suggests that the likelihood is more likely to be weekly and not daily.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	New risk escalated January 2024	08.12.2023	03.01.2024	28.02.2024

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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	Next Review Date
16	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	IF there is consistent backlog of Radiology reports THEN there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes RESULTING IN deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Update January 2024 Risk reviewed in November 2023. Risk reduced from 20 to 16 due to additional funding secured, £300,000 non-recurrent until end of March 2024, to be used for outsourcing reports. 250 CT per week, 200 MRI, monitoring to adjust greatest need. 6.5 consultant vacancies still stand, with active recruitment ongoing. Risk score remains under review as likelihood may increase when funding's ends due to sustainability. Risk to be reviewed mid January 2024.	Quality & Safety Committee Planning Performance & Finance Committee	16 or 20	C4xL4	4 C4xL1	Risk reduced from a risk score of 20 to a 16 in January 2024 Organisational Risk Register	08.02.2017	20.11.2023	15.01.2024
17	5579	Interim Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Children and Young Persons Weight Management Service	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	Update January 2024 Current actions: pathways and workforce models are in development, aiming for fully costed business case to be completed by end of January 2024.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	13.12.2023	31.01.2024
18	5602	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Captured in private session of the Committee due to business sensitivities.											
19	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 January 2024: Backlog remains for redress cases: Team Lead triaging backlog of cases, to ensure that cases are prioritised appropriately. Duty of Candour continues to be an area of increased activity, which should see more of an increase with the introduction of fixed recoverable costs in lower value claims. This is due to be implemented in April 2024. New 'Invest to Save' bid is in review stage of development, prior to submission. Other mechanisms such as overtime are being explored to manage the backlog.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	28.12.2023	01.02.2024
20	5427 (Replacing 5154)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	Update January 2024 - As at M8 the Health Board are reporting a forecast underlying deficit at the end of 23/24 of £35.7m (M7: £19.8m). This forecast assumes that the Health Board secures the £51.1m recurrent funding which is conditional on achieving the break-even Control Total for 23/24. This forecast will be updated in January and February as the Health Board reviews the WG Allocation Letter and develop the IMTP and financial plan for 24/25.	Planning, Performance & Finance Committee	16	C4xL4	12 C4 x L3	↔	28.04.2023	29.12.2023	1.3.2024
21	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	IF: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update January 2024 Links made with Once for Wales Central Team to assist with better reporting. A new report has been developed which gives more useful information in respect of inquests and any outstanding elements. Inquests are now being graded to identify high risk inquests (Red, Amber and Green). Legal Services staff are in the process of reviewing older inquests. Regular meetings continue with Legal and Risk and HMC to ensure open communication in order to manage any issues more efficiently.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	28.12.2023	01.02.2024
22	4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 Inquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update January 2024 - the system for the timeline is now in place and population of information linked to the repository has commenced. The resource implications are significant and therefore it will take some time for the Health Board to map and archive all information. The Covid-19 Inquiry Information Manager is exploring automation options with the Head of Information to explore whether this will support a more efficient archiving approach.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	23.11.2021	05.01.2024	01.03.2024
23	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	IF: the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. THEN: There will be delays in performing and reporting autopsies. RESULTING IN: * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update January 2024 Weekly Coroner meetings continuing. The number of Post Mortem (PM) requests has increased significantly as deaths increase. Additional private provider sessions to mitigate increase but current PM backlog is at 8 days. Risk to be reviewed 31.1.2024.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	02.01.2024	31.01.2024

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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	Next Review Date
24	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update January 2024 Escalation plan in place and level 2 escalation triggered. Occupancy increases over festive period has placed challenge on capacity. Currently this has not required further escalation although position remains fragile. Risk to be reviewed 31.1.2024.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	02.01.2024	31.01.2024
25	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update January 2024 The Legal Services team are prioritising other areas of work which have risk of penalties i.e. LFERs and Inquests New invest to save bid has been prepared and is being reviewed. Other mechanisms such as overtime are being explored.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	28.12.2023	01.02.2024
26	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.	January 2024 Update: Fulfilling our environmental and social duties and ambitions: Build environmental and social impact sections into health board project paperwork/cover sheets to ensure these have been considered as part of decision making processes. Timeframe: 28.6.2024. The Decarbonisation Action Plan (DAP) to be completed by March 2024. No Change to risk score as at this review.	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	8.1.2024	28.02.2024
27	3008	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 6. Ask other HB`s their MH requirements SBUHB online training package to be shared. 7. Directorate will Seek out any opportunities for online updating to support current practice 8. 2 registered nurses to undertake train the trainer and initially cascade to community midwifery staff, commencing Sept 2022. 9. Staff member identified to action monthly module B training to facilitate improvement in knowledge and skills- agreed 11.10.22 10. In agreement with MH team 2 midwives to undertaken 5 day TTT course for manual handling in July. Meeting arranged with MH team to arrange bespoke 3 hour course for all midwives to be implemented 2023/2024 for 100% compliance in 12 months.	Update January 2024 - Bespoke Manual Handling training was commenced in Sept 2023. The plan is that the agreed sections of the All Wales Manual Handling Passport will be completed by all staff over a 2 year period. Year 1 (Part1) – Mod A, B, part of C Year 2 (Part 2) - Mod C, D and E (with agreed exceptions) With regards to compliance, the majority of staff are already rostered to attend Part 1 between Sept 23 – July 24. A follow up email was sent to line managers and roster managers before Christmas reminding them to book on any staff who had not already been rostered. With regards to Part 2, when the training dates for next academic year are released, the roster managers will roster all of there staff on to training for the entire year so that we can see the compliance trajectory and chase up rebooking staff in an efficient manner should they not attend training for any reason.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	01.05.2017	11.1.2024	1.3.2024
28	3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update January 2024 - E-Learning (ESR/All Wales) package still not active (out of Clinical Engineering hands to activate this), compliance for Nursing staff has not increased significantly since last review. The ownership of this risk needs to be placed with the appropriate Clinical Service Group for this risk for Nurse training attendance - to be discussed with Patient, Care and Safety Function of appropriate action to move the risk ownership. Next review 29.3.2024.	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	04.01.2024	29.03.2024
29	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	Updated January 2024. Risk reviewed 22.11.2023. Non obstetric Ultrasound 7050 pts - 98 week wait - in-house Waiting List Initiatives (WLI), evenings and weekends MRI 2693 PTS - 50 week wait (main cohort of patients at 20 weeks) ongoing validation and planning for booking more complex cases e.g. arthrograms and General Anaesthetic paediatric lists. CT 2174 pts - 52weeks - active validation and cross site booking in progress Active review of compliance with Referral To Treatment (RTT) booking guidelines and streamlining. Next review scheduled for 15.1.2024.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	3.11.2023	11.12.2023

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
30	4337	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	**If:** The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers **Then:** The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	**Key Controls** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems, the ABHB Clinical Workstation or Local Authority system Numerous delays in NHS Wales progressing open architectural approach which results in CTM UHB being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Integrate Bridgend ICT Systems within CTM - 22/09/2023 - SLA Aligned to Infrastructure has been arranged to move to CTM in the majority as of October. Further work on the standalone systems has been made and a scheduled defined. Timeframe: 29.12.2023 Additional Funding for ICT Integration of Bridgend - WPAS funding for resource, workstream started Nationally led. estimated timescales arrive at 2025. Next review scheduled for 29.12.2023	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	22.09.2023	29.12.2023
31	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Update January 2024 - Meetings with Lead Nurse have taken place proposal training paper discussed at the 12/12/23 Mental Health and LD Health and Safety Committee. Recommendation 5 nurses are contracted to deliver PMVA training to the Care Group 25 days per year on band 4. PSA to provide professional governance. Deputy Head of Nursing, Mental Health is leading, existing trainers have been consulted on the proposal.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	02.01.2024	31.3.2024
32	4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	Update January 2024: LFER status is regularly monitored in: -Weekly Patient Safety, Complaints and Legal Services data meeting, -Weekly Executive Patient Safety Meeting and Quality & Safety Committee. New systems and processes have been in place for some time in respect of the management of LFERs. However, benefits from improvements are now coming to fruition, with LFERs being managed in a more efficient way. If non-engagement, more timely escalation is proving successful. A deadline for the end of January 2024 has been set by WRP to submit and have approved all LFERs triggered before 1st September 2023. Work continues on these. A review of the level of this risk will be undertaken after this target has passed with a view to downgrade.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	28.12.2023	01.02.2024
33	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 January 2024 - MHLD Care Group Director - 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.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	08.01.2024	28.02.2024
34	4671	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Captured in private session of the Committee due to business sensitivities.											
35	4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no Care of The Elderly (CoTE) service and no specialist advice available	Update January 2024: Senior Management Team reviewed, following clarity of ask from Executive Team. Unscheduled Care Group will hold responsibility for Consultant orthogeriatrician to be working with the wider Care of the Elderly Team on each site. Awaiting disestablishment of posts in planned care in order to fund. Risk rating remains at 16. New review date 28/02/24.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	05.01.2024	28.02.2024

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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	Next Review Date
36	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 November 2023 - the Health Boards Non Consultant Rate Card is now active. Medical Workforce Productivity Programme continues as detailed in the August update above and at this point risk score remains unchanged. Risk score will be reviewed in January 2024. Review scheduled for the 31.1.2024.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	31.10.2023	31.01.2024
37	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 1.0 wte Psychiatrist (clinical lead role, Uplift from 8a to 8b 0.6 wte Pharmacist, 1.0 wte Band 3 admin & 0.6 wte Band 3 HCSW - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Update at January 2024 - Activity ongoing in terms of further investment in the service. NDIP funding is currently on hold and further updates on this is awaited from Welsh Government. Job descriptions have been drafted in readiness for funding being made available. The risk of funding not being realised has been escalated internally due to the impact on new patient appointments if this gap cannot be resourced. Timeframe 31.3.2024. Risk will be reviewed 1.3.2024.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	10.1.2024	01.03.2024
38	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 November 2023 - October Programme Board agreed a preferred option, this option requires significantly less capital. The option has been presented to Welsh Government Capital Team, however, there are revenue elements to the option which require further exploration with Welsh Government. Update January 2024 - the business case is being developed and is due to be submitted to WG October 2024. Update January 2024 - A request was made to South Wales Fire & Rescue Service (SWF&RS) to extend the Fire Enforcement Notice by a period of 2 years to enable the remedial scheme to be implemented. SWF&RS have initially agreed an extension of 12 months, with the agreement the Health Board could apply for a further extension if necessary. The current Notice is now due to expire on 1st January 2025. There is documentation on this available on request from the Assistant Director of Health, Safety & Fire.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	09.01.2024	31.01.2024
39	4672	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	**IF:** The Health Board is not able to record information accurately and reliably, with complete and up to date information **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update as at November 202 from CIO - AVN External provider contract has finished and all day forward scanning continues to be undertaken in house by the Health Board scanning team in Williamstown. The Health Board is consistently maintaining the 48 hour turn around target for all scanning but legacy scanning has now been paused due to the end of the contract with the supplier. Longer term strategy now in early development stages to agree way forward for remaining paper notes across the organisation. The foundational building blocks which will enable the use of clinical e-forms interoperable with our integrated care record have developed well, with DHCW starting to enable integration to the record they hold. Clinical coding improvement programme has progressed strongly, with over 95% of episodes being coded within the month, and 25000 coding rules now built into the autocoder. The preparation for e-forms and ontologies is now under development. Data quality and completeness remains sub-optimal, with the intelligence suggesting that insufficient allocation of clinical resource and admin support to the maintenance of the record being the key contributory factors There remains a requirement for a fundamental change in the clinical information model, which is starting to be considered at the national level. The digital and data team have reviewed the risk and would ask that it remains at a 15 for now. Review date: end of December 2023.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	07.11.2023	31.12.2023
40	5040	Director of Digital	Central Support Function - Digital & Data	Chief Information Officer	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	**IF:** The Health Board can not integrate new applications into its digital architecture in a timely fashion **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered **Resulting in:** delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	New systems and processes have been in place for some time in respect of the management of LFERs. However, benefits from improvements are now coming to fruition, with LFERs being managed in a more efficient way. If non-engagement, more timely escalation is proving successful. A deadline for the end of January 2024 has been set by WRP to submit and have approved all LFERs triggered before 1st September 2023. Work continues on these. A review of the level of this risk will be undertaken after this target has passed with a view to downgrade.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	01.09.2023	30.12.2023
41	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	The Mental Health Care Group High Quality Record's workstream has developed a Clinical Information Access and Recording matrix (CIARM) for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service to enable safe sharing of information across sites. It is anticipated that digitisation of audit of compliance will be complete by 31 March 2024. In relation to WCCIS Digital Health Care Wales (DHCW) commissioned a review of the requirements under the existing programme and it has been confirmed that this will be withdrawn in January 2026. There is no confirmation of a national replacement system as yet. Director of Digital advised that a paper is planned for submission to the Improving Care Board on the 10th January 2024 regarding the consideration of future options. Next review 31.3.2024.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	08.1.2024	31.3.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
42	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case to be prepared and submitted to Welsh Government Inpatient Improvement Programme has been established - April 2023.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. SON completed to support strategic and systematic review of inpatient development opportunities. 3. Develop a strategic outline business case following no.2 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Update January 2024 - MHLD Care Group Director - 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.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	08.01.2024	28.02.2024
43	4699	Director of Digital	Central Support Function - Digital & Data (Information Governance)	Chief Information Officer	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Failure to deliver a robust and sustainable Information Governance Function	**IF:** The Health Board is not able to legally share the business and patient sensitive information for which it is a data controller and which it is required to shared for the delivery of care **Then:** There will be a loss of trust and confidence in the Health Board from its patients, population, staff and 'care providing partners' and thus will not have the information required to provide safe, high quality and effective care and to make informed evidenced based decisions. **Resulting in**: Poor outcomes for our population, a loss of reputation for our organisation, substantial delays in improving services, inability to collaborate regionally or deliver integrated care services.	**Key Controls:** - Adoption and implementation of All Wales IG and Data protection policies. - Continual improvement and progress made in mitigating non delivery of legislation (CLDC, DPA etc.) - Mandatory training in Information Governance with auditing functionality (such as NIIAS) built in to monitor compliance, - Accessible but robust data protection process for new and existing data sharing arrangements (DPIA procedures) - Joint data controllership arrangements with DHCW + WASPI -Professional (clinical) training and approach to maintain an accurate and timely medical record **Gaps in Controls:** 1. Shortfall in trained IG professionals 2. Inability to legally stipulated timescales for Freedom if Information and Subject Access Requests	Update January 2024. Review of risk score underway to consider if score can be reduced as a result of successful recruitment for the IG function. Three new members of the team have joined the function as of January 2024. Final response with the ICO audit team is taking place on 10/01/2024 where their final decision will be received as to whether they are satisfied with progress made. Ongoing challenges with meeting minimal operating requirements in Information Governance, however this is expected to improve with additional resource. Review of risk score and mitigation will be undertaken during next period. Review date: 28.02.2024	Digital & Data Committee	15	C3xL5	12 C3xL4	↔	18.06.2021	08.1.2024	28.02.2024

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
4348	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Compliance to the PUWER (Provision and Use of Work Equipment) Regs 1998, MHRA compliance, Wales Duty Of Quality Statutory 2023	If: The Health Board fails to deliver a robust and sustainable Clinical Engineering function. Then: Due to the quantity and complexity of medical devices being purchased the Health Board would not be able to provide a full service in terms of advice, maintenance & repair and compliance with relevant legislation and regulations. Resulting In: Non-compliance with the legislation / regulation such as PUWER, MHRA (Medicines and Healthcare Products Regulatory Agency) Managing Medical Devices 2021 guidance and Wales Duty Of Quality Statutory Guidance 2023	All calls and responses are being prioritised according to service risk and need. Some overtime is being utilised to cover some planned maintenance. Service contracts in place for life support Anaesthetics Equipment (a cost pressure) as a result of vacant B6 Technologist post.	Update November 2023 - Recruitment exercise completed and new staff are starting training period. Risk remains unchanged until new starters are fully trained and up to speed. Review risk again in 3 months with a view to close/reduce risk. Review date: 29.12.23 Continue to review risk to budget relating contracts in place and future workforce position.	Planning, Performance & Finance Committee	12 C4xL3	4 C4xL1	Risk Reviewed and likelihood score reduced to a score of 3 as function have reviewed outstanding Planned and Reactive Jobs . General reduction and downward trend noted of outstanding backlog of jobs. The risk will remain on the Facilities Risk Register as risks not completely mitigated and therefore target score not yet reached.
5425 (Replacing 5153)	Executive Director of Finance & Procurement	Sustaining our Future	Financial Stability Risk	Failure to achieve financial balance in 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2023/24. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 23/24 Context: The context is that the draft financial plan for 22/23, . This planned deficit is also dependent on the delivery of efficiency savings of £27.3m which is a significant step up in savings compared to recent years	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	Update January 2024 - The £8m stretch target has been allocated to Care Groups and their latest forecasts (post M7) are forecasting a £5m improvement compared to their M6 forecasts. The Health Board's M8 Finance report is now forecasting that the Health Board will achieve the break-even Control Total set by WG for 23/24.	Planning, Performance & Finance Committee	12 C4xL3	8 C4xL2	As at January 2024 – the £8m stretch target has been allocated to Care Groups and their latest forecasts (post month 7), are forecasting a £5m improvement compared to their month 6 forecasts. The Health Board's month 8 finance report is now forecasting that the Health board will achieve the breakeven controlled total set by WG for 2023-2024. The report also identifies a number of significant risks to the forecast position. In response to this update the likelihood of this risk being realised has been reduced, however, in recognition of the continuing pressures and challenges the target score has not yet been achieved.

	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	4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Ca	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Staffing levels do not meet standards for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	If the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), Then: the critical service will be unable to meet the need of patients requiring therapy, Resulting in: significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response.	Update January 2024 - SLT staff are now in post across all three critical care units. Gaps between current staffing levels and GPICS standards remain for Physiotherapy, Occupational Therapy and SLT, however no clinical incidents or concerns are being reported. However, a gap remains in relation to funding of Dietetics for POW, with clinical incidents being reported	Quality & Safety Committee	Jan-24	Following a review of this risk in December 2023 the target score had been reached and the risk has now been closed. Speech and Language Therapy (SLT) staff are now in post across all three critical care units. Gaps between current staffing levels and Guidelines for the Provision of Intensive Care Services (GPICS) standards remain for Physiotherapy, Occupational Therapy and SLT, however no clinical incidents or concerns are being reported. However, a gap remains in relation to funding of Dietetics for Princess of Wales, with clinical incidents being reported and a new risk is being developed.

Agenda Item
5.2

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

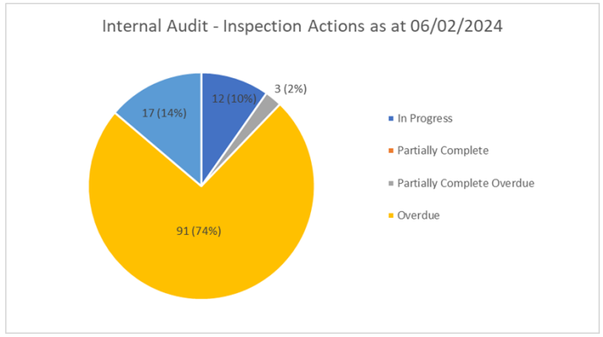
Pwrpas yr Adroddiad / Report Purpose	For Noting

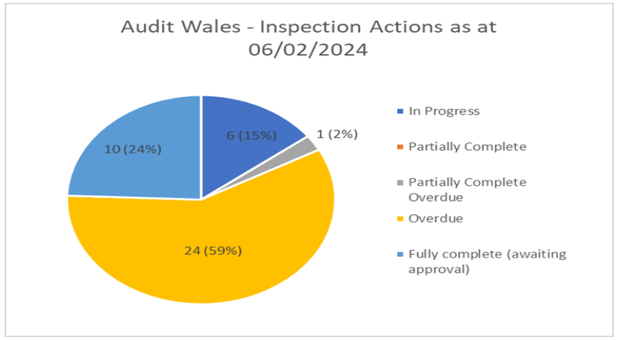
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

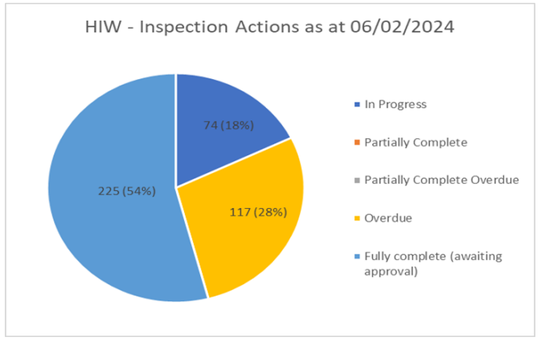
Acronyms / Glossary of Terms	
NWSSP	NHS Wales Shared Services Partnership

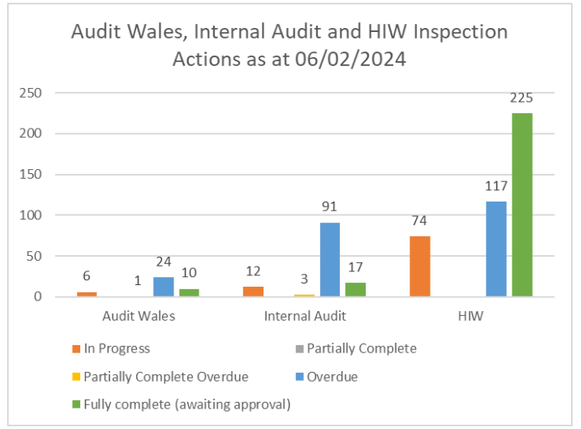
Tracker Dashboard

Status: Inspection Actions:









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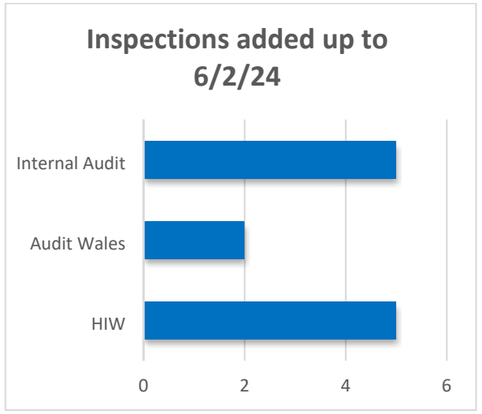

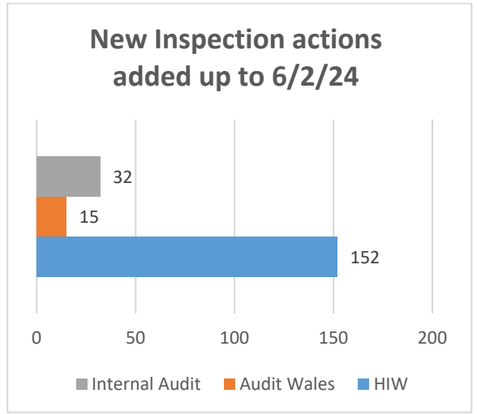

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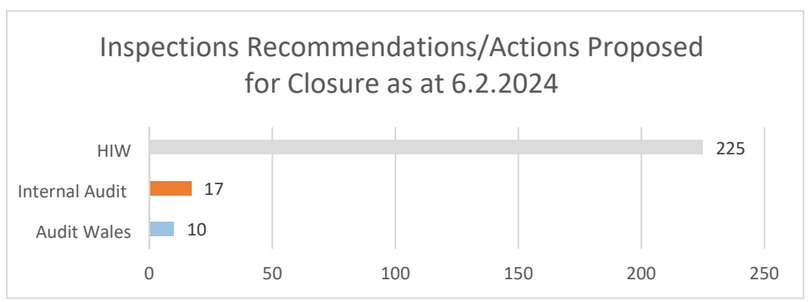

1. Situation /Background

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 AMaT inspection module.

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

1.3 For illustrative purposes the Health Inspectorate Wales (HIW) Improvement plans and Immediate Assurances inspections have been included, however, it is important to note that these are for illustrative purposes as still in transition to the AMaT System and in the purpose of being updated for Quality & Safety Committee in March 2024.

2. Specific Matters for Consideration

2.1 Please see the detailed tracker with progress updates in **APPENDIX 1.**

2.2 **Report format**

The Committee is asked to consider this first report in the context that it is a transitioning process and will continue to evolve.

The report at Appendix 1, is a hybrid approach on this occasion and has still required manual manipulation for some aspects. The Quality Governance and Compliance Team continue to work with the system provider on further developments needed to fully automate and provide a robust and effective report.

The proposed approach for this report was shared with Committee members and attendees via email on the 19th January 2024 for comment and feedback. No responses were received. To support further development the Committee are asked to consider:

- Is the combined report satisfactory to your needs or would you prefer them to be separated?
- The HIW tracker is currently in the process of being added and updated onto AMaT as these reports have slightly different elements to them. If the Committee do not wish to see the HIW reports (as they are also shared with Quality & Safety Committee), moving forward just the dashboard of the inspections could be provided?
- Priority levels, theming and identified risks will evolve over the next 6-12 months, however, is there any additional suggestions that the Committee would like to see?

Please note that 'Rationale for date changes' is being discussed with the system provider.

2.3 **Tracker Updates**

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

5 NEW Internal Audit Reviews have been added to the Audit Recommendations Tracker:

- Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)
- Follow-up: Facilities Systems. Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)
- Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11
- IT Infrastructure. Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)
- PCH Redevelopment Programme: Supervisor Role Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)

17 Internal Audit recommendations have been completed and are proposed for **CLOSURE**, these are:

- Clinical Service Group & Integrated Locality Group Quality Assurance 2.0
- Welsh Risk Pool Claims 2.1
- Decontamination 4.0
- National Incident Framework 1.2, 3.1, 4.1, 5.2.
- Concerns Follow Up Review 1.1, 4.1
- Deprivation of Liberty Safeguards 3.1, 3.2, 2.1, 4.1
- PCH Redevelopment Supervisor Role 1.1, 2.1, 3.1
- Medical Variable Pay 2.1

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

2 NEW External Audit Reviews have been added to the Audit Recommendations Tracker. These are:

- CONFIDENTIAL Audit of Accounts report Addendum Ref: 3727A2023
- Structured Assessment Ref: 3920A2023

10 external audit recommendations have been completed and are proposed for **CLOSURE**, these are:

- Audit Wales/HIW Quality Governance Follow Up Review R2.3, R3.5, R6.1, R8.6, 7.7b, R14.5
- Structured Assessment 2023 R1, R4, R5
- Audit of Accounts Addendum 2022/2023 R2

2.3.1 **Health Inspectorate Wales (HIW) - Reports** from Healthcare Inspectorate Wales will be included in brief for noting and observation.

The data concerning the HIW tracker is presented to the Quality & Safety Committee for monitoring and tracking.

5 New agreed Improvement Plans:

- Royal Glamorgan Hospital Admissions ward, Ward 21, Ward 22, Psychiatric Intensive Treatment Unit (ITU) (Ref: 03414)
- Glanrhyd Hospital Angelton Clinic. (Ref: 03445)
- Royal Glamorgan Hospital Tyrion Birth Centre (Ref: 03061)
- Ty Llidiard (Ref 03362)
- Princess of Wales Hospital Paediatric Ward

1 New Immediate Assurance (POWH Paediatric ward Ref: 03421)

225 Inspection actions fully **complete** and to be **closed.**

3. Key Risks / Matters for Escalation

4.1 The audit tracker will continue to be updated with a targeted focus on actions where the implementation date has passed.

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

4.3 Due to the change in the audit management and tracking process which is still a work in progress, there has been a requirement for extra manual inputting and management of the data in order to provide committee members with useable data. This has necessitated the requirement to adhere to a strict deadline for receipt of updates.

4.4 The team will continue to guide and support leads through this new automated process to ensure committee members are receiving robust, meaningful and timely updates.

4.5 Identification of themes and risks will continue to develop over the next 6-12 months.

5. 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.

Consider the questions posed in section 2.2.

Current Inspection Reports as at 6.2.2024

Inspection Code	Inspection Title	Date of Inspection	Recommendations	Actions
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	7	7
Audit Wales/2021/7	Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	01/08/2021	1	1
Audit Wales/2022/11	Equality Impact Assessments: more than a tick box exercise? Report of the Auditor General for Wales September 2022	01/09/2022	1	1
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	5	5
Audit Wales/2022/17	Commissioning and contracting arrangements post Bridgend boundary change - SB & CTMUHB 2020-21_October 2022 (Document reference: 2725A2021-22)	01/10/2022	1	1
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	01/10/2023	6	6
Audit Wales/2023/150	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	01/11/2023	9	9
Audit Wales/2023/18	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	01/02/2023	8	8
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	3	3
Internal Audit/2020/120	Health & Safety Management_Final Internal Audit Report August 2020 (Review reference: CTMU-1920-16)	03/08/2020	1	1
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	2	2
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	1	1
Internal Audit/2021/76	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	06/08/2021	15	15
Internal Audit/2022/123	CSG & ILG Quality Assurance_Final Internal Audit Report August 2022 (Review reference: CTMUHB-2122-05)	08/08/2022	1	1
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	1	1
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	8	8
Internal Audit/2022/40	Fire Safety Management_Final Internal Audit Report February 2022 (Review reference: CTM_2021_01)	07/02/2022	2	2
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	13	13
Internal Audit/2022/66	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	15/06/2022	4	4
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	24/10/2022	5	5
Internal Audit/2022/89	Follow-up: Consultant Job Planning_Final Internal Audit Report May 2022 (Review reference: CTM 2122.16)	12/05/2022	1	1
Internal Audit/2022/90	Welsh Risk Pool Claims_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-06)	15/06/2022	2	2
Internal Audit/2022/95	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	15/06/2022	1	1
Internal Audit/2022/97	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	10/10/2022	1	1
Internal Audit/2023/100	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	31/05/2023	3	3
Internal Audit/2023/107	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	08/08/2023	5	5
Internal Audit/2023/113	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	08/08/2023	8	8
Internal Audit/2023/117	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	28/07/2023	2	2
Internal Audit/2023/124	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	31/05/2023	4	4
Internal Audit/2023/146	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	11/10/2023	8	8
Internal Audit/2023/147	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	16/10/2023	7	7
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	09/10/2023	5	5
Internal Audit/2023/151	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	28/11/2023	8	8
Internal Audit/2023/152	PCH Redevelopment Programme: Supervisor Role_Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)	07/12/2023	4	4
Internal Audit/2023/37	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	06/06/2023	5	5
Internal Audit/2023/54	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	06/02/2023	6	6
Internal Audit/2023/57	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	03/04/2023	4	4
Internal Audit/2023/73	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	08/08/2023	4	4
Health Inspectorate Wales/2017/141	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019- follow up update submitted December 2022	30/01/2017	22	22
Health Inspectorate Wales/2020/136	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	10/12/2020	3	3
Health Inspectorate Wales/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	2	2
Health Inspectorate Wales/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	20/04/2021	1	1

Inspection Code	Inspection Title	Date of Inspection	Recommendations	Actions
Health Inspectorate Wales/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	17	18
Health Inspectorate Wales/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	20/07/2021	2	2
Health Inspectorate Wales/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)]	01/11/2022	6	10
Health Inspectorate Wales/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22/03/2022	7	7
Health Inspectorate Wales/2022/132	Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]	26/09/2022	3	3
Health Inspectorate Wales/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	17/10/2022	1	2
Health Inspectorate Wales/2022/36	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	14/11/2022	5	5
Health Inspectorate Wales/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07/03/2023	39	180
Health Inspectorate Wales/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)]	31/07/2023	2	2
Health Inspectorate Wales/2023/140	HMP Parc Prison	16/05/2023	7	7
Health Inspectorate Wales/2023/154	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	25/09/2023	1	2
Health Inspectorate Wales/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	50	50
Health Inspectorate Wales/2023/156	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	25/09/2023	1	1
Health Inspectorate Wales/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13/11/2023	25	26
Health Inspectorate Wales/2023/158	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	20/11/2023	19	19
Health Inspectorate Wales/2023/159	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	19/10/2023	5	22
Health Inspectorate Wales/2023/160	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	11/09/2023	20	32

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Lead Person	Date Due	Revised Due Date	Progress Status	Progress 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 R2.3 The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically; a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board c- The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework	The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows: • Strengthened focus on quality on strategic planning; • Individuals' voices are better heard; • Shared learning and continuous quality improvement; • Risk better articulated, shared and mitigated; • Strengthened two-way 'point of service delivery' to Board sight; and • Extensive review and improvement of the management of concerns and serious incidents. Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's . The revised framework will provide improved granular detail in respect of ILG governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSG/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded.	Patient Care and Safety - Lead Executive Lead: Greg Dix, Executive Director of Nursing / Deputy CEO Lauren Edwards, Executive Director of Therapies & Health Science	01/12/2021		Fully complete (Awaiting approval)	**February 2024 Update** - An update has not been provided against this recommendation on this occasion December 2023 Update - The Audit Wales report submitted to the October 2023 meeting highlighted that they felt that this recommendation had been fully implemented. Therefore this is proposed for closure. October 2023 update: OCP consultation completes 29/09/2023 at 17:00. Timeline agreed and aiming for structural implementation by December 2023. Alignment arrangements will be commenced from closure of OCP consultation and confirmation of agreed modelling by 13/10/2023.			
			Audit Wales/HIW Quality Governance Follow Up Review 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 - Lead Executive Lead: Greg Dix, Executive Director of Nursing / Deputy CEO Lauren Edwards, Executive Director of Therapies & Health Science	01/10/2021	Revised Due Date October 2024	Fully complete (Awaiting approval)	**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. December 2023 Update - Quality & Safety Committee now receive a Clinical Executive Quality & Safety report at each bi-monthly meeting. There is a weekly Executive Director led Patient Safety meeting which is chaired by the Executive Director of Nursing/Deputy CEO with support from the Executive Director of Therapies & Health Science. This group receives weekly data on all urgent quality and safety related issues that require Executive Director oversight and direction, weekly data related to Patient Experience, Concerns which includes: serious incidents, Early Warning Notices, LFER position updates as well as any issues of concerns relating to: Inquests, Investigation delays, patient safety incidents and complaints related concerns. Where escalation is required these matters are also discussed at this weekly group. The group receives oversight and assurance of performance where any concerns are raised related to quality and patient safety and experience. At the weekly ELG meeting each Clinical Executive provides an update on quality and safety for wider executive sharing. Each Care Group has their own Quality, Safety, Risk & Experience meeting in place with defined roles in relation to quality leadership, responsibilities, accountability and governance for quality and patient safety. Total quality management system set out within both the Quality Strategy & Quality & Safety Governance Framework. There are Governance leads across all Care Groups and service lines.			
			Audit Wales/HIW Quality Governance Follow Up Review R4.1 The roles and function of the QSRC need to be reviewed to ensure that it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following; a- Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively b- Improvements to the content, analysis, clarity, and transparency of information presented to QSRC c- Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications, and training.	Meeting structure to sit under Management Board being developed to support the operational oversight and Health Board wide co-ordination and learning.	Patient Care and Safety - Lead Executive Lead: Greg Dix, Executive Director of Nursing / Deputy CEO Lauren Edwards, Executive Director of Therapies & Health Science	01/12/2021		Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion December 2023 Update - The follow up review undertaken in August 2023 identified that Audit Wales felt that this recommendation had been partially implemented so this has been added back onto the tracker. An update against this recommendation has not been provided on this occasion.			
			Audit Wales/HIW Quality Governance Follow Up Review R6.1 There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	Health Board purchased CIVICA (captures population feedback using a patient insight software platform).	Patient Care and Safety - Lead Executive Lead: Greg Dix, Executive Director of Nursing / Deputy CEO	01/07/2021	Revised Due Date: Now December 2024 when Civica contract ends	Fully complete (Awaiting approval)	**January 2024 Update**- Band 2 recruitment/ onboarding unsuccessful - is now going through the apprenticeship scheme. Currently being re banded by workforce and then will be put on Trac. Band 3 started 2nd January. Have your say (paper copies) have now been inputted on the system and caught up. Supporting the input of Paediatrics team to input their data onto the system as a temporary basis (until caught up) Draft people experience report has been developed and will go out for approval mid Feb. Gynaecology is now set up on SMS. RGH roadshow cancelled due to winter pressures, Covid and resource etc. Social media campaign internally and externally being established instead for the Months of Feb and March. Comms & Engagement plan being developed. Rebuilding the Civica hierarchy to reflect the new care groups is currently being done. Looking into an iPad kiosk across acute sites, awaiting feedback from Infection Prevention & Control (IPC). ED SMS feedback mechanism now in operation. PALS team aligned to hospital sites and dashboards being developed to pull together data and qualitative information to inform patient and service user feedback. The first Peoples Experience Steering Group has taken place and the ToR is being reviewed for a substantive plan to strengthen strategic oversight and discussion on experiences of patients and service users. December 2023 Update - Band 2 has been recruited and starting 16th Dec 23. Band 3 has been recruited and starting 2nd Jan 2024. Issues remain on inputting paper copies onto system due to resource issues- Therefore the data on the system for Have Your Say is not a true reflection of response rates and feedback. Emergency Department survey went live on SMS 1st Nov. Roadshow in Princess of Wales has been completed with 3rd party stakeholders. RGH roadshow has been agreed for Feb 2024. Civica to be presented in the Senior nurse and Lead nurse Professional forum in Dec. Palliative Care survey- inpatient only to go live 1st Dec. CIVICA patient experience feedback from 22/23 presented to Q&SC September meeting.			
			Audit Wales/HIW Quality Governance Follow Up Review R8.6 The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.	Quality Governance Framework to reflect enhanced governance processes	Patient Care and Safety - Lead Executive Lead: Greg Dix, Executive Director of Nursing / Deputy CEO Lauren Edwards, Executive Director of Therapies & Health Science	01/12/2021		Fully complete (Awaiting approval)	**February 2024 Update** - An update has not been provided against this recommendation on this occasion December 2023 Update - The Audit Wales report submitted to the October 2023 meeting highlighted that they felt that this recommendation had been fully implemented. Therefore this is proposed for closure. October 2023 update: OCP consultation completes 29/09/2023 at 17:00. Timeline agreed and aiming for structural implementation by December 2023. Alignment arrangements will be commenced from closure of OCP consultation and confirmation of agreed modelling by 13/10/2023.			
			Audit Wales/HIW Quality Governance Follow Up Review R7.7b There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	Undertake audit of compliance against Royal College of Anaesthesia (RCOA) Standards (ACSA process) identify and develop standards to meet with RCOA recommended GPICS (set standards by RCOA for Anaesthetic services) baseline and inform continuous improvement programmes and improve compliance against the standards.	Medical Directorate Executive Lead: Dom Hurford, Executive Medical Director	01/07/2024		Fully complete (Awaiting approval)	**February 2024 Update** - An update has not been provided against this recommendation on this occasion December 2023 Update - The Audit Wales report submitted to the October 2023 meeting highlighted that they felt that this recommendation had been fully implemented. Therefore this is proposed for closure. October 2023 Update - This work will be picked up further following the completion of 'Phase 2', once the new Clinical Director for Anaesthetics has been recruited. This individual will take up the ACSA lead role.			
			Audit Wales/HIW Quality Governance Follow Up Review R14.5 The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Patient Care and Safety Executive Lead: Greg Dix, Executive Director of Nursing / Deputy CEO	01/09/2021	Revised Due Date June 2024	Fully complete (Awaiting approval)	**January 2024 Update** - The Health Board has a Listening and Learning Framework in place. The Listening and Learning forum is currently under review. The Health Board holds annual Learning and Learning event to share learning across the Health Board. The event for 2024 is due to be held in June 2024. The Health Board are part of the Enhanced Learning Programme coordinated by Welsh Risk Pool and have received the Enhanced Organisational Learning Template to localise for the Health Board. There is a Learning Repository on the Sharepoint system which has been shared with colleagues across Wales, with many organisations looking to follow suit. December 2023 Update - The follow up review undertaken in August 2023 identified that Audit Wales felt that this recommendation had been partially implemented so this has been added back onto the tracker. An update has not been provided against this recommendation on this occasion.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Lead Person	Date Due	Revised Due Date	Progress Status	Progress Updates	Risks	Barriers	Theming
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 Services Team. Executive Lead - Hywel Daniel, Executive Director for People	31/08/2021	Revised Due Date May 2024	**Overdue**	**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.			
Audit Wales/2022/11	01/09/2022	**Equality Impact Assessments: more than a tick box exercise? Report of the Auditor General for Wales September 2022**	Equality Impact Assessments R4 Reviewing public bodies' current approach for conducting EIAs: While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	CTM UHB welcomes the report's recommendations for a national approach to clarifying the scope of the duty to impact assess policies and practice and developing guidance for integrated impact assessment. CTM UHB is currently reviewing the EIA process, in line with the findings of this report, and the guidance available from the EHRC and the Practice Hub. As such work has commenced on benchmarking against other NHS organisations. Quality Assurance measures are also being designed to monitor EIAs, as well as monitor the impact of the decisions in the context of the PSED. In addition, further staff guidance and policies will be developed to ensure that the EIA process is both robust and informed. Consideration will be given, as part of the review, to determine whether the EIA forms part of a wider integrated impact assessment.	People Services Team. Executive Lead - Hywel Daniel, Executive Director for People	01/03/2023	Revised Due Date January 2024	**Overdue**	**January 2024 Update** – Newly revised EIA which also includes the Welsh Language Impact Assessment was approved at the EDI working group 17th Jan 2024 chaired by Linda Prosser. The new EIA process will be circulated via Health Board Communications on 25th January 2024 which will include link to drop in sessions (which will start fortnightly from Feb 2024). Work continues with the Health Boards across Wales to develop an All Wales approach to the EIA process. As part of the EDI working group; the EIA process will be continually evaluated to see what impact is being made and what additional interventions may need to be put in place to support the roll out and embedding of EIA process within CTMUHB. The governance around the completion of the EIAs will be held with policy holders; and number of completion (including quality and impact) will be discussed at the EDI working group which has been established to support the delivery of the Strategic Equality Plan of which EIA activity sits within. This can now be closed. December 2023 Update - Work on the EIA review and update is on track. Meeting with Welsh Language Lead to look at embedding Welsh language impact assessment into EIA so that there are not two different documents. Work continues with the Health Boards across Wales to develop an All Wales approach to the EIA process – this however will not delay CTMUHB EIA review and update. Deadline for completion is still January 2024 with a support offer to enable those undertaking EIA to develop more confidence and awareness on the importance of EIAs and its purpose. Once review is complete and the support offer is live – this process will be continually evaluated to see what impact is being made and what additional interventions may need to be put in place to support the roll out and embedding of EIA process within CTMUHB. The numbers completed and evaluation will be discussed at the newly formed EDI working group which has been established to support the delivery of the Strategic Equality Plan of which EIA activity sits within.			
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 Lead - Linda Prosser, Executive Director of Strategy and Transformation	31/03/2023	Revised Due Date 31 March 2024	**Overdue**	**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. " December 2023 Update - Director of Integration Post commenced to drive forward integration agenda. Implementation plan including reference to performance management arrangements and pooled budget arrangements. October 2023 Update - A model focusing on two pathways Urgent and emergency care and population health management have been agreed that aligns the efforts of 6 Goals of UEC, ACD and RIF. Regional work streams have been aligned to new national specifications and identified 'transformation resource' (RIF) to support local leadership, facilitate change and disseminate learning. By aligning programmes and core resources will support longer terms sustainability.			
			Transformational Leadership Programme Board – Baseline Governance Review 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 Lead - Linda Prosser, Executive Director of Strategy and Transformation	31/03/2023	Revised Due Date 31 March 2024	**Overdue**	**January 2024** Update - Some challenges remain over appointing to vacant posts. Awaiting clarity from Welsh Government regarding relaxation of RIF tapering for 2024/25. December 2023 Update - Directors drafted letter to HB (community capacity, adults) to provide collective assurance that risks to posts however level of risk to appoint to longer term posts varies and appointing organisations need to manage these risks. Varying terms and conditions exist across the region and between organisations. Workforce a key enabler to delivering the ambitions of the integrated pathways.			
			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 Lead - Linda Prosser, Executive Director of Strategy and Transformation	31/12/2022	Revised Due Date January 2024	**Overdue**	**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. December 2023 Update - Director for Integration post commenced November 2023. Capital planning officer started within regional team at the beginning of October. NEST Co-ordinator / Children and young people lead shortlisting 8th December for appointment early January 2024. 3x Capital Project manager roles (Funded through Integrated Care Capital Resource for 2 year fixed term), slightly delays. Expected to be advertised early January 2024 note one post to focus on digital/assistive tech development. Integration Director exploring cross overs and support levered through various strategic programmes.			
			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 Lead - Linda Prosser, Executive Director of Strategy and Transformation	31/03/2023	Revised Due Date 31 March 2024	**Overdue**	**January 2024 Update** - Challenges over mainstreaming RIF projects. Awaiting further guidance from Welsh Government over expectations. December 2023 Update - To be explored as part of integrated pathway developments.			
			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 Lead - Linda Prosser, Executive Director of Strategy and Transformation	31/03/2023	Revised Due Date 31 March 2024	**Overdue**	**January 2024 Update** - Market Stability report being updated. Challenges and opportunities to be discussed within RPB sub groups to take forward. December 2023 Update - Update to Market Stability report required in 2024. This will highlight any changing position in relation to regulated services staffing challenges. Exploring the use of assistive technology and digital solutions to better support individuals to maintain independence in the community.			
Audit Wales/2022/17	01/10/2022	**Commissioning and contracting arrangements post Bridgend boundary change - SB & CTMUHB 2020-21_October 2022 (Document reference: 2725A2021-22)**	CTMSB SLA Review R3 Our work identified that service users and patients' needs are not routinely assessed when variations to agreements are made, and we have seen no evidence of the use of quality impact assessments. The health boards should implement a process for conducting impact assessments when making changes to the way in which services are delivered for the Bridgend population.	Changes in patient flows and impact on patients is addressed in the cessation paperwork and is always discussed as part of the disaggregation discussions. Equality Impact Assessments have started to be completed for the cessation of the Clinical Capacity SLAs in NPTH as the changes will impact on patient flow and access to services. However, there is not enough corporate resource to complete a detailed impact assessment for each SLA cessation and in most cases the impact is not necessary as there is no change in patient flow. The Community Health Councils are kept up to date on all cessations and detailed engagement is undertaken where changes will affect patient flow.	Strategy, Planning and Transformation Executive Lead - Linda Prosser, Executive Director of Strategy and Transformation	01/11/2022		**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion December 2023 Update - The communication and engagement group continues to meet and there will be joint engagement with Llais on any service changes in the shared work programme. All service changes are subject to benefits appraisal, impact assessment and risk assessment prior to agreement of any changes to commissioned service arrangements. The Joint Executive Group approved an updated process flow chart which strengthens the agreed processes. (4.12.23). October 2023 Update - A communication and engagement group has been set up to provide coordination for all activities relating to SBUHB SLAs. This will enhance existing processes, enabling proactive engagement with Llais regarding service changes.			
Audit Wales/2023/149	01/10/2023	**Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)**	Structured Assessment 2023 R1 Public observation of Board Meetings Whilst the Health Board meets in public, it is not clear how members of the public can request to attend these meetings in person. The Health Board, therefore, should provide clear guidance on how members of the public can request to observe public Board meetings in person.	With effect from January 2024 the Health Board will include guidance on how members of the public can join Board meetings in person. This information will be captured on the Health Board's website and when sharing details of upcoming Board meetings via the Health Board's social media channels.	Corporate Governance Executive Lead - Director of Corporate Governance / Board Secretary	01/01/2024		**Fully complete (Awaiting approval)**	**February 2024 Update** - Complete: the public facing website now includes this detail. Please see link: https://ctmuhb.nhs.wales/about-us/our-board/			

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			Structured Assessment 2023 R2 Accessibility of videos The Health Board makes good use of videos in committee meetings to present patient and staff stories. However, they are not subsequently made available on the Health Board's website. The Health Board, therefore, should ensure that any videos shown during committee meetings are made available on its website for completeness with agreement of the contributors. (Medium Priority).	Shared Listening and Learning Story videos will be published with the relevant Board Committee papers following the meeting. The Corporate Governance Team will also link in with the Patient Experience Leads and Communications and Engagement colleagues to consider how awareness of these stories can be enhanced internally and externally using the various communication channels available.	Corporate Governance Executive Lead - Director of Corporate Governance / Board Secretary	01/03/2024		In progress	**February 2024 Update** - In Progress: Head of Corporate Governance and Board Business to meet with Patient Experience and Communication and Engagement colleagues to consider how to address this recommendation recognising the need to liaise with those individuals sharing their stories.			
			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 Executive Lead - Director of Corporate Governance / Board Secretary	01/03/2024		In progress	**February 2024 Update** - In Progress: Head of Corporate Governance and Board Business to consider how this recommendation can be achieved to improve transparency.			
			Structured Assessment 2023 R4 Confirmed minutes Whilst the Board and committees review and confirm the minutes of previous meetings, they are not always uploaded to the Health Board's website in a timely manner. The Health Board, therefore, should ensure that all confirmed minutes are uploaded to the relevant section of its website in a timely manner to ensure the public have full access to the approved records of meetings. (Medium Priority).	With effect from January 2024 the Health Board will introduce a dedicated page on the website for "Latest Confirmed and Unconfirmed Minutes" for each Board meeting and Board Committee.	Corporate Governance Executive Lead - Director of Corporate Governance / Board Secretary	01/01/2024		Fully complete (Awaiting approval)	**February 2024 Update** - Complete: this recommendation has been achieved for Board and Board Committee pages on the public facing website. Please see link: https://ctmuhb.nhs.wales/about-us/our-board/board-meetings-papers/			
			Structured Assessment 2023 R5 Health Board policies and procedures Whilst the Health Board has a dedicated area on its website for policies and procedures, some of them are out of date. The Health Board, therefore, should ensure that all policies and procedures on its website are up-to-date and, if not, put a clear plan in place to revise and approve them. (Medium Priority).	The following policies and procedures are available on the Health Boards public facing website: • Risk Management Strategy • Risk Management Policy • Standards of Behaviour Framework Policy • Incident Management Framework • Handling Concerns Policy • Raising Concerns Policy (Whistleblowing) • Freedom of Information Policy • Environmental Policy The Concerns Policy & Procedures which are linked to the review of the Incident Management Framework which is planned to be presented to the January 2024 Quality & Safety Committee for approval. With regards to the Incident Management Framework review and updating of this is in progress and expected to be completed by the end of the year. The other policies and procedures published on this page are in date in terms of their scheduled review.	Patient, Care and Safety Team Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/01/2024		Fully complete (Awaiting approval)	**January 2024 Update** - The Concerns Policy & Procedures was approved by the Quality & Safety Committee on the 23.01.24. The Incident Management Framework was approved by the Quality & Safety Committee on the 23.01.24. The SharePoint pages have been reviewed as part of the revision of the policy and supporting documentation. The SharePoint pages are subject to regular review to ensure they remain up to date.			
			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.	Perfomance Executive Lead Linda Prosser, Director of Strategy & Transformation (Performance Framework) Gethin Hughers, Chief Operating Officer (Operational Performance) Stuart Morris, Director of Digital (Performance Information	01/02/2024		Overdue	**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 27 February 2024), for approval.			
Audit Wales/2023/150	01/11/2023	**CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)**	Redacted - received in closed session. Business Sensitive		Finance Executive Lead: Sally May, Executive Director of Finance	01/04/2024		In progress	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
					Finance Executive Lead: Sally May, Executive Director of Finance	01/01/2024		Fully complete (Awaiting approval)	**February 2024 Update** While we agree with the finding that finance officers are able to prepare and post journals, we feel there are appropriate controls in place to ensure the risk is low and the benefit of introducing secondary review is not required. All finance officers are appropriately trained in preparing and posting journals and guidance is available on posting of journals. No non-finance staff are given access to prepare and process manual journals. There are a range of processes in place across finance to monitor cost centres and balance sheet to ensure miscoding are identified and corrected. There are regular balance sheet reviews and reconciliations to ensure low risk miscoding to balance sheet. Given the above an additional journal review check would not add value in reducing risk.			
					Finance Executive Lead: Sally May, Executive Director of Finance	01/04/2024		In progress	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
					Finance Executive Lead: Sally May, Executive Director of Finance	01/11/2023		Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
					Finance Executive Lead: Sally May, Executive Director of Finance	01/11/2023		Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
					Finance Executive Lead: Sally May, Executive Director of Finance	01/03/2024		In progress	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			

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					Finance Executive Lead: Sally May, Executive Director of Finance	01/11/2023		Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
					Finance Executive Lead: Sally May, Executive Director of Finance	01/12/2023		Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
					Finance Executive Lead: Sally May, Executive Director of Finance	01/11/2023		Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. New recommendation so no previous updates.			
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 Executive Lead - Director of Corporate Governance / Board Secretary	30/10/2023	Revised Due Date 31.3.2024	Overdue	**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. December 2023 Update - The Health Board would like to benchmark with how other Health Boards are approaching Advisory Groups. The Director of Corporate Governance & Board Secretary appointed in September 2023 would also need sufficient time to attend and review these meetings in order explore any further support needed. It is anticipated that the pace of change for the Advisory Groups may take longer than originally assessed and a revised implementation date of 31.03.2024.			
			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.	Perfomance Executive Lead Linda Prosser, Director of Strategy & Transformation (Performance Framework) Gethin Hughers, Chief Operating Officer (Operational Performance) Stuart Morris, Director of Digital (Performance Information	30/09/2023	Revised Due Date December 2023	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
			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 Executive Lead Linda Prosser, Director of Strategy & Transformation (Performance Framework)	01/09/2023		Partially complete (Overdue)	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
			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 Executive Lead: Stuart Morris, Director of Digital (Performance Information	31/12/2023		Overdue	**Update February 2024** - An update has not been provided against this recommendation on this occasion. October 2023 Update - We have completed the initial recruitment with colleagues starting during September and October. However given the current recruitment constraints we are unable to recruit further at this point in time. August 2023 Update - An update has not been provided against this recommendation on this occasion.			
			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.	All Executives.	30/06/2023		Overdue	**Update February 2024** - Added back onto the Tracker December 2023. No update received on this reccomendation. 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.			
			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 Lead: Sally May, Executive Director of Finance	31/12/2023		Overdue	Update February 2024 - Added back onto the Tracker December 2023. No update received on this reccomendation. 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. Comtract in excess of £1m require WG Ministerial approval CLOSED, b) Quarterly Capital reports included on PPF agenda, c) FCP review ongoing			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Lead Person	Date Due	Revised Due Date	Progress Status	Progress Updates	Risks	Barriers	Theming
			Structured Assessment 2022 R8 Enhancing financial reports to the Board Structured Assessment 2022 R8: Whilst the Health Board has effective arrangements for reporting financial performance to the Board, we identified opportunities to enhance these reports further. The Health Board should: a) provide greater assurances that mitigating actions are in place to address key financial risks highlighted in the reports; NOT COMPLETED b) report the financial performance of the new Care Groups at the earliest possibility.	The monthly finance reports to the Board and the Planning, Performance and Finance (PPF) Committee summarise the key risk and opportunities facing the Health Board. These reports will be reviewed to ensure they provide assurance to the Board that mitigating actions and plans are in place and that the PPF Committee has confidence the risks are being appropriately managed. These reports will capture financial performance of the the new Care Group Model.	Finance Executive Lead: Sally May, Executive Director of Finance	31/07/2023		**Overdue**	**Update February 2024** - Added back onto the Tracker December 2023. No update received on this reccomendation. June 2023 Update - 1. Board Report reviewed and updated for 2023-24. 2. Care Group level reporting continues into PPF. Any issues of concern will be escalated to Board through committee reports.			
			Structured Assessment 2022 R10 Strengthening Board-level oversight of estates issues and risks Structured Assessment 2022 R10: There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should: a) ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee NOT COMPLETED; b) update the committee's Terms of Reference to reflect these responsibilities; and c) establish a clear process for ensuring appropriate cross referral of estate issues which may have a significant health and safety impact with the Quality and Safety Committee NOT COMPLETED	On publication of Welsh Government's annual Estates, Facilities Performance Management System data, the findings are reported to the Planning, Performance and Finance (PPF) Committee. The report includes the Health Board's performance measured against the national estates key performance indicators which are Physical Condition, Statutory and Safety compliance, fire safety, functional suitability and space utilisation. In addition the report includes the estates operational planned and reactive performance data for statutory and mandatory jobs and also captures helpdesk request data, the reported data is compared against previous years so that trends can be analysed. The report also includes the organisations energy performance and Carbon Dioxide (CO2) emissions which is measured and reported against the Welsh Government performance targets. At all of the Health Board's Health, Safety and Fire Sub Committees there is a standard agenda item for an Estates Safety and Compliance report and a fire safety report. These reports cover the critical infrastructure systems such as high and low voltage electricity, medical gases, ventilation and water. The Estates and Capital Directorate has its own risk register which is reported quarterly to the Estates / Capital Governance Board, the risks identified with a score above 15 are subsequently reported to Corporate Governance for inclusion on the Health Board's Organisational Risk register. The Health Board is also considering its approach to developing an Estates Strategy within the Health Board and how this will align with other key strategic documents and plans. The Planning, Performance & Finance Committee Terms of Reference will be reviewed to reflect the responsibility to receive Board level oversight of estates issues. The Health Board has a defined Committee Referral process which will be used if there are matters considered at either the PPF Committee or HS&F Sub Committee that require consideration at the Quality & Safety Committee. The HS&F Committee will also ensure any estates issues will be notified to the Q&S Committee through the Committee Highlight Report.	Finance Executive Lead: Sally May, Executive Director of Finance	31/10/2023		**Overdue**	**Update February 2024** - Added back onto the Tracker December 2023. No update received on this reccomendation. Revised Due Date October 2023 (Original Due Date In accordance with the Committee Cycle of Business for the PPF Committee and Health, Safety and Fire Sub Committee – Circa April / May 2023) August 2023 Update - This recommendation is proposed for closure in light of the update provided in June 2023 June 2023 Update - Revised date to reflect expected publication of Estates and Facilities Performance Management System data.			
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 Group and Unscheduled Care Care Group. Executive Lead: Gethin Hughes, Chief Operating Officer	01/05/2023		**Overdue**	**Update 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. August 2023 Update - An update has not been provided against this recommendation on this occasion.			
			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 Group and Unscheduled Care Care Group. Executive Lead: Gethin Hughes, Chief Operating Officer	01/01/2024		**Overdue**	**Update February 2024** - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting. August 2023 Update - An update has not been provided against this recommendation on this occasion.			
			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 Group and Unscheduled Care Care Group. Executive Lead: Gethin Hughes, Chief Operating Officer	01/04/2024		**In progress**	**Update February 2024** - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues across these areas and a specific update will be available at the next meeting. August 2023 Update - An update has not been provided against this recommendation on this occasion.			

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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 Function Executive Lead - Hywel Daniel, Executive Director of People	01/01/2021	Revised Due Date June 2024	Partially complete (Overdue)	**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. November 2023 Update - The Health and Safety Team will be undertaking 1 main audit and 2 flash audits using iPassport over the next 6 months to enable an evaluation of iPassport.			
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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/04/2021	Revised Due Date February 2024	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - position remains the same as a consequence of staffing resource. It is hoped that the resolution of the OCP process will mitigate this situation. Too early to make a commitment - so update will be available for the meeting in February 2024. October 2023 Update - no further progress to report. Until the vacancies that exist as a consequence of phase 2 of the OCP are filled there will not be the management capacity to undertake this piece of work.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/12/2020	Revised Due Date January 2024	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. 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.	Facilities Function Executive Lead - Gethin Hughes, Chief Operating Officer	01/04/2020	Revised Due Date January 2024	Partially complete (Overdue)	**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. December 2023 Update - there has been no progress with regard additional Capital resources. Issues with server security certification has delayed further the data migration and was resolved on 24 November 2023 between ICT, DHCW and supplier, therefore no further progress has been noted on this. Target date now for RF-ID migration 15 January 2024 and further information will be available at the next meeting.			
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 01 Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/09/2021	Revised Due Date June 2024	Overdue	**January 2024 Update** - The contract between Linc and the main contractor (Wynne) has now been signed, and a start date for the health centre has been agreed as 3rd June 2024. Linc's Employer's Agent and Contract Administrator (Expedite) can now commence preparation of a PEP, which will be available before start on site which has been delayed to June 2024. December 2023 Update - An addendum to the approved FBC was approved by Welsh Government and a revised funding letter was issued 21st November. The project can now restart and the full meeting structure re established. This was initiated at Project Board on the 23rd November where previous ToR for the subgroups were shared with members for review with updates to be provided before the next meeting for review and sign off.			
			Sunnyside Health & Wellbeing Centre 04 Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/03/2022	Revised Due Date July 2024	Overdue	**January 2024 Update** - The delayed start on site has now been confirmed as 3rd June 2023 hence delay to the restart of this reporting Expedite, the Employer's agent and Contract Administrator will provide monthly reports detailing the required information regarding provisional sums and contingencies. December 2023 Update - Date revised as approval received in November. Contract expected to be signed late November/early December. Provisional sums and contingency values will be reported through the project Board structure when the reporting for the scheme re starts in January 2024.			
			Sunnyside Health & Wellbeing Centre 05 Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/01/2022	Revised Due Date August 2024	Overdue	**January 2024 Update** - The delayed start on site has now been confirmed as 3rd June 2023 hence delay to the restart of this reporting Expedite, the Employer's agent and Contract Administrator will provide the required monthly reports. December 2023 Update - Business case approved in November, Contract expected to be signed late November/early December. There is unlikely to be a PM/CA report provided covering the December period but this will be restarted in time for return after this which is due in March 2024 (returns are bi monthly).			
			Sunnyside Health & Wellbeing Centre 07 Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	These are available and will be supplied by the developer.	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/09/2021	Revised Due Date February 2024	Overdue	**January 2024 Update** - These documents have been requested now that the contract has been signed and a pre-start meeting has taken place. December 2023 Update - As above, funding approved in November, contract due to be signed and then all required documentation will be requested.			
			Sunnyside Health & Wellbeing Centre 10 Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	This will be provided when the project restarts and all design works are completed.	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/12/2023	No original agreed Due by Date / Revised Due Date July 2024	Overdue	**January 2024 Update** - Any contract variations will be tracked and reported by Expedite, the Employer's Agent and Contract Administrator, and none will be agreed without explicitly confirmation from the HB. Cannot evidence this until scheme starts onsite December 2023 Update - Linc are due to enter into contract for the completion of the health centre late November/early December. Once signed the new contractor will agree the form of contract variations and the HB will implement the arrangements for sign off of variations outlined in the updated PEP.			
			Sunnyside Health & Wellbeing Centre 11 The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/03/2022	Revised Due Date December 2023	Overdue	**January 2024 Update** - This is explicit in the contract between Linc and the main contractor, Wynne and was reiterated at the pre-start meeting. The HB will be fully engaged and consulted on any notice of delay. December 2023 Update - Once the new contract is signed a reminder will be given to the contractor of the requirement for a contractual notification of any delays.			
			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 Function Executive Lead - Sally May, Executive Director of Finance	01/11/2021	Revised Due Date July 2024	Overdue	**January 2024 Update** - A cost risk register is maintained by Expedite, the Employer's Agent and Contractor Administrator, and will be reviewed at monthly progress meetings. December 2023 Update - This will form part of monthly reporting to the Board which will restart in full detail from January in contract is signed in Nov/Dec.			
			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 Function Executive Lead - Sally May, Executive Director of Finance	01/09/2021	Revised Due Date July 2024	Overdue	**January 2024** - This will be actively monitored and managed as an integral part of the above action once project starts on site. December 2023 Update - This will form part of monthly reporting to the Board which will restart in full detail from January in contract is signed in Nov/Dec.			
			Sunnyside Health & Wellbeing Centre 15 The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/01/2021	Revised Due Date February 2024	Overdue	**January 2024 Update** - Now that the contract has been signed, the HB has requested copies of all relevant documentation. December 2023 Update - As soon as new contracts are signed (late Nov/Early Dec) these will be requested from the developer, reviewed and reported on as appropriate.			
			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 Function Executive Lead - Sally May, Executive Director of Finance	01/01/2022	Revised Due Date June 2024	Overdue	**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.			

			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 Function Executive Lead - Sally May, Executive Director of Finance	01/03/2022	Revised Due Date June 2024	**Overdue**	**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.			
			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 Function Executive Lead - Sally May, Executive Director of Finance	01/01/2022	Revised Due Date February 2024	**Overdue**	**January 2024 Update** - Benefits will be periodically reviewed as part of the Project Board agenda moving forward. December 2023 Update - Benefits will be periodically reviewed as part of the Project Board agenda. The frequency of this will be discussed in February 2024 as there are other significant agenda items in Dec/Jan.			
			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 Function Executive Lead - Sally May, Executive Director of Finance	01/01/2022	Revised Due Date February 2024	**Overdue**	**January 2024 Update** - Benefits will be periodically reviewed as part of the Project Board agenda moving forward. December 2023 Update - Benefits will be periodically reviewed as part of the Project Board agenda. The frequency of this will be discussed in February 2024 as there are other significant agenda items in Dec/Jan.			
			Sunnyside Health & Wellbeing Centre 09 Performance of relevant parties should be monitored appropriately	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable although there will be a delay with the appointment of a new contractor.	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/09/2021	Revised Due Date February 2024	**Overdue**	**January 2024 Update** - Performance of the main contractor will be managed and monitored via the HB's appointed Clerk of Works (DRAC), the Employer's Agent and contract Administrator (Expedite) and via regularly progress meetings and reports. These in turn will be reported up to Project Board and its sub-groups. KPI's will be lifted from the contract once received. December 2023 Update - Plan for performance monitoring will be agreed by Project Board. Contract will confirm agreed KPIs and will be used to monitor ongoing performance.			
			Sunnyside Health & Wellbeing Centre 17 Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	The Health Board already has in place processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Capital and Estates Function Executive Lead - Sally May, Executive Director of Finance	01/11/2021	Revised Due Date January 2024	**Overdue**	**January 2024 Update** - Now contract is signed this is controlled via the JCT Design & Build contract, and managed by the Employer's Agent and Contract Administrator. The HB is fully involved in any changes proposed and none will be made without formal HB sign off. December 2023 Update - As above, once signed the new contractor will agree the form of contract variations and the HB will implement the arrangements for sign off of variations outlined in the updated PEP.			
Internal Audit/2022/123	08/08/2022	CSG & ILG Quality Assurance_Final Internal Audit Report August 2022 (Review reference: CTMUHB-2122-05)	CSG & ILG Quality Assurance 2.0 Quality governance training should be provided to all relevant staff in the ILGs and their constituent CSGs to ensure a sound understanding of quality assurance principles and practices	The Health Board launched a new Patient Safety Incident Management Framework and Toolkit in June 2022. This describes the responsibilities of colleagues in managing patient safety issues from an initial incident and investigation through to complaints, redress, inquests and claims. In July 2022, the Health Board also launched a rolling programme of patient safety investigation training, which includes good governance in relation to quality and patient safety, Datix and patient experience. The training also introduces the important concepts of psychological safety, human factor errors and safety thinking. Attendance is recorded on the Health Board's Electronic Record System, which ensures that those undertaking incident investigations are appropriately, and consistently trained to improve standards and performance. Bespoke Datix training has been rolled out by the Datix Management Team following the adoption of the Once for Wales incident module, and is ongoing. The corporate team have initiated good governance training in relation to assurance report writing and preparedness for Boards and Committees as well as Risk Management Awareness Training. Training sessions are supported by the Health Board's Communication channels, Intranet SharePoint system where further information and assistance for colleagues is signposted by the Patient Care and Safety site. A further opportunity to raise awareness and understanding of the quality assurance principles and practice to the wider workforce will be the publication of the Quality and Patient Safety Framework.	Patient, Care and Safety Team. Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/12/2022	Revised Due Date January 2024	**Fully complete (Awaiting approval)**	**January 2024 Update** - Link to Internal Audit Incident Management Recommendation 2.1 and Internal Audit Concerns Management Recommendation 3.1. The Incident Management Framework and Concerns Policy & Procedures were approved by the Quality & Safety Committee on 23.01.24. To support implementation a training strategy setting out the requirements for training at all levels of the Organisation is being developed. This will be presented to Executive Weekly Patient Safety Meeting for approval on the 05.02.24. In conjunction with the Care Groups a training needs analysis will be undertaken and a rolling 12 month programme implemented that will include all aspects of incident / complaints management. December 2023 Update - Link to Internal Audit Incident Management Recommendation 2.1 and Internal Audit Concerns Management Recommendation 3.1. As part of the review of the Incident Management Framework and Concerns Policy & Procedures a training strategy is being developed. This will set out the requirements for training at all levels of the Organisation. In conjunction with the Care Groups a training needs analysis will be undertaken and a rolling 12 month programme implemented that will include all aspects of incident / complaints management.			
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.	Finance Team Executive Lead - Sally May, Executive Director of Finance	01/05/2022	Revised Due Date February 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Following a lack of progress, a meeting has been set up in December with Finance Colleagues to finish draft and work towards finalising the Financial Control Procedure. October 2023 Update - Sian Lewis liaised with Finance on 03.10.23 to advise this is the only outstanding item left from our Audit. Finance will look into this and provide us with an update of a completion date.			
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.	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/08/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.			
			Patient Pathway Appointment Management Process Follow Up 1.3 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.	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/08/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.			
			Patient Pathway Appointment Management Process Follow Up 1.5 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	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/09/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - opinion sought from Performance.			
			Patient Pathway Appointment Management Process Follow Up 2.1 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.	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/08/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.			

			Patient Pathway Appointment Management Process Follow Up 2.2 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.	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/08/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - email has gone from Deputy COO to all Operations Directors asking for validation to be undertaken. In addition, targeted email going to Ops Directors and Service Group Managers as appropriate, with circulation lists and areas of greatest concern outlined. In addition, discussion has taken place with Internal Audit and have asked colleagues within Performance for areas of greatest concern to inform the above. Specific Bridgend information also requested.			
			Patient Pathway Appointment Management Process Follow Up 2.3 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	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/08/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken in pathways. In addition, individual emails going to the Operations Directors and some appropriate Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation. Colleagues from Performance have been asked to assess areas of greatest concern so that areas can be targeted.			
			Patient Pathway Appointment Management Process Follow Up 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.	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/09/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Given the delays with completion of this audit but building upon the progress that has been made, the matter will now be discussed and resolved at the January 2024 meeting of the Operational Management Board, where a brief paper outlining actions carried out and needed will be presented and discussed. Meeting to be held with Internal Audit colleague on 20 December 2023 to discuss detail of paper. October 2023 Update - Email has been sent from the Deputy COO instructing all Care Group Directors to ensure that the validation is undertaken within pathways. In addition, individual emails going to the Operations Directors and some Service Group Managers with specific queries. Discussions held with Internal Audit also on resolving this recommendation.			
			Patient Pathway Appointment Management Process Follow Up 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	Acute Services General Management and Head of Information Executive Lead - Gethin Hughes, Chief Operating Officer	01/09/2022	Revised Due Date January 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. 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/2022/40	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 Team Executive Lead - Hywel Daniel, Executive Director for People	01/03/2022	Revised Due Date June 2024	**Overdue**	**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. November 2023 Update - Work continues within the Fire Team to update the Site Specific Documents where site changes have taken place. Completion should have taken place by the June 2024 deadline.			
			Fire Safety Management 4.1 Management should develop an appropriate medium-term strategy to demonstrate co-ordination of efforts in managing the fire risk.	The Health Board will develop a medium term strategy for fire safety across its sites.	Health, Safety & Fire Team Executive Lead - Hywel Daniel, Executive Director for People	01/03/2022	Revised Due Date Feburary 2024	**Overdue**	**January 2024 Update** - Outline Plan for 2024/25 will be presented to the next Health, Safety and Fire Sub Committee which has been changed to 4th March 2024. December 2023 Update - Outline Plan for 2024/25 is in draft and will be presented to the next Health, Safety and Fire Sub Committee in February 2024			
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.	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/01/2023	Revised Due Date January 2025	**Overdue**	**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. October 2023 Update - Work to identify the preferred decant option is ongoing, a further option was considered at the August project Board to be reported on in the November Board. Once this has been confirmed then work can commence on the business case.			
			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.	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/01/2023	Revised Due Date March 2024	**Overdue**	**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 . Tender will be completed for the design consultants, discussion to be held with NWSSP SES regarding appropriate procurement process for appointment of modular theatre supplier as Framework is available for direct award. October 2023 Update - Please see note above this action will be addressed once there is an approved business case in place.			
			POW Theatres Fire Safety Works 4.2 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	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date January 2025	**Overdue**	**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. October 2023 Update - As above action remains open pending business case preparation and approval. Only then will a construction contract be let and this can be actioned.			
			POW Theatres Fire Safety Works 4.3 The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Agreed	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date January 2025	**Overdue**	**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. October 2023 Update - As above this will be required on the next phase of the development.			
			POW Theatres Fire Safety Works 6.1 Upon recommencement of the project, management should utilise Key Performance Indicators in accordance with the contract.	Agreed. These will be applied as required.	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/01/2023	Revised Due Date January 2025	**Overdue**	**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. October 2023 Update - It is proposed that the SCP contract be ended and this will be discussed on the 21st September 2023 Project Board. If this action is taken then this will be closed if the scheme continues outside of the current framework.			
			POW Theatres Fire Safety Works 8.1 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.	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date February 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Now preferred option is agreed the fees required to develop the business case can be developed. Spend against current fee allocation will be reported to the project board once spend commences. October 2023 Update - This will be part pf the formal project Board update - expected to be agreed as a template in September Board and implemented for October Board.			
			POW Theatres Fire Safety Works 9.1 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.	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/01/2023	Revised Due Date November 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Discussions with a Designed for Life Framework Manager confirmed that because the scheme has changed so significantly and the FEN works cost will be below the current D4L limit of £4m the HB are no longer obliged to continue with the SCP. It is considered that better value for money for both the construction costs and design fees to be undertaken via traditional contract routes with a medium sized contractor on an open tender for the smaller scale works. Consequently, the Project Board agreed to terminate the D4L contract and appoint an alternative design team. NWSSP-SES have been informed and the Health Board informed the SCP on 4th October 2023. Procurement route for appointment of modular supplier still to be agreed. October 2023 Update - In the light of the LHP outcome this is not a likely outcome. However it does remain important that value for money is evidenced in any solution as part of the option appraisal.			
			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	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date January 2025	**Overdue**	**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. October 2023 Update - This is part of the Project Board remit and will be a standing item on the Project Board.			

			POW Theatres Fire Safety Works 10.2 Management should actively monitor and report the value of residual risk v remaining contingency.	Agreed	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date January 2025	**Overdue**	**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 funded project - based on current timeline this is scheduled to be January 2025. October 2023 Update - This will not be a requirement until we have a revised and funded project allocation. As the preferred option is not yet identified this can not be reviewed.			
			POW Theatres Fire Safety Works 10.3 Risks should be individually assigned to those best placed to control them, with time parameters for action.	Agreed	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date December 2023	**Overdue**	**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. October 2023 Update - The Project Board will oversee the risk register, updates and risk allocation.			
			POW Theatres Fire Safety Works 10.4 An exception report should be published of targeted risk mitigations not achieved.	Agreed	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date December 2023	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - As above this will be actioned as part of project board. October 2023 Update - This will be actioned as part of the Project Board Agenda.			
			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.	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/01/2023	Revised Due Date October 2024	**Overdue**	**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. October 2023 Update - Delays in the identification of the preferred option will further delay the preparation of the business case and preparation of appropriate resource schedules. This is a future recommendation based on a specific event and the date needs to tie in with the latest proposed business case date.			
			POW Theatres Fire Safety Works 7.1 The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works.	Agreed	Health, Safety & Fire Executive Lead - Executive Director of Strategy & Transformation	01/08/2022	Revised Due Date January 2024	**Overdue**	**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. October 2023 Update - Please see note above this will be part of the business case process.			
Internal Audit/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	Financial Systems 8.1 Management should ensure that staff responsible for approving requisitions and processing purchase orders are aware of the correct procurement process as stated in the Requisition of Goods and Services FCPO and the All-Wales No PO No Pay policy.	Procurement will increase the training and cascade information relating to the No PO No Pay policy. We will identify the areas of retrospective ordering, implement a plan and ensure bespoke training to these areas.	Finance & Procurement Team Executive Lead - Sally May, Executive Director of Finance	01/07/2022	Revised Due Date March 2024	**Overdue**	**February 2024 Update** - No PO Policy, Communication plan and exemption list completed and presented to DDOFs in November by Head of Corporate Finance, further work prior to approval at NWSSP shared service committee. AW Launch planned for January 2024. As part of monthly P2P CTM group, plan in place and being monitored monthly. CTM already undertaking focused P2P training, Facilities and Estates completed, identifying further areas as part of No PO review (Top 3 monthly with systems). What does good Procurement session held with Care groups within Operational Management Board. AW P2P governance group disbanded by Finance Academy, proposed at NWSSP Shared services committee. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
			Financial Systems 8.2 In cases where it is appropriate, management should explore the use of alternative mechanisms for raising orders and paying invoices, for example the use of 'call off' orders.	We will identify the areas where retrospective orders are raised and review alternative mechanisms for order or payment.	Finance & Procurement Team Executive Lead - Sally May, Executive Director of Finance	01/03/2023	Revised Due Date November 2023 pending AW P2P group	**Overdue**	**February 2024 Update** - Alternative methods of payments being reviewed as part of AW PO exemption list T&F group. AW T&F group being led by Head of Corporate finance and Head of Procurement and Final exemption list presented at DDOFs in November 2023. Ongoing review into 24/25 through DDOFs/Shared services committee. December 2023 Update - An update has not been provided against this recommendation on this occasion			
			Financial Systems 8.3 Where a retrospective order is deemed appropriate, staff should be encouraged to complete the notes section of Oracle explaining the reason for use of a retrospective order, including details of who requested the goods or service to be procured.	Where retrospective orders are deemed acceptable, further training will be given to end users to ensure notes are completed within Oracle	Finance & Procurement Team Executive Lead - Sally May, Executive Director of Finance	01/03/2023	Revised Due Date November 2023	**Overdue**	**February 2024 Update** - Refer to the update provided for 8.1. Retrospective review being undertaken as part of AW P2P T&F group completion Sept 2023. Further training needs are being identified through local CTM P2P group monthly. Retrospective order over £5k being reported to Audit Committee. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
			Financial Systems 8.4 Documentation to support all orders should be retained made available if required	Documentation will be made available via SharePoint.	Finance & Procurement Team Executive Lead - Sally May, Executive Director of Finance	01/03/2023	Revised Due Date November 2023	**Overdue**	**February 2024 Update** - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant P2P information including virtual training guides. Stretched resource and increased demands on Savings engagement has delayed completion of CTM share point. NWSSP Buyers toolkit completed but awaiting sign off by NWSSP prior to implementation. On completion - communication will be cascaded through CTM finance systems updates to HB. December 2023 Update - An update has not been provided against this recommendation on this occasion.			
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, Pharmacy & Specialties Executive Lead - Gethin Hughes, Chief Operating Officer	30/11/2022	Revised Due Date December 2023	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - ToR have now been produced in draft format. A Site Superintendent has been nominated to lead this work. A further update will be provided in December 23. October 2023 Update - Initial scoping meeting took place on 13/09/23 with People's Services. An identified sponsor and leads to take this forward established. The leads are currently establishing a ToR and will arrange the T&F working group on completion of ToR.			
			Radiology Service Review 2.1 a) Where scheduled quarterly meetings fail to take place, to prevent large time gaps, consideration should be given to rearranging the meeting, as opposed to waiting to next scheduled quarterly meeting. b) To prevent Quality Improvement & Governance group meetings being cancelled when the Chair is not available, a Vice-Chair should be appointed.	a) The service management team have scheduled quarterly meetings from December 2022 through to April 2024. The Radiology Quality, Improvement & Governance Structure Meeting arranged on 9 November 2022 will address the quoracy structure and appointment of Vice Chair to ensure that the meetings are not cancelled unless there is not quorate. In the event of a cancelation the members will review the agenda to assess whether there are any urgent matters that require action and re arrange the meetings as necessary. b) The Terms of Reference for the Quality & Governance Group will be reviewed and updated on 9 November 2022. This will identify a Vice Chair for the meetings.	Diagnostics, Therapies, Pharmacy & Specialties Executive Lead - Gethin Hughes, Chief Operating Officer	30/11/2022	Revised Due Date December 2023 (as a consequence of Phase 2 and decisions to be taken)	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - additional governance support has been provided to facilitate a review of the governance structure. A further update will be provided in December 2023. October 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager. A management structure including the governance role has been submitted to the executive board for approval. This is not reflected in new structure in OCP document as it cannot be fully funded at present. ToR established and Vice Chair appointed.			
			Radiology Service Review 2.2 Consistent approaches to monitoring and governance arrangements should be in place across the localities. Where groups exist that operate on a locality basis, standardised terms of reference should be in place.	The Terms of Reference for all existing groups will be reviewed to ensure that there is a standardised approach.	Diagnostics, Therapies, Pharmacy & Specialties Executive Lead - Gethin Hughes, Chief Operating Officer	01/12/2022	Revised Due Date December 2023 (as a consequence of Phase 2 and decisions to be taken)	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - additional governance support has been provided to facilitate a review of the governance structure. A further update will be provided in December 2023. October 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including the governance role has been submitted to the executive board for review in Phase 2. This post has not been included in the OCP document as it cannot be fully funded at present.			
			Radiology Service Review 3.1 a) Due to the volume of policies and procedures that require reviewing, a plan should be developed with clear objectives, targets and responsible officers to ensure that all are reviewed and disseminated to staff in a timely manner. Once a list of all existing policies and procedures has been created, work needs to progress collectively across all localities to determine what needs to be updated, deleted, or amalgamated, while also recognising that some policies are site specific. b) Going forward, a policy and procedure register should be maintained identifying the document owner and the review dates in order to make it easier to keep them up to date.	a) A review of all policies and procedures will be scheduled and responsible officers identified to oversee the process of updating, deleting or amalgamating. A formal circulation list for review of any policies / procedures has been developed. A Radiology adapted Policy for the Management and Authorisation of Radiology documents has been drafted for ratification on 1 December 2022. b) A policy and procedure register is established and maintained to identify the owner and review dates. Investigation to try and automate reminders for policy review via SharePoint underway.	Diagnostics, Therapies, Pharmacy & Specialties Executive Lead - Gethin Hughes, Chief Operating Officer	30/06/2023	Revised Due Date December 2023 as structure is under review	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - additional governance support has been provided with a view to review the governance structure. A further update will be provided in December 2023. October 2023 Update - Ongoing discussion around Radiology Management Structure and lack of dedicated Governance Manager to manage this work stream. A management structure including support for the governance role has been submitted to the Executive Board for approval. This post has not been reflected in the OCP document as it cannot be fully funded at present.			

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 Services Executive Lead - Executive Director for People	01/12/2022	Revised Due Date Spring 2024	**Overdue**	**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. December 2023 Update - The non-consultant rate card launched on the 19th October 2023. As per the previous update work is progressing to develop the Consultant Rate Card ready for launch in early 2024.			
Internal Audit/2022/90	15/06/2022	Welsh Risk Pool Claims_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-06)	Welsh Risk Pool Claims 1.1 Management should ensure that required documentation is submitted to the WRP within the specified timeframes and monitoring takes place to ensure compliance with this requirement.	1.1a Legal Services SOPs to be reviewed and updated. 1.1b Monitoring process to be implemented in respect of deadlines for various paperwork submissions. 1.1c Spot check audit to be undertaken bi-monthly on paperwork submissions against deadlines i.e. CMRs, LFERs etc.	Patient, Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/12/2022	Revised Due Date February 2024	**Overdue**	**January 2024 Update** - All actions completed. Audit tool drafted. Awaiting audit to be undertaken by BI team to provide full assurance. In house audit undertaken on CMRs by Claims Handlers. Revised Implementation date February 2024. December 2023 update - All actions completed. Audit tool drafted. Awaiting audit to be undertaken to provide full assurance.			
			Welsh Risk Pool Claims 2.1 Procedures should be in place that provide staff with clear guidance on how to process claims, especially the dates that are to be used in relation to the 'Decision to Settle' and 'Final Payment', and the circumstances of when these dates should be updated in Datix. Guidance should also cover the other issues we identified including the correct process for capturing financial transactions in Datix and the process that should be followed if a claim is dismissed when taken to court.	2.1 Legal Services SOPs to be reviewed and updated and staff to be retrained where appropriate. 2.2 SOP to be devised to assist staff through the financial process if a claim is dismissed.	Patient, Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/12/2022	Revised Due Date December 2023	**Fully complete (Awaiting approval)**	**January 2024 Update** - Management agreed actions completed. CRM report being undertaken and audited for assurance purposes. December 2023 Update - Management agreed actions completed. CRM report being undertaken by the BI Team. Thus providing further assurance for the monitoring process.			
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 Services Executive Lead - Dom Hurford, Executive Medical Director Executive Lead for People	01/11/2022	Revised Due Date April 2024	**Overdue**	**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. December 2023 Update - Pending December 2023 LNC meeting - aim to have completed.			
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 Executive Lead - Stuart Morris, Director of Digital	01/04/2024		In progress	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update: Started to collocate some of the Records staff at Bridgend but this is a significant piece of work which will run through 2024/2025. October 2023 Update - Work Ongoing New Assistant Director of Digital Transformation - with responsibility for the Medical Records team has now commenced in post. Core part of their role will be to take this work forward.			
Internal Audit/2023/100	31/05/2023	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	Welsh Risk Pool 1.1 1.1a Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases. 1.1b Regular monitoring oN the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported.	1.1a Staff will be reminded of importance in next meeting in respect of closure. A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team. A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required. 1.1b In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	Patient, Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/06/2023	Revised Due Date February 2024	**Overdue**	**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 wekly 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. December 2023 Update - A checklist has been developed outlining the current stages and requirements for closing records. This needs to be tested on Datix Cymru. An SOP to support the training has been developed. Training has been delayed due to long term sickness within the team. This is now due to take place December 2023. Monthly audits will commence in 12th December 2023. A final audit is due by the end of the year, which should show compliance and therefore enabling this action to be closed.			
			Welsh Risk Pool 2.1 Management should ensure that required documentation is submitted to the WRP within the specified timeframes, appropriately recorded on Datix Cymru, and monitoring takes place to ensure compliance with this requirement.	In respect of LFER's a new process and SOP is being drafted to ensure timely submission of LFER's. In respect of CMR's there is a process that currently picks up on upcoming CMR's. The process around monitoring CMR's will be solidified by the new dashboard which will allow a more robust monitoring process. Individuals who have missed deadlines will be reminded of importance of CMR deadlines and provided with additional training & support.	Patient, Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/06/2023	Revised Due Date March 2024	**Overdue**	**January 2024 Update** - A process map has been completed following consultation. Assistant Director of Quality & Safety is awaiting an external report following a review of Legal Services, to allow for all comments to have been considered the process map remains in draft and will be finalised by the end of February 2024 therefore implementation date revised to March 2024. December 2023 Update - The SOP for LFERs has been amended following new Welsh Risk Pool reimbursement procedures - COMPLETED. Final comments received - COMPLETED. Due to go to Weekly Exec meeting for review in December 2023. All actions completed, however awaiting audit to be undertaken by the BI team to provide full assurance. This is due in December 2023.			
			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 Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/06/2023	Revised Due Date February 2024	**Overdue**	**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. December 2023 Update- All actions are complete. Audit programme of new, closed and ongoing claims planned for December 2023.			
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 - IPCN/ Decontamination Lead Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/11/2023	1a October 2023 1b December 2023 1C March 2024	**Overdue**	**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. December 2023 Update - The Decontamination Policy has been updated and is currently out for comment prior to it being presented at the next Decontamination Committee meeting on the 5th December 2023 prior to going to IPC Committee in January 2024.			
			Decontamination 2.0 A review of locally held decontamination procedures should be carried out to ensure standardised approach to the quality, content and approval.	2a Audit tools for approval in the next Decontamination Committee meeting (see action 5.1). 2b Audit programme to be carried out across all appropriate areas within CTM to inform local SOP status and revisions where required (see action 5.2). 2c All local SOPs are to have been reviewed and ratified for ongoing implementation.	Patient Care & Safety - IPCN/ Decontamination Lead Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/09/2024		In progress	**January 2024 Update** - The SOP template was agreed at Decontamination Committee and circulated to service users for use. Current SOPs to be transferred to new template and will be ratified at local site decontamination meetings. On target to meet 2b and 2c. December 2023 Update - Audit tools finalised and audit programme commenced. A SOP template for decontamination has been developed and will be presented at the Decontamination Committee meeting in December 2023.			
			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 - IPCN/ Decontamination Lead Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/10/2023	Revised Due Date 3a July 2023 / 3b October 2023 / 3c March 2024	**Overdue**	**January 2024 Update** - Strategic review of IPC service ongoing. Led by Richard Hughes, Deputy Executive Director of Nursing. December 2023 Update (Date of Review 29/11/23) - Concerns escalated to Deputy Medical Director. The issue was discussed further in IP&C committee on the 17/10/23. We have been informed that the Consultant cover in POW will form part of the IP&C strategic review. The Deputy Executive Director of Nursing is leading the review.			

			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 - IPCN/ Decontamination Lead Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/06/2024		In progress	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - 3 audit tools agreed in September 2023 as planned. Action 5a completed. October 2023 Update (Date of Review 4/10/23) - 3 audit tools agreed in September 2023 as planned.			
			Decontamination 4.0 The Terms of Reference for the Local Decontamination Groups should be reviewed and revised (where applicable) and presented to the Decontamination Committee for overall approval.	4a Update the terms of reference for the local decontamination meetings in CTM. 4b Updated and agreed terms of reference to be presented to the Decontamination Committee for discussion and ratification. 4c Present reviewed and agreed local decontamination terms of reference to IPC Committee for noting.	Patient Care & Safety - IPCN/ Decontamination Lead Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/10/2023	Revised Due Date 4a August 2023 / 4b December 2023 / 4c January 2024	Fully complete (Awaiting approval)	**January 2024 Update** - 4b completed. Terms of reference agreed. 4c Terms of reference do not need to go to IPCC. December 2023 Update - The ToR will be presented to the next Decontamination Committee meeting for approval on the 05/12/23. October 2023 Update - Terms of reference have been developed and will be presented at the next Decontamination Committee meeting for approval. Rationale for revised implementation date - The terms of reference were not updated in time to be presented at the last Decontamination committee which has delayed them being presented at IPCC.			
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident Framework 1.2 The Incident Management framework should be reviewed and updated where necessary to take account of the Health Boards new operating model, the recently published updated guidance and incorporate information on reporting processes.	The Health Board's Incident Management Framework to be reviewed in line with the recommendation, duty of Candour requirements and agreed proposal to remove reference to the Locally Reportable Incident Proforma.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/10/2023	Revised Due Date January 2024	Fully complete (Awaiting approval)	**January 2024 Update** - The revised Incident Management Framework was approved by the Quality & Safety Committee on the 23.01.24. December 2023 Update - A task and finish group has been established to review the Incident Management Framework. A number of meetings have been held and input received from key leads. The document will be circulated for consultation on the 04.12.23. The final document will be submitted to January's Quality & Safety Committee. Cross reference to the Incident Reporting policy, Concerns Policy & Procedures and NHS Executive Policy is included as part of the review. The Central patient safety team are members of the All Wales Investigation Management Process task and finish group, led by the NHS Executive and actively involved in the development of the policy. A project has been initiated centrally, to introduce patient safety link nurses to all appropriate Health Board areas, this project is in its infancy with support from the QI team.			
			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 Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/11/2023	Revised Due Date February 2024	Overdue	**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. December 2023 Update - A training strategy is being developed which reflects the scope of the Concerns Policy & Procedures, Incident Management Framework and Datix Cymru requirements. The strategy is being developed alongside the review of the Concerns Policy & Procedures and Incident Management Framework. An analysis has been completed of all records held centrally, of health board staff that have received RCA training since 2019. The staff records have been identified into their care groups and are being cascaded to the Heads of Quality and Safety and triumvirates. To support the training needs analysis to be undertaken. RCA training has recently been updated following extensive evaluation of user feedback. The training is delivered by the central patient safety team, via the articulate platform, plus a face to face session 6 weekly across all HB sites. Bespoke care group training sessions are being developed for all staff groups, with drop in sessions for Q&A.			
			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 Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/09/2023	Revised Due Date February 2024	Overdue	**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. December 2023 Update - All incidents reported are subject to a quality assurance process via the Care Group structure and this forms part of the questions raised at the Quality Assurance panels. Oversight of this is undertaken by the Quality & Safety / Patient Safety Team. These arrangements will be outlined in the Incident Management Framework. The assurance process commences at the initial rapid review meeting. There is a dedicated proforma for the review and care group or central governance leads attend all rapid reviews providing assurance of a suitable investigator that is RCA trained. All documents are available as appendices uploaded to the Investigation Framework on SharePoint. QA documents are uploaded to the Datix system by the central admin team following the approval of NRI closure bundles by the Executive team.			
			National Incident Framework 3.1 Management should ensure all documentation in relation to NRIs is appropriately completed with relevant documentation saved to Datix. This includes: • Evidence of rapid review meetings taking place or confirmation that one was not required. • NRI forms capturing the proposed investigation timeline which will allow future monitoring and reporting to take place. • The quality assurance checklist recording all relevant information such as who the RCA training investigators are, as opposed to just ticking that someone is RCA trained. • All relevant fields within Datix completed as required. • Copies of the RCA report saved to Datix. • A consistent approach to the saving of panel minutes to Datix, giving consideration to if a panel reviews more than one case, the data protection implications of saving the full set of minutes to individual Datix records.	Reminder to be sent to all Care Groups of the need to ensure that all documentation has been uploaded to Datix Cymru. Datix Cymru Incident Management Training to include the requirement to upload all documentation to Datix Cymru. The quality assurance process will include a check that ensures all required documentation has been uploaded. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible Care Group.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/09/2023	Revised Due Date January 2024	Fully complete (Awaiting approval)	**January 2024 Update** - An email was sent out to all Care Groups Leads by the Executive Director of Nursing, Midwifery and Patient Care on 05.07.23. A follow up email was sent on the 05.08.23. The quality assurance checklist is included in the updated and approved Incident Management Framework. December 2023 Update - The quality assurance checklist is currently being reviewed and updated as part of the review of the Incident Management Framework. Staff are also reminded in the Face to face RCA training session and at all other opportunities, to upload all documents to Datix, complete progress notes and utilise the actions module to log and assure all actions are completed.			
			National Incident Framework 4.1 Further work should be carried out to explore the option of accessing the action plan module in Datix, thus allowing the NRI to be closed in Datix more timely following completion of the investigation, yet still allowing the monitoring of the implementation of actions. Whilst this option is explored, it should be ensured that the action plans saved to Datix are adequately completed with evidence of actions taken to date and if necessary, a process for following up on actions following submission of the paperwork to the NHS Wales Executive (formerly the DU.)	Ensure that all required staff have access to the actions module and appropriate training is provided. This will be linked to the implementation of the revised Incident Management Framework. The quality assurance process will include an assessment to confirm that an action plan has been developed and upload to Datix Cymru. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/10/2023	Revised Due Date December 2023	Fully complete (Awaiting approval)	**January 2024 Update -** The requirement to use the action functionality is included in the approved Incident Management Framework. As part of the roll out training will include guidance on the use of the action functionality. Challenges with extraction and reporting continue to be addressed. December 2023 Update - A programme for robust implementation of the actions module is currently being developed. Requirements for recording actions within Datix Cymru will be included in the revised Incident Management Framework. The action module will be used for all upheld PSOW cases from the 04.12.23.			
			National Incident Reporting Framework 1.1 Management should ensure all out of date guidance documents are removed from the intranet and only relevant policies and procedures are made available.	All policies and procedures relating to Incident & Concerns Management will be uploaded to SharePoint and previous versions removed.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/10/2023	Revised Due Date January 2024	Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - Following approval of the Concerns Policies & Procedures, Incident Reporting Policy and Incident Management Framework a review of all SharePoint sections relating to Concerns, Datix, Quality & Safety will be reviewed and updated. October 2023 Update - Following approval of the Concerns Policies & Procedures, Incident Reporting Policy and Incident Management Framework a review of all SharePoint sections relating to Concerns, Datix, Quality & Safety will be reviewed and updated. Rationale for revised implementation date: From Oct 23 to Jan 24 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.			
			National Incident Reporting Framework 5.2 In order to allowing monitoring and ensure compliance with the 72-hour timeline placed in changing the new incident to 'make safe', the make safe date should be captured within Datix.	An audit programme of new, open and closed incidents to be implemented to ensure that all required fields are completed in the required timescales. Feedback from the audits will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/10/2023	Revised Due Date December 2023	Fully complete (Awaiting approval)	**January 2024 Update** - Monitoring of compliance with timescales for incident management has commenced. Information is provided at Executive, Care Group, Specialty and Site Level. This information will be further strengthened and audited following the launch of the Incident Management Framework. December 2023 update - A data validation checklist is being developed to inform all users of the data requirements. Once this has been disseminated, weekly audits will commence. This will be implemented as part of the launch of the Incident Management Framework.			
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.	Digital & Data Executive Lead - Stuart Morris, Director of Digital	01/01/2024	Revised Due Date January 2024	Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - Work Ongoing - Performance Framework being updated by end of December 2023 - proposing to take to January 2024 Board. October 2023 Update - Ongoing; work incomplete.			

			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 Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Digital & Data Executive Lead - Stuart Morris, Director of Digital	01/12/2023	Revised Due Date December 2023	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update: Performance framework being produced / plan to complete by December 2023. October 2023 Update - Work Ongoing - no progress to date.			
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 1.1 1.1a The concerns SOP should be revisited ahead of approval to ensure all sections are populated and reference is made to other relevant SOPs / supplementary documents. Consideration should be given to re-naming the SOP and removing the reference to 'written' concerns only. 1.1b The revised Concerns Policy and Standard Operating Procedures should be formally approved and made available to staff. The concerns pages on the CTM internet site should also be updated with the revised policy and the previous version removed.	1.1a The Concerns SOP will be reviewed in line with the recommendation above and will be renamed and written concerns will be explained. 1.1b The various SOPs/policy will be made available on SharePoint for all staff to access once approval has been received in Quality & Safety Committee in July 2023.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/08/2023	Revised Due Date January 2024	**Fully complete (Awaiting approval)**	**January 2024 Update** - The Concerns Policy & Procedures was approved by the Quality & Safety Committee on the 23.01.24. The SharePoint pages have been reviewed as part of the revision of the policy and supporting documentation. The SharePoint pages are subject to regular review to ensure they remain update. December 2023 Update - Approval of the Concerns Policy & Procedure has been deferred to January 2024 due to the impending release of the updated PTR guidance and the review of the incident management Framework following revised National Incident Guidance from the NHS Executive. The Health Board's Concerns Share Point pages are being reviewed to ensure they are up to update and accurate information is available to support staff involved in the management of concerns. Rationale for revised implementation date: From Sept to Dec 23 Completion of the Concerns Policy & Procedures and Incident Management Framework has been impacted by the review of Putting Things Right and the issuing of revised guidance from the NHS Executive in relation to Nationally Reportable Incidents.			
			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 Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/10/2023	Revised Due Date February 2024	**Overdue**	**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 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. December 2023 Update - The Incident Management Framework and Concerns Policy & Procedures are currently being reviewed. To support the implementation of these documents a training strategy is being developed. Once these documents have been finalised a training needs analysis will be undertaken in conjunction with the Care Groups. A rolling 12 month training programme will established to support the robust management and investigation of concerns.			
			Concerns Follow Up Review 4.1 The information within the draft Early Resolution SOP in relation to re-classification of cases to PTR status should be reviewed to provide greater clarity on the exact timeframe and process to be followed.	Early Resolution SOP to be reviewed in line with the updated PTR Guidance, with more clarity around timeframes and process.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/06/2023	Revised Due Date December 2023	**Fully complete (Awaiting approval)**	**January 2024 Update** - Clarification and guidance has been provided to all Complaints team members. Appropriate recording of complaints is monitored via the weekly audit programme. Feedback meetings are undertaken on a weekly basis and reminders of accurate recording given. CLOSE. December 2023 Update - A standard operating procedure for the management of early resolution complaints is in place. Further review will be required following the release of the updated Putting Things Right Guidance.			
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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/09/2023		**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/01/2024		**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/01/2024		**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/03/2024		**In progress**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/01/2024		**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/03/2024		**In progress**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/03/2024		**In progress**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/03/2024		**In progress**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 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.	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.	Facilities Function Executive Lead - Gethin Hughes, Chief Operating Officer	01/02/2024		**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Required Training is still underway. Over 75% of staff are now trained and several more training sessions planned. The Department is in the process of completing the action tracker and preparing key performance indicators to monitor progress. Date for completion stands.			
			Facilities Systems Follow Up Review 6.0 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 Function Executive Lead - Gethin Hughes, Chief Operating Officer	01/10/2023	Revised Due Date February 2024	**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - The review was not followed up correctly in October 2023. Preparation is underway to progress the matter accurately. Update will be available at the February Meeting.			
			Facilities Systems Follow Up Review 1.0 Management should ensure that staff who are yet to attend training sessions identified as a requirement for their role, do so as soon as is practicable.	A change in the Facilities structure was implemented in September 2023. The hub and non-hub services have merged into one service. The ILG service Managers are no longer accountable for Facilities services. Leadership is new and all facilities services are under review. Training records will be amalgamated. Any employees who have missed the training will receive the recommended training. A total of 77% have completed Qlik Finance system training and 66% have completed P2P Procurement training. Further training to be arranged.	Facilities Function Executive Lead - Gethin Hughes, Chief Operating Officer	01/02/2024		**Overdue**	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			

			Facilities Systems Follow Up Review 2.2 2.2a Management should continue to work with Procurement to review arrangements with suppliers where large numbers of retrospective orders continue to be raised, with a view to using 'call off / open' orders instead (where practicable). 2.2b In liaison with Procurement, clear guidance should be developed for when it may be acceptable to use 'call off / open' orders and the process staff need to follow to ensure appropriate controls are in place. The FCP should be updated accordingly.	2.2a We will continue to work closely with Finance and Procurement colleagues to identify further opportunities for using call of orders instead of using retrospective orders. 2.2b We have developed and issued a new action card to remind staff of their responsibilities for attaching supporting information/documentation in respect to open/call off orders and to provide information on the retention of information/documentation to support orders. Although informative action cards have been designed there is no evidence that the cards are utilised and adhered to. A monitoring procedure will be added to Facilities Key Performance Indicators and will be monitored monthly."	Facilities Function Executive Lead - Gethin Hughes, Chief Operating Officer	01/02/2024		Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			Facilities Systems Follow Up Review 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.	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.	Facilities Function Executive Lead - Gethin Hughes, Chief Operating Officer	01/02/2024		Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			Facilities Systems Follow Up Review 4.0 The level of ongoing additional support provided by procurement to Facilities should be reviewed with an aim to reducing it over time as more Facilities staff complete training. Facilities staff should reminded suppliers that queries should be directed through 'Action Point' in the first instance, and not directly with the department.	We have requested the reinstatement of the 'invoices on hold' reports with an agreed frequency from procurement. Reports are generated and distributed.	Facilities Function Executive Lead - Gethin Hughes, Chief Operating Officer	01/10/2023		Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
			Facilities Systems Follow Up Review 5.0 Management to ensure that outstanding staff receive QlikView training as soon as practicable.	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.	Facilities Function Executive Lead - Gethin Hughes, Chief Operating Officer	07/10/2023		Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion.			
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 Function Executive Lead - Stuart Morris, Director of Digital	30/06/2024		In progress	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - Aged assets will continue to be reviewed and replacement prioritised balanced against limited funds. Funding decisions around AWIP are due mid-December, funding for the cyber bid has been approved.			
			IT Infrastructure 3.1 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 Function Executive Lead - Stuart Morris, Director of Digital	30/06/2024		In progress	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - Recruitment has been successful into our cyber team that will pick up this action.			
			IT Infrastructure 4.1 The approach to patching and the mechanisms for undertaking this should be set out within formal documentation.	Create a patching policy and procedure document to cover patching of managed devices.	Digital & Data Function Executive Lead - Stuart Morris, Director of Digital	31/12/2023		Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 - An update has not been provided against this recommendation on this occasion			
			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 Function Executive Lead - Stuart Morris, Director of Digital	31/03/2024		In progress	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - Progress continues on the CMDB as well as active conversations on ITSM tooling.			
			IT Infrastructure 6.1 The network topology and make up should be recorded outside of the monitoring tools.	Plans in place to review and document individual sites. Staffing levels will determine the time it will take to complete the work. Priority will be given to the critical sites, as this also supports the review work required for NIS-D assessment.	Digital & Data Function Executive Lead - Stuart Morris, Director of Digital	31/03/2024		In progress	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - We are actively trying to recruit additional resource to enable us to complete this action.			
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 3.1 A review of the current application management system should be undertaken to determine what additional data should be captured that facilitates monitoring of applications, completion timeframes and the issues encountered that prevents timely completion.	Benchmarking with neighbouring Health Boards has been completed to establish what systems they use to monitor timeframes and issues experienced. Both SBUHB and ABUHB use a similar system to the one currently in place.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/11/2023		Fully complete (Awaiting approval)				
			Deprivation of Liberty Safeguards 3.2 Each application should be allocated a sequential reference number that allows monitoring to ensure logged applications are not deleted from the spreadsheet in error.	Options of management systems will be explored in partnership with the performance and information team and digital colleagues within CTMUHB, to ensure a robust management system within the DoLS team. One that will allow a sequential reference number.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/04/2024		Fully complete (Awaiting approval)	**January 2024 Update** - The current management system has been adapted to capture key dates for the DoLS authorisation process, allowing for improved oversight and identification of delays. This addresses the recommendation with the exception of a sequential reference numbers. The DoLS Team Leader, along with Head of Safeguarding are further exploring digital options with colleagues within CTMUHB.			
			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 Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/04/2024		In progress	**January 2024 Update** - The development of a standard operating procedure in in progress.			
			Deprivation of Liberty Safeguards 2.1 Management should monitor DoLS / MCA training completion rates at the various levels and take action to escalate concerns where training is not being completed.	CTMUHB compliance in MCA reset following work to allocate competencies to reflect new MCA/DoLS training. Since the audit the following changes have been implemented: • A scorecard has been developed to evidence numbers of staff who have received MCA and DoLS Training. This will continue to be monitored quarterly through the Safeguarding Operational and Executive Group (SEG). • The DoLS/MCA team now attend the CTMUHB monthly Core Learning Compliance Group to discuss compliance and highlight any areas of concern.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/01/2024		Fully complete (Awaiting approval)				

			Deprivation of Liberty Safeguards 3.3 Consideration should be given to maintaining a log of returned applications, and the data used to identify if there are any training needs in certain wards or departments.	• Following the discussions prior to this report, a new returned applications log has been developed and trialled. This is completed on a daily basis and any returned applications are followed up the next day by the next BIA monitoring the inbox. • Quarterly quality assurance meetings will be held by the Head or Deputy Head of Safeguarding to review a selection of returned applications and assessments for the purposes of identifying themes and barriers. These meetings will also facilitate oversight of audits and action plans.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/01/2024	Revised Due Date April 2024	**Overdue**	**January 2024 Update** - The trial period for the updated applications log has resulted in these being utilised by the team on a permanent basis. The log allows the team leader to keep an overview of allocations, performance management, themes and trends. The development of the quality assurance meetings is delayed due to staff sickness. Terms of reference will be complete by February, with the first meeting scheduled to now take place at the start of the new year. It is requested that approval is given to move this completion date to April 2024.			
			Deprivation of Liberty Safeguards 4.1 Management information reports should include data and commentary on application numbers where the desired timeframe was not achieved and where possible analysis of reasons behind this.	• The monthly performance management report submitted to the Deputy Head of Safeguarding by the DoLS Team Leader will be strengthened to include data analysis, identifying barriers in meeting the 7 day and 21 day statutory timescales. • Breaches in legislative time frames will be monitored and reported quarterly through the Safeguarding Executive Group.	Patient Care & Safety Executive Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/01/2024		**Fully complete (Awaiting approval)**	**January 2024 Update** - Monthly reports are developed and discussed between the DoLS Team Leader and Head of Safeguarding. The reports include team performance, including the agency undertaking assessments. Reports include themes and barriers to CTMUHB achieving authorisations within statutory timescales. These monthly reports form part of the quarterly reports presented to the Safeguarding Executive Group.			
			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 Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/02/2024	Revised Due Date April 2024	**Overdue**	**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.			
			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 Lead - Greg Dix, Executive Director of Nursing / Deputy Chief Executive	01/01/2024	Revised Due Date February 2024	**Partially complete (Overdue)**	**January 2024 Update** - Performance management spreadsheets have been amended to reflect all stages of DoLS authorisations, are completed monthly and discussed between the Team Leader and Deputy Head of Safeguarding. The development of the quality assurance meetings is delayed due to staff sickness. Terms of reference and any preparatory work will be completed by February, with the first meeting scheduled for April 2024. It is requested that approval is please given to move this completion date to April 2024. This action links with recommendation DoLS 3.3			
Internal Audit/2023/152	07/12/2023	PCH Redevelopment Programme: Supervisor Role_Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)	PCH Redevelopment Supervisor Role 1.1 The management of observations / defects (and specifically the rate of closure) should be highlighted at progress meetings to gain increased traction.	Agreed. Will highlight within Supervisors presentation at monthly Site Progress meetings.	Finance, Capital & Estates Executive Lead - Sally May, Executive Director of Finance	01/12/2023		**Fully complete (Awaiting approval)**	**February 2024 Update** - Supervisor's report re-formatted to draw attention to outstanding defects.			
			PCH Redevelopment Supervisor Role 2.2 The data provided in respect of defects/observations closed/outstanding, could be enhanced to provide information regarding the priority nature of the defects which have not been actioned (e.g. high priority/low priority).	Agreed	Finance, Capital & Estates Executive Lead - Sally May, Executive Director of Finance	01/01/2024		**Overdue**	**February 2024 Update** - Supervisor's report re-formatted to draw attention to priority of outstanding defects. Further consideration of presentation required.			
			PCH Redevelopment Supervisor Role 2.1 The monthly Supervisor Reports could be improved in terms of the clarity of key information provided. The following is suggested: • Assurance dials could be used for each key area (progress against programme, quality of works, progress in closing defects/observations etc.), with an indication of movement from the prior month.	Agreed, though some of these areas are subjective.	Finance, Capital & Estates Executive Lead - Sally May, Executive Director of Finance	01/01/2024		**Fully complete (Awaiting approval)**	**February 2024 Update** - Supervisor's report re-formatted to include visual representation of assurance status.			
			PCH Redevelopment Supervisor Role 3.1 Formal KPI monitoring for the Supervisor appointment should be considered.	Agreed, will consider introduction of relevant KPIs.	Finance, Capital & Estates Executive Lead - Sally May, Executive Director of Finance	01/01/2024		**Fully complete (Awaiting approval)**	**February 2024 Update** - Consideration given and dialogue undertaken with NWSSP for suitable KPI's relating to Supervisor's activity. In the absence of pertinent indices the Supervisor's performance will continue to be monitored with due diligence at the project.			
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	Strategy & Transformation Executive Lead - Linda Prosser, Executive Director of Strategy & Transformation	01/09/2023	Revised Due Date January 2024	**Overdue**	**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. December 2023 Update - The planning and commissioning team is providing a project team to develop the resources and has collated a draft SLA and service specification template which is being considered by a number of expert teams (e.g. procurement and quality and safety) to ensure that all legal and service requirements are appropriately considered. A checklist has been developed to support SLA cessations and a further checklist is being developed for initiating SLAs. These will be temporary documents pending a more detailed piece of work to establish a policy structure. Links are being made to all Wales peer groups to collaborate with and learn from other NHS organisations in Wales in the approach to commissioning.			
			SLA Arrangements 2.0 Data in the register of agreements should be checked to confirm its accuracy and completeness. • Once the current completeness and accuracy of the register of agreements has been confirmed, procedures will need to be put in place to ensure that changes are promptly notified so that it remains accurate and up to date. • The register of agreements should be checked before setting up an SLA agreement with a provider to ensure that multiple SLAs are not set up with the same provider for the same service and that no issues have been identified which would suggest that setting up the SLA agreement should not proceed. The columns for end date and review date in the register of agreements should be regularly used to identify when periodic reviews are due and whether they have been completed on schedule.	The register of agreements will be reviewed by a process of sharing with all corporate and service (Care Groups) teams for review and supported by a structure of meetings between the Strategy and Transformation Team (Commissioning leads) and the Care Groups to manage and monitor SLAs. All third sector SLAs have been reviewed and the register will be updated to reflect the latest status.	Strategy & Transformation Executive Lead - Linda Prosser, Executive Director of Strategy & Transformation	01/08/2023	Revised Due Date January 2024	**Overdue**	**January 2024 Update** - The register of agreements has been reviewed by care groups and new agreements will be added as they are created. December 2023 Update - Commissioning meetings are now in place with all care groups. Care groups have received the register of agreements and are providing updates. All contracts will have confirmed HB contracts for planning/commissioning and service teams and agreed frequencies for monitoring. This work will progress and embed during the next cycles of the commissioning meetings.			
			SLA Arrangements 5.0 Adequate data should be obtained in line with SLA requirements to allow effective performance, quality and financial monitoring of the SLA to take place. The supporting data should be provided in sufficient time before SLA reviews are scheduled to occur so that it can be properly considered at the review. Evidence and supporting data should be retained of the SLA review process.	Please refer to action four above, which confirms that information requirements and review frequency will be determined with Care Groups. The capacity of the Strategy and Transformation team's commissioning function has been a limiting factor in the robust development of processes. A Commissioning Support Officer vacancy is being considered by the organisation's scrutiny panel. This post will lead on organisation of the administration of the register of agreements and the meetings with Care Groups. A Head of Commissioning job description has been developed and has been sent for Agenda for Change banding. This post will be recruited to on a fixed-term basis while the Head of Planning post is vacant due to secondment. Should this role provide successful, every effort will be made to structure the team to retain this function, however this will be dependent upon the team budget.	Strategy & Transformation Executive Lead - Linda Prosser, Executive Director of Strategy & Transformation	01/09/2023	Revised Due Date January 2024	**Overdue**	**January 2024 Update** - Care group meetings take place regularly and there is a structure in place to support the monitoring of all agreements. December 2023 Update - Please refer to the update in the Management Action section. Commissioning Support Officer now in place. Meeting schedule is in place with care groups and meetings have commenced. The register of agreements is being updated and will include confirmation of monitoring arrangements.			
			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.	Strategy & Transformation Executive Lead - Linda Prosser, Executive Director of Strategy & Transformation	01/09/2023	Revised Due Date January 2024	**Overdue**	**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. December 2023 Update - Guidance documents are in development. The implementation of commissioning meetings provides a mechanism for testing and assurance of all SLAs pending completion of the guidance document.			
			SLA Arrangements 4.0 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.	Strategy & Transformation Executive Lead - Linda Prosser, Executive Director of Strategy & Transformation	01/09/2023	Revised Due Date January 2024	**Overdue**	**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. December 2023 Update - SLA review is a component part of the commissioning meeting structure and the allocation of both service and planning/commissioning leads for each SLA will ensure this is undertaken. The review of the register of agreements that will deliver this is ongoing currently.			

Internal Audit/2023/54	06/02/2023	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 2.1 2.1a The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. 2.1b The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	2.1a The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. 2.1b Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	Medical Directorate & People Services Team Executive Team - Dom Hurford, Executive Medical Director	01/06/2023	Revised Due Date November 2023	Fully complete (Awaiting approval)	**January 2024 Update** - We have now achieved a 98% DE compliance due to the introduced policy. The remaining non-DE are on medium/long term contracts and when they conclude will only be replaced with DE rates. As such we are happy to close this risk/concern down. December 2023 Update - We have now achieved 97% DE across the HB. There are a few remaining non-DEs that were part of agreement before we applied the new rues. These will not be repeated when agreement comes to an end.			
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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	30/04/2023	Revised Due Date December 2023 given additions to process and need to revisit policy	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Awaiting update from Director of Planned Care following update. October 2023 Update - Following feedback received by the Director of Planned Care and updated guidance from WG on the management of RTT patients this SOP will need to be presented at the next OMB for approval.			
			Reasonable Offer Process 2.3 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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	30/06/2023	Revised Due Date February 2024 as a consequence of appointments around OCP 2.	Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - Awaiting the outcome of OCP 2 which has been delayed. October 2023 Update - This will be completed when Phase 2 of the OCP is complete in December 2023.			
			Reasonable Offer Process 3.1 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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/08/2023	Revised Due Date February 2024	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - Awaiting SOP update from Director of Operations Planned Care. October 2023 Update - additional work has been required and an update on the SOP Is imminent.			
			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 - Care Group Executive Lead - Gethin Hughes, Chief Operating Officer	01/08/2023	Revised Due Date February 2024	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - as a consequence of the phase 2 OCP process, the position remains the same as that in October 2023. There will be an update in February 2024. October 2023 Update - In terms of reports this has not changed since previous update as one report on application of RTT rule is not available. In mitigation to this we have agreed that an escalation route through weekly RTT meetings of any identified areas of noncompliance with RTT rules which are identified by performance and reporting team where actions on patients pathways are not inline with guidance.			
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 3.0 In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. Staff should be reminded that it is their PDR and therefore they need to engage in the process and complete any relevant paperwork ahead of the meeting, allowing the actual meeting to be more meaningful and efficient.	Current compliance as at 10/07/23: • POW 82.5% • RGH 60.8% • PCH 66% Significant improvement noted at PCH with increased compliance from 39%. The team have booked and planned PDRs around incremental dates. All managers have been asked to review and ensure all dates are reflected accurately on ESR. It has been noted that some staff are lacking confidence in completing the new PDR document prior to the planned PDR. Staff are encouraged to engage in the process and work through the document with their line manage during the PDR or seek support prior to the PDR.	Mrs Claire Brown	01/02/2024	Revised Due Date February 2024	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - at the end of September the compliance was reported at 65.07% compliance. A number of staff at POW are now out of compliance and work is being undertaken to address and improve the situation. There will be further a update at the next meeting. October 2023 Update - Current compliance for September 2023 71.93%. Previous compliance for August 2023 71.02%. The team continue to drive performance compliance with site plans.			
			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.	Mrs Claire Brown	01/09/2023	Revised Due Date February 2024	Overdue	**February 2024 Update -** An update has not been provided against this recommendation on this occasion. December 2023 Update - work ongoing with learning development team as described in October. There have been issues identified with spaces for training for Resus and Patient Handling. Work is ongoing and there will be an update at the next meeting. October 2023 Update - Contact made with People's Services and L&D. The workforce team has been assigned to create new ESR positions for roles where there are differing requirements. Awaiting a further update from L&D. People's Services have also sent a chaser email.			
			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.	Mrs Claire Brown	01/12/2023	Revised Due Date December 2023	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - staff are encouraged to undertake core mandatory training. Training dates for departmental Resus and Patient Handling have been issued for December and January. October 2023 Update - Current compliance September 2023 64.13%. Increased compliance since August 2023 - from 64.04%. Teams are driving compliance in all areas. BILS training booked for Consultants on 09/10/23. Monthly reports sent out to all superintendents. Plans being developed to run in house training for Resuscitation and Manual Handling.			
			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	Mrs Claire Brown	30/09/2023	Revised Due Date December 2023	Overdue	**February 2024 Update** - An update has not been provided against this recommendation on this occasion. December 2023 Update - job plan meetings have been set up for those who are either out of compliance or will be out of compliance scheduled throughout November and December. October 2023 Update - POW 6 signed off, 1 in first sign off, 1 in second sign off. 1 Awaiting a second JP meeting due to a flexible working application.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
Health Inspectorate Wales/2017/141	30/01/2017	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022	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 Open Eyes 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.	Mrs Claire Brown	01/03/2023		Overdue	Stage 1 – to be completed by March 2023. Stages 2 & 3 – BC dependent – objective is to start implementation in first half of 2023/24. December 2023 Update (Date of review: 12/12/23) - Roll out of Open Eyes has been delayed nationally, with CTM & C&V the only 2 HBs live with EPR for glaucoma in hospitals. The programme plan was to implement glaucoma EPR in all hospital sites nationally as stage 1, e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialties in Ophthalmology as stage 3; the timeline has been delayed with host changeover from C&V to DHCW. OpenEyes implemented in CTM hospital glaucoma clinics since March 2023. Further work on admin training and integration with hospital digital systems (WPAS & CITO) ongoing. Primary Care have worked with the DHCW programme team to provide contact details for all optometrists requiring access/relevant training, currently focusing on national pilot of NHS email addresses for community optometrists (2 per HB to start) What next? By when? By whom?			
			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.	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Dec 23 Completed - new optometry contract phased implementation began Oct'23 2- implementation of EPR across HB remains an ongoing process Dec 23 update The new national optmetry contract will promote fuller conversations between patient and optometrist during WGOS service assessments, with optometrists [as part of the patient assessment]explaining how risk behaviours can effect their eye health and also enable practitoners to signpost paitents to alternative services where required. EPR is already established within glaucoma clinics within HES . HB is working with national digitilisation programme to launch EPR system across primary and secondary care as a matter or urgency Actions 1. the national contract will be monitored monthly by primary care teams on an ongoing basis as part of the new contract arrangements. 2- the primary & secondary care staff will continue to engage with the national programme/DHCW to support implementation within the HB.			
			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	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Completed: all schemes are now established within CTM Dec 23 update Data for these schemes are reviewed monthly on an ongoing basis by the primary/secondary teams and pan HB team/practice meetings are held regularly to review schemes. All schemes will begin to fall under the new optometry contract through phasing in of new contract / WGOS and monitored by primary care.			
			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	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Dec 23 update newsletters will continue to be sent to practices via primary care team regarding updates and new referral pathways. There will be ongoing engagement with practices due to the implementation of new contract/WGOS services and communication sent to relevant services ie GMS/pharmacy/secondary care on any relevant changes. Most practices are now engaged with ACD under the new contract obligations and work will continue to engage with those practices not yet engaged. HB ECCG will be the platform for primary care to share updates with secondary care on new contract/WGOS.			
			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.	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Dec 23 update the review of quality referrals sent by optometry practices will be an ongoing process			
			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.	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Dec 23 update this is done by the admin staff across the HB in order to ensure that optometrists are kept uo to date with patients status within HES. This will be an ongoing process by the service manager to ensure that when a patient is refered by the optometrist that a copy of the clinic correspondence is sent to them for information. All new starters to be informed of the process.			
			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.	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Dec 23 update this will be an ongoing process. Optometry Advisors will continue to work with both practices and HES to ensure the submission of high quality referrals. Implementation of the EOR system will also support /improve referral process.			
			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.	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update (Date of review 12/12/23) See Item 1What next? By when? By Whom?			
			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	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Dec 23 update Date of review: 03/08/2023 What next? The health board has a comprehensive selection of patient information leaflets available. In order to ensure that these meet the needs of our patients, these leaflets need to be well stocked and updated nationally through the EIDO programme to ensure that they reflect best practice. Objective to be discussed at directorate meeting to raise awareness to both clinicians and nursing staff about supplying patients with information during their clinical consultations. By when? Weekly review of lealfet stock within clinical area. Objective to be discussed at directorate meeting on 8th August 2023 By whom? Service Manager / Senior Nurse to cascade information to team. Information gathered from the clinical teams regarding what literature is available within the clinical departments. Objective to be discussed at directorate meeting to raise awareness of both clinicians and nursing staff supplying the patients with information during their clinical consultations.			
			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	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update (Date of review: 01/01/24) - What next? To continue to monitor the FUNB list across all sub specialties within ophthalmology By when on a weekly basis By whom service manager			
			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.	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update - this will need ongoing review by the service manager to ensure that the most clinically urgent patients are booked with priority. Ongoing review by the service manager, this practice is currently undertaken in Bridgend but will need to be put into practice in all parts of the HB to ensure a pan CTM approach.			
			Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A Significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update - this work will be ongoing to ensure lists re kept up to date and 'clean' at all times. Ongoing review by the service manager to validated and ensure correct ratio of new and follow patients in all clinic templates.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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.	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update (Date of review: 12/12/2023) - What next? Band 5 1.0 Vacancy not appointed in to - position being re-advertised on Trac. Position escalated to HON and CSGM to look for support in the short term. CSGM to determine if harm review team funding can be extended past March 2024 as the project is still ongoing. Macular cluster report due by 15/12/2023, good progressing being made towards this but absence of the Band 5 FLO support is stalling the work. By when? Closing date TBC for band 5 position. A/w feedback about alternate staffing to support in the short term. CSGM to feedback if funding can extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSGM September 2023 Update (Date of review: 03/08 /2023) - What next? Vacancies for harm review workforce are currently out to advert. An cluster RCA commissioning meeting is to be arranged within the next 2/52 regarding the macular service and the patients who have experienced moderate and above harm as a result of a follow up not being booked By when? to be reviewed in 2/52 with update. By whom? Senior Nurse. An SBAR for additional harm review workforce was submitted to Planned care recovery and funding was approved in July 2023 for 2 fixed term positions until the end of March 2024. These positions include 1 WTE Band 7 clinical investigator, 1 WTE band 5 governance support officer / family liaison officer. The workforce will be dedicated to support the legacy open NRI's from 2016-Feb 2022 from RTE, as well as the review all legacy and current open incidents under the Ophthalmology service. The workforce will be supporting any commissioned RCA's and will work closely with the clinical and administration teams in the review of action plans and learning from events. Date of review: 08/11/2023 What next? Band 7 1.0 Vacancy filled with 2 individuals job sharing and fixed term until the end of March 2024. Band 5 Investigation support officer currently in shortlisting phase - this role to act as the FLO for all, 2 candidates for interview, date TBC. CSGM to determine if funding can be extended further. By when? Interview for band 5 post to take place in the next 2/52. CSGM to feedback if funding can extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSGM.			
			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.	Mrs Claire Brown	01/04/2024		In progress	Further review is required / Action to be removed and replaced with a subsequent agreed action December 2023 Update (Date of review: 12/ 12 /23) - New clinical policy approved to allow for unregistered staff to instill eyedrops, freeing up registered staff for more skilled tasks/faster clinic flow - implementation imminent. Optometry Dept SBAR demonstrating value of workforce & need for expansion completed. Secured fixed term contract extension for 2 sessional optometrists supporting Medical Retina clinics for next Q (via VBHC), further extension required to maximise clinic planning. MDT workforce working group for GIRFT process due to start in Dec '23, tasked with evaluating non-medic workforce/skill mix and maximising use of MDT (to top of license). Optometrist role expansion into glaucoma laser delivery successful (training, signoff & SOP complete) - SLT WL reduced to 12/52. What next? By when? By whom?			
			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	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update (Date of review: 12/12/23) - Community optom completed funded academic course successfully, placement pending 2024 (delayed due to consultant workload). Community optom post-grad placements widely delayed due to HES workload/lack of funding - Joint collaboration with Cardiff University to co-host placements in 2024, reducing time intensive burden on hospital site. Funding request for admin placement co-ordinator role submitted to HEIW. AMD community scheme live (June 2023), running well with consultant feedback. What next? By when? By whom?			
			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.	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update - No update received.			
			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	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update - No update received.			
			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	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update - No update received.			
			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.	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Complete 01/12/2023 Dec 23 update Date of review: 12 / 12 /23 ECCG re-established as of 1/12/23, regular directorate meetings ongoing What next? By when? By whom?			
			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).	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update (Date of review: 12/12/23) - Optometry SBAR detailing need for hospital optometry workforce expansion in size and clinical role completed. Funding secured from HEIW for 3 hospital optometrists to complete Higher Certificate in Medical Retina qualification (commencing March '24). Optometry-led laser service in situ in RGH, successfully brought laser WL down. What next? By when? By whom?			
			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.	Mrs Claire Brown	01/04/2024		In progress	December 2023 Update (Date of Review: 12/12/23) - As above, await outcomes from GIRFT MDT workforce working group that will be reviewing the workforce. What next? By when? By whom?			
			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	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Dec 23 update - Date of review: 12 / 12 / 23 4 shared-care schemes established with frequent cross-sector contact/consultant input/feedback sessions etc. Consultant Connect implemented for Glaucoma scheme (Nov '23) to allow community optoms direct access to Glaucoma team for advice & guidance. ECCG re-established 1/12/23 with good cross-sector collaboration and attendance. HB Optometry Liason Group long established - continues bimonthly, with both primary & secondary care rep. What next? By when? By whom?			

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Health Inspectorate Wales/2020/136	10/12/2020	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	The health board must provide HIW with assurance that staffing levels are not currently impacting on the effectiveness of care being delivered to patients and that any changes resulting from the review into staffing establishments at the unit will help reduce the pressures faced on existing members of staff.	During the pandemic additional staff above the established levels for the unit have been agreed to support the pressures within the unit. However filling the shifts was problematic despite agency and bank requests being made to staff bank 6 weeks in advance. The fill rates; October 2020; 64% equivalent to 155 shifts filled and 86 shifts remain unfilled. November 2020; 62% equivalent to 131 shifts filled and 79 shifts remained unfilled. Every effort is made to fill the shifts by offering staff overtime at enhanced rates as agreed by the Health Board. The sickness levels for the unit are robustly monitored; December 2020 9.1% January 2021 10.2% February 2021 6.37% The team are hopeful with the reduced pressures from the pandemic that the sickness trajectory will continue to improve. CDU staffing establishments have been agreed for the 24 bed ward with the GP assessment area being managed separately. Posts have been filled with staff members commencing March 2021 the remaining vacancy rate will be 0.34WTE. In response to the pandemic and high acuity levels within the hospital the surge capacity within CDU has been utilised in line with the escalation policy, the use of these additional 4 beds is being monitored. Continuous quality monitoring continues through the use of a number of systems inclusive of ward based assurance audits, Datix incident reporting, Serious Incidents and patient feedback (complaints/complements). The data is triangulated and continues to indicate that there is no increase in harm or compromised care for patients.	Mrs Claire Brown	01/03/2021		Overdue				
			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.	Mrs Claire Brown	01/03/2021		Overdue				
			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.	Mrs Claire Brown	01/03/2021		Overdue				
Health Inspectorate Wales/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.	Mrs Claire Brown	01/12/2020		Overdue	IPC strategy to be presented at the July 2023 IPC Committee meeting for approval.			
			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.	Mrs Claire Brown	01/10/2020		Overdue	Escalation plan developed and out for consultation.			
Health Inspectorate Wales/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.	Mrs Claire Brown	10/07/2021		Fully complete (Awaiting approval)	Partially Complete. ▪ Training plan was instigated with trajectory for 85 % compliance by 10 July 2021. At time of reporting (10/7/21) compliance is April 21 July 21 ILS 6% ↑64% BLS 0% ↑38% PMVA – Mod D 20% ↑73% PMVA Mod A/B – 41% ↑87% PMVA Mod C 8% ↑67% Fire 50% ↑87% Covid risk assessment 46% ↑80% ▪ PMVA mod A/B&C is time intensive training (6 hours per person) and clinical pressures have delayed completion. Additional pay has been used to release capacity to ensure 85 % compliance by 10th August 2021. ▪ BLS attendance has been impacted by availability of training sessions with ward based model now established to address 10th September 2023 Confirmation received from Brahms Robinson that the whole of the 2021 Seren Ward Action Plan has been completed			
Health Inspectorate Wales/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.	Mrs Claire Brown	01/10/2022		Overdue				
				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.	Mrs Claire Brown	01/06/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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	Mrs Claire Brown	01/08/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	31/10/2022		Overdue				
			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.	Mrs Claire Brown	31/10/2022		Overdue				

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			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	31/10/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	01/10/2022		Overdue				
			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.	Mrs Claire Brown	01/03/2023		Overdue				
			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.	Mrs Claire Brown	01/12/2022		Overdue				
Health Inspectorate Wales/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.	Mrs Claire Brown	30/11/2021		Overdue	October 2023 Update (Date of Review: 20/10/2021) - Further to discussions with the Head of Mental Health Nursing it has been advised that that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however, continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times.			
			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.	Mrs Claire Brown	30/11/2021		Overdue	October 2023 Update (Date of Review: 14/10/2021) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&D department: 1) Review hierarchy lists; 2) Ensure Group alignment numbers are correct; 3) Look at appropriate required compliance and accurate records and L&D department will take forward to the subject experts on teams' behalf. Regular meetings with new L&D representatives to address and correct the issues associated with core mandatory training compliance.			
Health Inspectorate Wales/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	Mrs Claire Brown	28/04/2023		Fully complete (Awaiting approval)				
				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 (Abilify and Paliperidone). For all other depot medication staff who order these medication will audit at the same time.	Mrs Claire Brown	28/04/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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	Mrs Claire Brown	28/04/2023		Overdue	Medical staff booked in to attend 'Safeguarding People			
			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	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	28/04/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	21/02/2023		Fully complete (Awaiting approval)				
				The inspection findings will also form part of our local QSRE meetings standard agenda to maintain monitoring of the review	Mrs Claire Brown	28/04/2023		Fully complete (Awaiting approval)				
Health Inspectorate Wales/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.	Mrs Claire Brown	01/08/2022	01/09/2023	Overdue	Revised Completion Date 01/09/2023 September 2023 Update - new consultant appointments enable 2 sessions of elective work to be staffed by consultant obstetricians. Awaiting 1st consultant to agree job plan 18.09.23 to commence one session a week, moving to 2 session in January 2023.			
			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	Mrs Claire Brown	31/01/2024		Overdue	September 2023 Update - recent concern from PCH identifies that learning and improvement is still required in this area.			
			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.	Mrs Claire Brown	01/08/2022		Overdue	September 2023 Update - The stamps are available to all clinicians, the review of the annual record keeping audit will be completed and presented by CSfM team in November 2023 meeting.			
			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.	Mrs Claire Brown	01/08/2022		Overdue	September Update (Date of Review: 08/09/23) - email sent to Medical Director of care group for advice on how to progress this recommendation.			
			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	Mrs Claire Brown	31/01/2024		Fully complete (Awaiting approval)	Sept Update - 8.9.23 email sent to OH lead to advice on progress with this recommendation. Email response from Nicola Bevan - OH Lead giving assurance. The Occupational Health service has successfully recruited into the long-standing vacancies within the service and are due to be fully established by end of September 2023. The previous substantive OH Consultant retired in April 2023 and a new provider has been procured providing two clinics per week plus 5 day clinical support if required. A new OH Physiotherapy template has also been developed to ensure there is sufficient capacity within the service to deliver the full range of Occupational Health Physiotherapy activities. As a result, the waiting times within the department have significantly reduced. In October 2023 CTM Occupational Health Service will be transitioning to a new OH software system as part of an All Wales Occupational Health initiative. One aspect of the new system will introduce an online management referral system which will improve the quality of the referrals and the communication mechanisms between managers and Occupational Health, which will increase transparency and allow the manager to monitor the progress of the referral-Action reviewed by Head of Midwifery (SF) and update to a closed and complete action.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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.	Mrs Claire Brown	01/06/2022	01/10/2023	Overdue	Revised Completion Date 01/10/2023 September Update (Date of Review: 08/09/23) - email sent to care group's People's Services Lead to advice on progress with this recommendation.			
			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.	Mrs Claire Brown	01/06/2022	01/10/2023	Overdue	Revised Completion Date 01/10/2023 September 2023 Update - incident report monitored by executive team. Timely review and closure for moderate harm and above incidents but low and no harm process requires further reviewing and dedicated allocation of time.			
Health Inspectorate Wales/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)	Mrs Claire Brown	30/04/2024		In progress	Assessment for accreditation for UNICEF Baby Friendly to be completed by October 2023. Update 28.03.23 Assessment confirmed for December 2023. All staff will have attended 1 day update by September 2023, overseen by Infant feeding Coordinator (Maternity) - Sept 2023-Pre assessment audit completed and advised by UNICEF BFI to postpone for 3 months to drive further improvement in practice. New specialist midwife commences role 18.09.23 (vacant role for 3 months)			
			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.	Mrs Claire Brown	01/02/2023		Fully complete (Awaiting approval)	Revised Completion Date Autumn 2023 New record keeping audit due to be commenced Autumn 2023 - Sept Update - added to annual record keeping audit sept 23-24. Email advice from service pharmacist 7.8.23 to advise of correct prescribed method for obstetricians as requested			
			Review Birth Rate Plus and ensure that staffing requirements are appropriate for the unit.	Current establishment is compliant with 2019 Birth Rate Plus report.	Mrs Claire Brown	01/02/2023		Fully complete (Awaiting approval)	Draft report received April 2023 Sept Update-CTMUHB Birthrate plus report 2023 has been agreed by DOM and recommendations around actions will be presented to executive team in October 23			
Health Inspectorate Wales/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.	Mrs Claire Brown	01/02/2023		Overdue	July 2023 Update - Working across CTM to ensure standardised audits are implemented.			
				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.	Mrs Claire Brown	01/12/2023		Overdue				
Health Inspectorate Wales/2022/36	14/11/2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [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.	Mrs Claire Brown	28/04/2023		Fully complete (Awaiting approval)	See Appendix 9 for all estates issues and progress			
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Sept Update-Action complete July 2023 Update-Outcome Measures working group established. Additional outcome measures training day arranged for 01/08/2023 with PHW. Appropriate OMs identified.			
Health Inspectorate Wales/2023/130	07/03/2023	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.	Mrs Claire Brown	30/06/2023		Overdue	September 2023 Update - Lead Nurses to meet on 18/09/2023 to review workstreams and action progress. Further updates will be provided following this meeting for all actions relating to the Discharge Review.			
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				Completion of mental health and physical health checks will be added to the Admission Pathway for all inpatient wards.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Dec 23 update - Completed during this period			
				Audit data will be reported/escalated through Care Group Governance Framework	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Dec 23 update - Completed during this period			
			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.	Mrs Claire Brown	31/07/2023		Overdue				
				All staff who are expected to complete clinical risk assessment will receive training in WARRN (nationally recognised) risk assessment and formulation.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023	31/01/2024	Overdue	Revised Due Date 31/01/2024 December 2023 Update - Compliance for WARRN Risk Assessment training is at 68% as at 24/11/23			
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	30/06/2023		Overdue				
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Dec 23 update Completed during this period			
				Compliance/non-compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Dec 23 update Completed during this period			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				Audit data will be reported/escalated through Care Group Governance Framework	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	30/06/2023		Overdue				
				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	Mrs Claire Brown	30/06/2023		Overdue				
				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.	Mrs Claire Brown	30/06/2023		Overdue				
				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.	Mrs Claire Brown	30/06/2023		Overdue				
				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.	Mrs Claire Brown	30/06/2023		Overdue				
				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	30/06/2023		Overdue				
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mrs Claire Brown	30/06/2023		Overdue				
				Audit data will be reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	30/06/2023		Overdue				
				Audit information will also be will be communicated to all staff through Ward training boards, daily safety briefing etc.	Mrs Claire Brown	30/06/2023		Overdue				
			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)	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	A review of ward round arrangements across the Health Board will be undertaken. This will include include: Consultation with patients and carers Consultation with the multi-disciplinary team Benchmarking with other mental health services	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				An audit tool for the monitoring of these standards will be developed and included as part of the Health Board Electronic System.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				Audit data will be reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
			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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Overdue	December 2023 Update - Reorganisation of the MHLD Care Group in progress.			

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				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework).	Mrs Claire Brown	31/08/2023		Overdue				
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mrs Claire Brown	31/08/2023	21/11/2023	Overdue	Revised completion date 21/11/2023			
				Audit data will be reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	31/08/2023	21/11/2023	Overdue	Revised completion date 21/11/2023			
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023	31/01/2024	Overdue	Revised completion date 31/01/2024 December 2023 Update - WARRN Risk Assessment Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24			
				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.	Mrs Claire Brown	31/07/2023	31/01/2024	Overdue	Revised completion date 31/01/2024 December 2023 Update - PMVA Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24			
				Care and Treatment Planning	Mrs Claire Brown	31/07/2023	31/01/2024	Overdue	Revised Completion Date 31/01/2024 December 2023 Update - Information Governance Training compliance as at 24/11/23 is 81% Revised completion date to 31/01/24.			
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				This will also enable reporting of training compliance through monthly Integrated Performance meeting chaired by the Care group Service Director.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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).	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				Additional bespoke training will be developed in response to the TNA the completion of the work of the Safe Discharge Workstream.	Mrs Claire Brown	31/08/2023		Overdue				
			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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Overdue	December 2023 Update - Reorganisation of the MHLD Care Group in progress.			
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				An audit tool for the monitoring of these standards will be developed and included as part of the Health Board electronic audit system.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Audit tool developed but not yet digitised. Manual audit to be undertaken until audit can be digitised. Completed during this period.			
				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Audit data will be reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
			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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Audit tool for the monitoring of these standards will be developed and included as part of the Health Board electronic audit system.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/1/12023 December 2023 Update - Completed during this period			
				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Audit data will be reported/escalated through Care Group Governance Framework	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				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.	Mrs Claire Brown	31/08/2023		Overdue				
			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 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 .	Mrs Claire Brown	31/08/2023		Overdue				

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				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	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
			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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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 .	Mrs Claire Brown	31/08/2023		Overdue				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				Compliance/non-compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Audit data will be reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
			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	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				The care group will audit all cases who are considered to have been subject to "expedited discharge" using standards agreed within the procedure.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				Compliance/noncompliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				Audit results will be shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Audit data will be reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				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).	Mrs Claire Brown	30/06/2023		Overdue				
			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	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				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%.	Mrs Claire Brown	31/07/2023	15/03/2024	Overdue	Revised Completion Date 15/03/2024 December 2023 Update - Revised completion date. Revised timescale refers to the ratification of the new S140 policy.			
			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	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	31/08/2023		Overdue				
			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."	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023			
				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	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023			
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023			
				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)	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023			
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023			
			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.	Mrs Claire Brown	30/06/2023		Overdue	December 2023 Update - Status relates to the Implementation of WCCIS Update to be provided to HIW 31/01/1024 The Health Board is working closely with Digital Health and Care Wales and other Health Boards in relation to implementation. However, in light of implementation challenges faced by another Health Board, discussions at a national level are ongoing in relation to the preferred digital solution to a unified patient clinical record system.			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
				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 will start in July/ August 23 chaired by MHLD Service Director and IT/ Digital Senior manager. WCCIS Implementation Plan timescales for MHLD to be refreshed and presented to WCCIS workshop on 15th June 23.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	WCCIS implementation aim end 2024			
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023			
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023			
			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"	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	31/08/2023		Overdue	Reorganisation of the MHLD Care Group in progress			
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Compliance/non-compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed during this period			
				Audit data will be reported/escalated through Care Group Governance Framework	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date December 2023 Update - Completed during this period			
			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.	Mrs Claire Brown	31/08/2023		Overdue				
				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.	Mrs Claire Brown	31/08/2023		Overdue				
				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	Mrs Claire Brown	31/08/2023		Overdue				
				The procedures will be shared with all staff through Communication and Learning Framework (Recommendation 40)	Mrs Claire Brown	31/08/2023		Overdue				
				Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mrs Claire Brown	31/08/2023		Overdue				
				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).	Mrs Claire Brown	31/08/2023		Overdue				
			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	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	30/06/2023		Overdue				
				This standard is explicit within the Health Board Discharge Procedure (MH40) standards.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				The High Quality Clinical Records Workstream will provide solutions for the monitoring of discharge follow up by community teams using different record systems.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	30/06/2023		Overdue				
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023			
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023			
				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	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023			
				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.	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023			
				Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023			
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023			
			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.	Mrs Claire Brown	30/09/2023		Overdue	December 2023 Update - Capital works in PCH are ongoing. The Care Group is working closely with colleagues at Prince Charles Hospital as part of the estates planning processes and to implement a substantive arrangement for crisis assessment. Capital works in PCH are due to be completed end of January 2024 which will give the care group opportunity to access to dedicated space in PCH ED. May 2023 Update - Please note this timescale is for the medium term solution. An update on substantive arrangements will be provided 30 Sept 2023.			
				Crisis and Liaison Staff risk assess the patient and depending on need will remain with them in the room at all times.	Mrs Claire Brown	30/09/2023		Overdue				
				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.	Mrs Claire Brown	30/09/2023		Fully complete (Awaiting approval)				
				Hand held panic alarms have been ordered and will be delivered to Crisis Team w/c 12th June 23	Mrs Claire Brown	30/09/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	30/09/2023		Overdue	Status relates to the substantive arrangements for unscheduled/crisis assessment in PCH			
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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 .	Mrs Claire Brown	31/07/2023		Overdue	December 2023 Update - Reorganisation of the MHLD Care Group in progress.			
			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.	Mrs Claire Brown	31/07/2023		Overdue				
				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	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				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; Unplanned care & Diverse workforce Workstreams.	Mrs Claire Brown	31/07/2023		Overdue				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
				Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	30/09/2023		Overdue				
				"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 reduced numbers for group sessions."	Mrs Claire Brown	30/09/2023		Fully complete (Awaiting approval)	Revised Completion Date 21/11/2023 December 2023 Update - Completed this period			
			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.	Mrs Claire Brown	31/03/2024		In progress				
				At Therapies Governance meeting on 18/05/2023 the Health Board reviewed HIW recommendation 31, and is in agreement that a multi-professional review of demand and capacity of the MH therapy workforce is required and will be undertaken. This review will entail a (not exclusive) range of Allied health Professionals including Psychology, Art Therapy, Physiotherapy, Dietetics and SALT. This review of the therapies workforce is underway and is considering: •Strategic workforce drivers •National guidance •Quality standards •Demand and capacity The Occupational Therapy review and subsequent job planning exercise has been completed and the Deputy Head of OT reports that the Occupational Therapy workforce is at full capacity and as such is able to meet demands for assessment, treatment and review that are presented on the Adult inpatient units.	Mrs Claire Brown	31/03/2024		In progress				
				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.	Mrs Claire Brown	31/03/2024		In progress				
				This review has many interdependencies with the Improvement programme work streams and as such will have a completion timescale of 31 March 2024	Mrs Claire Brown	31/03/2024		In progress				
				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	Mrs Claire Brown	31/03/2024		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period - 8c Clinical Psychologist Adult Inpatientl Lead commenced in post from October 2023			
				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	Mrs Claire Brown	31/03/2024		In progress				

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				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	Mrs Claire Brown	31/03/2024		In progress				
				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.	Mrs Claire Brown	31/03/2024		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	31/03/2024		In progress				
			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.	Mrs Claire Brown	31/08/2023		Overdue				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	Revised Completion Date 31/10/2024 December 2023 Update - Completed during this period			
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
				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.	Mrs Claire Brown	31/05/2024		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	31/08/2023		Overdue				
				"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"	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
				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.	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	30/06/2023		Overdue				
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period. Manual audits are being undertaken until audits can be digitised.			
			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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)	Revised Completed Date 21/11/2023 December 2023 Update - Completed during this period			
				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.	Mrs Claire Brown	31/07/2023		Fully complete (Awaiting approval)				
			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.	Mrs Claire Brown	01/06/2024		In progress	December 2023 Update - The HB has revised its process for the ratification of policies which will lead to more timely ratification and will enable all policies and procedures to be ratified by 01/06/24. There are 39 expired MH policies/ procedures. These have been prioritised for updates. The Mental Health Policy Review Group will monitor this review schedule at each meeting. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy.			
				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.	Mrs Claire Brown	01/06/2024		In progress				
			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	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
				The organisational risk register includes risk with a score of over 15. The organisational risk register has been reviewed across the Health Board. Aggregate workforce shortage and training risks are included for CTM. Specific Mental Health risks including clinical records and environmental risks are recorded on the organisational risk register. Risk registers with scores over 12 are monitored at Care Group level via Quality Safety Risk and Experience Group – (see Appendix 1 for governance arrangements), and all other risks are monitored via the Clinical Service Group performance arrangements. The Head of Quality and Safety will lead an operational care group governance meeting to monitor compliance with Putting Things Right, action plans and risk review timescales. Agenda item in performance meeting at senior nurse level in order to encourage escalation and culture of owning risks and mitigation as local level.	Mrs Claire Brown	30/11/2024		Fully complete (Awaiting approval)				
				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	Mrs Claire Brown	31/08/2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period			
			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.	Mrs Claire Brown	30/06/2023	31/10/2024	Overdue	Revised Completion Date 31/10/2024 The Mental Health Care Group is exploring a way for social workers to be able to report incidents directly through Datix with the Health Board Governance Team and ICT team. This has been delayed by issues with allowing non HB personnel access to HB and NHS systems and organisational changes to the CTM governance and Datix teams. In the meantime, a process for reporting and feeding back on social worker identified incidents in multi-agency meetings and so that learning can be shared will be implemented.			
			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."	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				
			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 agendad 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."	Mrs Claire Brown	30/06/2023		Fully complete (Awaiting approval)				

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Health Inspectorate Wales/2023/134	31/07/2023	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)]	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.	Mrs Claire Brown	01/11/2023		Overdue				
			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.	Mrs Claire Brown	01/11/2023		Overdue	65% compliance aim November 2023 with 100% compliance February 2024			
Health Inspectorate Wales/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	Mrs Claire Brown	31/05/2023		Overdue	September 2023 Update - No update received			
			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.	Mrs Claire Brown	31/08/2023		Overdue	September 2023 Update - No update received			
			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.	Mrs Claire Brown	31/08/2023		Overdue	September 2023 Update - No update received			
			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.	Mrs Claire Brown	30/09/2023		Overdue	September 2023 Update - No update received			
			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.	Mrs Claire Brown	31/10/2023		Overdue	September 2023 Update - No update received			
			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.	Mrs Claire Brown	30/11/2023		Overdue	September 2023 Update - No update received			
			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.	Mrs Claire Brown	31/08/2023		Overdue	September 2023 Update - No update received			
Health Inspectorate Wales/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	Mrs Claire Brown	30/11/2023	03/03/2024	Overdue	Revised Completion Date 03/03/2024 December 2023 Update -By end Nov 2023.QR code still piloted in maternity. 6/12/23 Daily checks undertaken 100% November 23. Revised implementation date due to the ongoing pilot in of the QR code across a number of audits in PCH - A status review against the required action will be completed by the end of March 2024.			
				All patient safety audits to be captured via AMaT system monthly and compliance monitored at the CYP monthly safety and effectiveness service level meetings.	Mrs Claire Brown	31/10/2023	Jun-24	Overdue	Revised Completion Date June 2024 December 2023 Update (Date of Review: 12/12/23) - As maternity colleagues continue with their pilot - Children's ward have established their own QR code .The CPD lead is responsible for ensuring staff are aware of how to record. This will be piloted in Paediatrics for 6 months commencing 1/1/24. Patient safety checks undertaken on AMaT audit monthly. Reported to patient safety and effectiveness group Implementation date revised until June 24.			
Health Inspectorate Wales/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 will continue to work in partnership with Cardiff and Vale UHB to develop the Regional Network for stroke services and in doing so 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. Work is already underway in our GP Practices to target patients at increased risk of stroke and we will continue to build on this. Learning will be fed back through the CTM UHB Stroke Strategy Group for implementation across the Health Board area.	Mrs Claire Brown	01/04/2024		In progress	Ongoing across 2023/24			
			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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing across 2023/24			
			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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing across 2023/24			
			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.	Mrs Claire Brown	01/04/2024		Fully complete (Awaiting approval)	Achieved and ongoing			
			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 already underway to ensure the robust management of patient flow. Each site has an established daily Safe2Start meeting which gives assurance around site based escalation, staffing, patient safety and clinical priorities. This meeting allows the identification of clinical priorities, including stroke patients and time frames for movement to inpatient beds. Any 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 is 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. This will be introduced in October 2023 as a test of change before launching in November as a new template. We have introduced Electronic Whiteboards on every ward that tracks each of stage discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. We will continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Mrs Claire Brown	01/11/2023		Overdue	Ongoing			
			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. Additional investment would be required and service and resource prioritisation discussions are ongoing within CTM UHB. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards	Mrs Claire Brown	01/04/2024		In progress				

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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 and timely blood requests to the phlebotomy team would be required. We will look to develop this going forward, in conjunction with improved EDD and use of whiteboard communication.	Mrs Claire Brown	01/04/2024		In progress				
			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 is being explored by the USC Group as an option which may have a positive impact on patient flow. We are currently benchmarking different models nationally to understand resources required and outcome measures which if positive and achievable we would be seeking to replicate.	Mrs Claire Brown	01/02/2024		Overdue				
			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 appreciates and has significant experience of using predictive methods to enhance patient and system outcomes. Development of models and tools is on the work plan for this year.	Mrs Claire Brown	01/04/2024		In progress	Timescale In 2023/24-exact timescale dependent on resource availability			
			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.	Mrs Claire Brown	01/04/2024		In progress	November launch. Full implementation 24-25.			
			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	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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.	A review of current training will take place in relation to Act FAST training. 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.	Mrs Claire Brown	01/10/2024		In progress	Review March 2024. Implementation October 2024.			
			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 is underway 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.	Mrs Claire Brown	01/10/2024		In progress				
			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.	Stroke and flow performance indicators 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	Mrs Claire Brown	01/10/2024		In progress				
			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. 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.	Mrs Claire Brown	01/10/2024		In progress				
			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 is underway 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	Mrs Claire Brown	01/01/2025		In progress				
			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. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Mrs Claire Brown	01/01/2025		In progress				
			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.	Mrs Claire Brown	01/01/2025		In progress				
			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.	Mrs Claire Brown	01/10/2024		In progress				
			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, there is a plan to streamline processes and ensure the domains of quality are 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 on other sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation where possible. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Mrs Claire Brown	01/10/2024		In progress				
			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.	Work is already underway to implement the use of Brainomix within CTM UHB.	Mrs Claire Brown	01/01/2024		Overdue				
			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 CTM UHB Stroke Operational Group will analyse the stroke pathway through from receivership at hospital front door to discharge. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Mrs Claire Brown	01/01/2024		Overdue				
			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.	The National Clinical Guideline will be 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.	Mrs Claire Brown	01/01/2024		Overdue				
			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	Mrs Claire Brown	01/10/2024		In progress				
			Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	With CTM UHB, all patients presenting in the thrombolysis window (Code 1 stroke) are 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 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.	Mrs Claire Brown	01/10/2024		In progress				
			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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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 prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around ring fenced 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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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 within 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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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.	Current ESD service is well established working out of Prince Charles Hospital. Expansion of ESD whole CTM UHB is currently underway following HB investment. Additional ESD workforce are being recruited to and referral criteria/pathway being established so that the service will become CTM-wide.	Mrs Claire Brown	01/12/2023		Overdue				
			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. A review of therapy workforce provision will be completed to explore the best models for therapy provision.	Mrs Claire Brown	01/01/2024		Overdue				
			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	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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 will include detailed consideration of the environment.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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 will be 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 newly established integrated discharge delivery board, linking directly to oversight and improvement actions associated with pathway of care delays. The Red2Green and SAFER principles will be embedded into all board rounds pan CTM to support timely patient review, planning and discharge when clinically optimised.	Mrs Claire Brown	01/11/2024		In progress				
			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 above, work is underway as part of the 6 Goals national programme for improvement, to ensure the early identification of internal and external delays. Reflecting these on the electronic white board will allow us to perform thematic analysis in order to positively impact frequent delay issues. The Red2Green and SAFER principles will be embedded into all board rounds pan CTM to support timely patient review, planning and discharge when clinically optimised.	Mrs Claire Brown	01/11/2024		In progress				
			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 Discharged to Recover then Assess pathways (D2RA), which is overseen by the integrated discharge delivery board. A new referral and trusted assessment 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.	Mrs Claire Brown	01/03/2024		In progress				
			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 implementation of D2RA, a new supported discharge notification (SDN) has been created to identify patients who require support form a social worker. This is triaged in the discharge hub. Proportionate assessment in an acute setting is promoted through the use of trusted assessment. 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.	Mrs Claire Brown	01/12/2023		Overdue				
			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.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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 are monitoring the volume of Pathway 1 discharges as part of monthly D2RA compliance and have seen an increase in Home First (Pathway 1) from initial baseline data January 2023 51% ﹤ 66% July 2023.	Mrs Claire Brown	01/04/2024		In progress	Ongoing			
			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.	Mrs Claire Brown	01/04/2024		In progress				
			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 are reviewing inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicated discharges are identified through the cross site be meetings, in addition they form part of the out of hours and weekend planning cycle.	Mrs Claire Brown	01/01/2024		Overdue				
			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 are reviewing inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicated discharges are identified through the cross site be meetings and form part of the out of hours and weekend planning cycle.	Mrs Claire Brown	01/01/2024		Overdue				
			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.	Mrs Claire Brown	01/10/2024		In progress				
			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.	Mrs Claire Brown	01/04/2024		In progress	Action to be removed and replaced with a subsequent agreed action.			
			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	Mrs Claire Brown	01/04/2024		In progress	Action to be removed and replaced with a subsequent agreed action.			
			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	Mrs Claire Brown	01/04/2024		In progress	Action to be removed and replaced with a subsequent agreed action.			
			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	Mrs Claire Brown	01/04/2024		In progress	Action to be removed and replaced with a subsequent agreed action.			
			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	Mrs Claire Brown	01/04/2024		In progress	Action to be removed and replaced with a subsequent agreed action.			
			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	Mrs Claire Brown	01/04/2024		In progress	Action to be removed and replaced with a subsequent agreed action.			
Health Inspectorate Wales/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.	Mrs Claire Brown	31/12/2023		Overdue	**January 2024 Update** (Date of Review: 04/01/2024) - Progress continues on Sharepoint December 2023 Update (Date of Review: 06/12/23) - Reviews in progress April 2024. Review of all paediatric policies and procedures underway across CTMUHB. This is being cleansed on Sharepoint.			
Health Inspectorate Wales/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.	Mrs Claire Brown	01/04/2024		In progress	In Progress Estimated Completion Date April 2024 See Appendix 1			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 2			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/1[2]/2023 See Appendix 3			
			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%	Mrs Claire Brown	01/01/2024		Overdue	In Progress Estimated date for completion January 2024 See Appendix 4			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 5a, 5b + 5c			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 6a + 6b			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 Appendix 7, 7a, 7b, 7c,7d, 7e, 7f,7g, 7h, 7i + 14			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 8a + 8b			
			•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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 8			
				A full environmental audit within Angelton Clinic will be completed to address and identify any further additional maintenance issues.	Mrs Claire Brown	01/01/2024		Overdue	In Progress Estimated date for completion Jan 2024			
			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%	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 10			
			•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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 11a, 11b, 7e and 7f			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 12a + 12b			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 13			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7h + 14			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 15a +15b			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 16			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 18a,18b + 18c			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 22a + 22b			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 18			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 21			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 22			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7h + 23			
			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.	Mrs Claire Brown	31/01/2024		Overdue	In Progress Due for completion end of Jan 2024			
			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. The Cascade and Escalate Standard Operating Procedure document describes the process.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7f + 25			
Health Inspectorate Wales/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.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.	The Health Board undertakes a fair and equitable recruitment process, in order to ensure that all staff are employed based on the qualities, values, skills and the experience they demonstrate during recruitment. It is, of course, not lawful to discriminate or make such decisions based on gender. The Royal Glamorgan Hospital (RGH) Senior Nursing team work across adult and older persons wards and will support each ward to ensure that there is an optimal skill, and when possible, gender mix. All shift requirements are monitored at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate Prevention and Management of Violence and Aggression (PMVA) trained staff on shift. Daily Huddle Documentation; Evidence 1 There is opportunity to alter staff skill and when necessary, gender mix to address needs of an individual e.g. If patient is sexually disinhibited or targeting staff due to gender. In extremis the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and CAMHS Mental Health wards, and there have been examples of recent good practice.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.	It is a priority of the Health Board to support the communities we work with to make positive decisions about their health, and we maintain a commitment to support all patients and staff to give up smoking. Since the "Smoke-free Premises and Vehicles (Wales) Regulations 2020" came into force in the Mental Health Unit (MHU) in September 2022, smoking on there has been prohibited. Following implementation, the significant challenges this presented to individuals who found smoking cessation measures to be ineffective or unwelcome were noted, and after discussion with staff and patients the Mental Health Smoking Cessation group agreed that in the RGH MH unit we would create small designated outside smoking areas for restricted use. This seemed to be well received by the patient group, but following an anonymous concern being raised with the Health Inspectorate Wales in summer 2023, this arrangement was halted while the measures were reviewed. Following presentation of a mitigating paper to the Health Board Executive Leadership Group, a "Derogation in compliance" was agreed for a period of six months while the Mental Health Care Group develop options for a permanent solution across all Mental Health sites. It is recognised by the Health Board that this temporarily contravenes the Smoke-free Premises and Vehicles (Wales) Regulations 2020. Mental Health Directorate Smoking Mitigation Paper; Evidence 1.1 Practically, on the RGH MHU, this means that there is an availability of managed smoking sessions at designated times in a space within the footprint of the MHU on the patios/terraces directly off the ward corridor. This is an arrangement that is clearly documented within the care plan of all patients who identify this as being their wish following smoking cessation assessment. The conditions and restrictions of the designated smoking area are made clear to all patients and signposted across the wards. Ash trays are being purchased for designated smoking area, there is a bin currently in place as an alternative. Patio Photo; Evidence 2 Patio Photo; Evidence 3	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			The health board must ensure that Welsh speaking staff wear the appropriate lanyards and badges to help identify them as Welsh speakers.	The Health Board is committed to making the "Active Offer" around services in the Welsh language, as defined in the Welsh Language Measure 2011. A review is underway to identify all Welsh speakers across the MHU. Competence at all levels will be noted and improvement encouraged through Personal Development (PADR). As the routine use of lanyards by Nursing staff in clinical areas is prohibited due to Infection Prevention and Control measures, the Health Board supplies all staff who have a competence in Welsh language with insigniad uniforms that identify them to those who wish to communicate in Welsh . For ease of recognition, this identifying uniform will be displayed to patients and visitors on Information Boards in each of the clinical areas. Welsh Language Notice; Evidence 4 Welsh Language Notice; Evidence 5	Mrs Claire Brown	28/02/2024		In progress				
			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.	Mrs Claire Brown	30/06/2024		In progress				

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			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	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			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	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			The health board must ensure that out of date medication is disposed of appropriately.	Following the HIW Review in November 2023, all medication cabinets across the MHU were inspected and no further out of date medications were found. Review of all medication dates and returns to pharmacy is monitored through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 14 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			The health board must ensure that MAR charts are fully completed.	Inpatient Senior Nurse and Mental Health pharmacist will revisit the role of pharmacist technician to ensure that review of MARS charts will be included in their routine checks. An email has been sent by the Clinical Director to all medical team to reaffirm the documentation standards required on clerking and reviewing medication. A sample of MARS charts are reviewed through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 15 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			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.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			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.	Mrs Claire Brown	30/04/2024		In progress				
			The health board must ensure that there are more variety of choices for patients with specific dietary requirements.	All Health Boards in Wales follow a menu which is based on The All-Wales Catering & Nutrition Standards. The Health Board Catering Service works with clinical teams to adapt the patient menus to patient specific requirements. The present patient menu changed in September 2023 to a two-week rolling menu which replaced an `a la carte' style menu. The new menu was reviewed by the All-Wales dieticians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing teams seek feedback from patients via the Inpatient Community Group and "Have Your Say" suggestion boxes (which are regularly monitored). This feedback informs discussions with the wider service i.e. Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Team recognise the need to increase the frequency of the menu review and change and are currently working on the new version for 2024.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			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.	Mrs Claire Brown	01/06/2024		In progress				
			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.	Mrs Claire Brown	31/03/2024		In progress				

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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 posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate. While there is a high degree of scrutiny around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage recruitment into the hospital.	Recruitment of band 5 registered nurses remains a challenge and the HB is taking steps to ensure that all vacancies are being filled. The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are currently exploring the financial implications and opportunities of the recommendations. The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maximise SSP opportunities for recruitment.	Mrs Claire Brown	09/01/2024		Fully complete (Awaiting approval)	Completed			
			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.	Mrs Claire Brown	31/03/2024		In progress				
			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. Present guidance on the use of ECA will be revised and formalised by the Senior Nurse by 31 January 2024.	Mrs Claire Brown	31/01/2024		Overdue				
			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. The Inpatient Senior Nurse will lead on development of the Ward Transfer proforma in collaboration with a working group of qualified and Health Care Support Workers in in order to ensure that all key communications are considered, and the process addresses the concerns about miscommunication of decision.	Mrs Claire Brown	28/02/2024		In progress				
Health Inspectorate Wales/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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Finance secured and replacement blinds ordered.	Mrs Claire Brown	01/02/2024		Overdue	February 2024			
				AMAT environmental audit undertaken monthly.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Tirion to be added to the RGH site rolling maintenance programme for paintwork.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Environment included within rolling programme of Purposeful Visiting annually.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
			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.	Mrs Claire Brown	01/12/2023		Overdue	December 2023			
				Identify all welsh speaking members of Tirion staff to ensure appropriate uniform with iaith gwaith logo.	Mrs Claire Brown	01/02/2024		Overdue	December 2023 - February 2024			
				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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Implement use of an iPad to support translation and interpreting services for non-English speakers.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Specifically looking at setting up an event in partnership with the University of South Wales to engage with students from overseas.	Mrs Claire Brown	01/03/2024		In progress	March 2024			
				Programme of community-based engagement through Baby Shower events for all prospective service users to attend, which is supported by Tirion birth centre team.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
			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.	Mrs Claire Brown	01/02/2024		Overdue	February 2024			
				Baby Abduction drill planned: Table-top baby abduction drill & local baby abduction drill.	Mrs Claire Brown	01/12/2024		In progress	December 2023			
				Baby Abduction drill planned: Full baby abduction drill	Mrs Claire Brown	01/01/2024		Overdue	January 2024			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Where negativity regarding the model of care is identified, learning via patient story and feedback/reflection by staff is undertaken.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Family stories shared at departmental meetings/forums.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Tirion 'marketing' video developed and shares family's experiences of using Tirion.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
			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.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
				Guideline Service Group produces an annual plan of work to ensure timely review of guidelines.	Mrs Claire Brown	01/01/2024		Overdue	January 2023[4]			
				Staff updated via email and staff social media Comms to ensure awareness of extension of these guidelines.	Mrs Claire Brown	01/01/2024		Overdue	January 2023[4]			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
				There is a maternity/ gynaecology/ISH guideline group which monitors guidelines which are coming out of date.	Mrs Claire Brown	28/12/2023		Fully complete (Awaiting approval)	Complete			
Health Inspectorate Wales/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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 2			
			The health board must ensure that the language preference of each young person is identified and recorded in a place that is easily accessible for staff to be aware.	The part A referral form provides a prompt to document the young person's language preference. This is filed at the front of each patient record for ease of reference. See attached, language preference highlighted in yellow. Medical secretaries to monitor full completion of the referral document prior to saving on the patient file. The Part A contains all patient demographics and is filed at the front of the medical record by the ward clerk.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 3			
			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.	Mrs Claire Brown	01/05/2024		In progress	In Progress Estimated to be completed by May 2024			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A			
				Operational procedure in place to guide staff members on the reporting system for environmental maintenance.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A			
				Senior Nurse to escalate environmental maintenance concerns via Quality Safety Risk and Experience report	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A			
				Locality manager can escalate any issues via Health and Safety meeting	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
				Cleaning schedule of the staff toilets was increased to twice daily on 06/11/2023	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
				IPC added to the nurse meeting agenda.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 5 + 6			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 7			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 8 + 9			
			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.	Mrs Claire Brown	01/05/2024		In progress	In Progress Estimated to be completed by May 2024			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 10			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 11 + 12			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 13			
			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. The registered nurses are trained in paediatric immediate life support that covers management of adverse drug reactions.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 14			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 15			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1			
			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.	Mrs Claire Brown	01/05/2024		In progress	In Progress Estimated to be completed by May 2024			
			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	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
				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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
				Weekly acuity is assessed using Levels of Care. This supports the reporting of patient acuity within the unit.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
				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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
				Any concerns about staffing levels can be escalated through the senior nurse Quality Safety Risk and Experience report.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			
				The Head of Nursing holds weekly drop in sessions where staff can raise issues or concerns, including those related to staffing.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023			

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates	Risks	Barriers	Theming
			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.	Mrs Claire Brown	13/11/2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 16, 17 + 18			

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee
Internal Audit Progress Report

February 2024

NWSSP Audit and Assurance Services

Contents

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

1 Introduction

1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at 12 February 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 December meeting of the Committee two reports have been finalised, three reports are in draft, and we have ongoing fieldwork in relation to nine reviews. A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
Performance management of 4-hour target	4	2	-	6	Limited
IT Service Management	1	4	1	6	Reasonable

3 Delivering the Plan

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

Table 2 – Performance Indicators 2023/24

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	Green	77%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days per Internal Audit Charter]	Red	55%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

4 Feedback

4.1 Our final reports are issued with a post audit questionnaire, which is our way of getting feedback on the audit process so that we can look to make improvements. We have issued feedback requests for each finalised report.

5 Other activity

Meetings

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

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

Appendix A – 2023/24 Programme of work

Table 3: Core programme of work for Q1-Q4

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

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
2	Gastro-intestinal pathway	Limited	Q1	Draft	Y	-	Fieldwork complete. Report issued 05.02.24.
6	Management of controlled drugs	Reasonable	Q2	Draft	-	-	Draft report issued 13.02.24.
9	Adult mental health – CSG review	-	Q2	WIP	-	-	Fieldwork started 06.10.23. Delay auditor sickness.
-	Follow up – Patient pathway appointment management	-	-	WIP	-	-	Review was brought into 23/24 as implementation date of management actions were revised.
13	Decarbonisation	-	Q3	WIP	-	-	Fieldwork started 13.11.23.
1	Leadership and management development	-	~~Q1~~ Q4	WIP	-	-	Management request to move to Q4 as internal development ongoing. Fieldwork started 16.01.24.
24	Follow up – digital operating model	-	Q3	WIP	-	-	Fieldwork started 29.01.24.
17	Risk management	-	Q4	WIP	-	-	Fieldwork started 01.02.24.

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
23	Follow up – medical variable pay	-	~~Q2~~ Q4	Planned	-	-	Rescheduled as audit tracker identified implementation of actions moved to end of October 2023. Brief agreed 05.01.24
25	Follow up – reasonable offer	-	~~Q3~~ Q4	Planned	-	-	Rescheduled as audit tracker identified implementation of actions moved to end of October 2023. Brief issued 05.01.24
20	Technical resilience	-	Q4	Planned	-	-	Brief agreed. Work to start March.
14	Welsh Risk Pool	-	Q4	Planned	-	-	Brief agreed. Work to start March.
8	Finance - Budgetary controls	-	Q2	Planning	-	-	On going planning. Awaiting management information.
15	Embedding the quality framework	-	Q4	Planning	-	-	Awaiting meeting with management.
16	New care group model	-	Q4	Planning	-	-	-

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
12	Finance – Savings delivery	-	Q3	Defer	-	-	Audit Wales doing work in this area.
11	Job planning medical pay	-	Q3	Defer	-	-	Management request to defer to 24/25 due to operational pressures.

Table 4: Status of PCH plan work 2023/24

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

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

Table 5: Hosted bodies programme of work

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

Plan Ref.	Review	Rating	Review period	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
4	EASC – Acute Critical Care Transfer Service (ACCTS)	-	-	Planning	-	-	Planning meeting held with EASC on 18.01.24. Brief being drafted.

4-hour Emergency Department Performance Reporting

Final Internal Audit Report

February 2024

Cwm Taf Morgannwg University Health Board

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

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Contents

Review reference:	CTMUHB-2324-03
Report status:	Final
Fieldwork commencement:	22 June 2023
Fieldwork completion:	29 September 2023
Debrief meeting:	18 December 2023
Draft report issued:	30 October 2023
Management response received:	31 January 2023
Final report issued:	6 February 2024
Auditors:	Emma Samways, Deputy Head of Internal Audit Liz Vincent, Principal Auditor
Executive sign-off:	Gethin Hughes, Chief Operating Officer
Distribution:	Sarah James, Deputy Chief Operating Officer Sarah Follows, Service Director – Unscheduled Care Group
Committee:	Audit & Risk Committee

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

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

Executive Summary

Purpose

The overall objective of the audit was to provide assurance on the accuracy of the reporting of the Health Boards 4-hour ED performance target.

Overview

We have issued limited on this area. The significant matters which require management attention include:

- Lack of a Health Board standard operating procedure to set out application of WG guidance.
- Lack of standardised training.
- Inconsistent approaches, terminology and definitions in place across sites.
- Inconsistent and incomplete records with errors occurring upon transfer to WPAS.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Policies and Procedures	Limited
2	Systems in place and training	Limited
3	Waiting times appropriately captured	Limited
4	Data validation process	Limited
5	Monitoring and review of performance	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Lack of standardised operating procedures	1	Design	High
2	CAS card completion	2	Operation	High
3	Training	2	Operation	High
4	Accuracy and consistency of capturing information	3	Operation	High
5	Validating data and adjustments	4	Operation	Medium
6	Monitoring and reporting	5	Operation	Medium

1. Introduction and background

1.1 Our audit of reporting in relation to the 4-hour emergency department target 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 The NHS Wales Performance Framework & Guidance documents 2022/23 set out performance measures, mapped to the 'Healthier Wales' quadruple aims. All NHS Wales health boards are required to report their performance against the measures relevant to them. Quadruple aim 2 includes the measures for urgent and emergency care, one being the 'percentage of people who spend less than four hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge'. The Welsh Government (WG) have set a 95% target against this performance measure.

1.3 The national 4-hour performance measure is intended to indicate the percentage of patients that have been in A&E longer than the 4-hour target period where there was not a medical reason for keeping them there. The basic calculation used, is the number of minutes that elapsed between the administrative start time, when the patient arrives at the emergency department (ED), and administrative end time. However, the administrative end time is not necessarily the time the patient leaves the ED. For example, it could be when a clinical decision is made about a patient.

1.4 In 2011 WG established a series of clinical exceptions, also known as breach exemptions, which are instances where a patient may be in the ED more than 4 but they would not be counted in the data for patients exceeding a 4 hour stay (the 4-hour target). The five breach exemptions include the need for ongoing ED treatment, investigations and awaiting transport. In the instances where a breach exemption is identified, the treatment completed time, which is the point at which a clinical decision is made about the patient's ongoing treatment, becomes the administrative end time. If the time between the patient's arrival and the time the treatment is completed is greater than 4-hours, then the patient will still be classed as a breach regardless of there being a clinical exemption. However, if the clinical decision is made within the 4-hours, and there is a valid breach exemption, the patient is not deemed as exceeding the 4-hour target.

1.5 The Health Board's ED units at its three main sites use 'CAS' (casualty) cards to capture the patient's journey through the ED. These capture the treatment start time, the treatment completion time and discharge time, which is entered into the Welsh Patient Administration System (WPAS). The data is used to calculate if the patient's treatment has been within the 4-hour target or has breached the target, and a decision to be made on whether a breach exemption can be applied.

1.6 In addition, breach reason codes have been created by the Health Board to categorise breaches over 4 hours that are not exempt. This data allows monitoring and identification of where there are delays moving patients out of the ED.

1.7 Each month, 4-hour performance target data is submitted to WG and is reported within the Health Board via the performance dashboard that is presented to the Board. The September 2023 data shows that 62.3% of patients were within the four-hour target, which is a fall from the July performance of 64.5%.

1.8 We understand that work is taking place within the Health Board to improve performance. Our review focused on the systems and process in place for capturing, recording and validating the data used to calculate the performance target.

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

- Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed.
- Where data is inaccurate, areas of poor performance may not be properly identified, and corrective action taken.
- Exposure to reputational issues for the Health Board, should reported data found to be inaccurate or incomplete.

2. Detailed Audit Findings

Objective 1: There are up to date procedures in place setting out the process for calculating the four-hour performance.

2.1 In 2011 the WG set out their expectations for measuring and reporting Unscheduled Care for 4 & 8 hour ED waits. This includes the situations where a breach exemption code may be applied. We also note that WG letter included a flowchart setting out start and end times.

2.2 We have seen some limited local guidance at the hospital sites, but there is no standard operating procedure (SOP) setting out a consistent approach across the Health Board that interprets the WG guidance. For example, RGH has a list of exemption codes and breach reasons and were updating a draft SOP, PoW has a number of guidance documents but they do not cover all aspects of the process, and PCH had no guidance in place. **(Matter Arising 1)**

2.3 Our testing identified that the definition used to identify the treatment completion time differed, as did how breach exemptions were classified. Both of these could impact both the calculation of the 4-hour timeframe and the number of patients classed as being breach exemptions. **(Matter Arising 1)**

2.4 We also note that the approach to entering information on WPAS varied. At PCH and RGH information was entered onto WPAS by the Nurse in Charge during the shift, but at PoW the process was completed by administrators the following day. **(Matter Arising 1)**

2.5 Finally, the clinical breach reasons, used for internal monitoring, vary between PoW and the other sites. The breach reason codes were developed by the former sites, before the formation of CTM in 2019. As such, monitoring the reasons for exceeding the 4-hour target is not consistent across the Health Board. **(Matter Arising 1)**

Conclusion:

2.6 There are no Health Board wide procedures in place setting out the approach to capture and record data used to calculate the 4-hour ED performance target information. We saw different terminology, approaches and interpretations made by each site resulting in inconsistent calculations and reporting. We have provided limited assurance against this objective.

Objective 2: A suitable system is in place for capturing and recording data, and relevant staff have been trained in the use of the system and application of the procedures.

2.7 WPAS is used for capturing and recording patient information, including the information required for calculating the 4-hour performance metrics for the EDs. PCH and RGH sites use the Health Board's WPAS, whereas PoW use the Swansea Bay University Health Board system. We understand that PoW will transfer to the Health Board's system in 2025.

2.8 CAS card data is used to update WPAS. However, the cards differ across sites, and where to record key date and time data on the card is not always clear. We also note that the cards were not always completed consistently. This lack of clarity can mean that the person transferring the data to WPAS may need to interpret the information on the CAS card. As we note above, the person updating WPAS varies across the sites, with clinical staff performing the role at RGH and PCH and administrators performing this role at PoW. **(Matter Arising 2)**

2.9 At PCH and RGH WPAS is updated by the Nurse in Charge during a shift. Training on use of the system is provided by the WPAS team, and access to the system is not provided until training has been completed. Training records are maintained by the WPAS team.

2.10 Training guides are provided to new users by the WPAS team which includes a specific guide to the ED aspects of the system. This includes a list of breach exemptions and reasons, that are used at both PCH and RGH. However, as the reasons for breaches are based on a clinical decision, the WPAS team do not provide this element of training. Training on the use of breach codes is delivered by the senior nurses on-site. As there is no Health Board wide standard process, the on-site-training is based on the knowledge of the nurse who provided the training. **(Matter Arising 3)**

2.11 At PoW, WPAS, is updated the following day by administrative staff. Training on use of the system may have been provided by the Digital Services Team or by colleagues on-site. While user guides have recently been created and we understand that training has been provided, our fieldwork identified that refresher training may be needed to ensure that the principals behind the process are embedded. **(Matter Arising 3)**

Conclusion:

2.12 The WPAS system is used to record the required data. However, the CAS card system used to capture the information for inputting into WPAS is not consistently

completed. Training on use of WPAS has been provided to staff at RGH and PCH prior to accessing the system, but this is not always the case at PoW. The lack of a standardised procedure across all sites has meant that training in relation to the application of breach codes is provided on site by existing staff resulting in variation. We have provided limited assurance against this objective.

Objective 3: Waiting time are appropriately captured in line with WG guidance.

2.13 In order to correctly calculate the 4-hour performance metric and determine how many patient waits exceed 4 hours and / or had a breach exemption code applied, comprehensive information must be captured on the CAS card and be accurately transferred to WPAS.

2.14 For a date in May 2023, data shows that 594 patients presented at the Health Board's three ED units.

- 63% were either treated and discharged within 4 hours or did not wait to be seen.
- 7% breached the 4-hour target, however a breach exemption code was applicable and they were therefore reported as being within the target time.
- 30% breached the 4-hour performance target.

2.15 We tested a sample of 60 patient records for one day in May to establish if the CAS cards had been appropriately completed and the data accurately transferred to WPAS, so supporting the outcome reported for the patient. We identified that CAS cards were incomplete in relation to the treatment start time, treatment completion time and discharge time. At least one of those pieces of data was missing from 46% of the CAS cards that we sampled, and only 26% of the cards were fully completed with all three pieces of data. **(Matter Arising 4)**

2.16 Our testing regarding the treatment completion time identified that the information was not directly recorded on 65% of CAS cards that we reviewed. However, our discussions with staff at all three sites established that the treatment completed time can be derived from alternative information on the CAS card. But, in the absence of a SOP, all three sites use different criteria to determine the treatment completion time. PCH and RGH identify the treatment complete time as the time the clinical decision is made, although the interpretation of when a clinical decision is made varies between the two sites. At PoW, the treatment complete time and discharge time are always the same. PoW management consider that if a patient remains in the ED unit after 4-hours they will continue to receive ED treatment until they have been discharged. **(Matter Arising 4)**

2.17 Our testing also identified that in 23% of the cases where data had been recorded on the CAS card, the information had not been correctly transferred to WPAS. **(Matter Arising 4)**

2.18 We note that incomplete CAS cards meant that some patients recorded as breach exemptions were not classified as an exemption as there was not enough data on the card to determine that the treatment completion time was within 4hours.

Similarly, we saw that the inaccurate transfer of information to WPAS meant that some patients were reported as breaches when they should not have been.

Conclusion:

2.19 The accurate, comprehensive and consistent completion of CAS cards is essential to allow data to be transferred to WPAS for performance calculations to be determined. However, we saw numerous occasions where data was not being captured at all, captured in different ways across different sites and not accurately transferred to WPAS. All of these will have an impact on the Health Board being able to accurately calculate it's 4-hour performance data and support the decision for breach exemptions. We have provided limited assurance against this objective.

Objective 4: Data validation processes are routinely undertaken to ensure reported data is complete, valid, timely, accurate, relevant and reliable.

2.20 We note that PoW uses a different data validation approach to PCH and RGH. Validation should take place by 11am each day in order for the previous days data to be submitted to WG at midday.

2.21 At PCH and RGH, where possible, breach codes are applied 'live' by the Nurse in Charge of the shift as a patient approaches the 4-hour waiting time. When the patient is discharged, their WPAS record is updated with information from the CAS card. The following day the CAS cards of those patients that are reported as breaches and had a breach exemption code applied, are reviewed by the senior nurse. The information on WPAS is validated back to the CAS card and adjustments are made in WPAS if time data errors are identified. However, as we note above, the CAS cards do not always include sufficient information to support an amendment to WPAS, and in these cases the patient's ED visit is reported as a breach.

2.22 Our review of the process at PCH and RGH identified a number of issues, including the length of time spent validating information. We observed instances where informal feedback is given to the staff member that recorded information if it is entered incorrectly. However, these instances are not recorded to inform training needs. Our review of data for May 2023 established that both sites had an average of 171 patients per day. On average each day, 7 retrospective adjustments were made to WPAS records at RGH, and 14 at PCH. **(Matter Arising 5)**

2.23 PCH and RGH maintain spreadsheets that are updated daily to record the total number of adjustments made, and therefore the revised number of breaches. This information is captured as management are concerned that the daily figures being reported to WG are not incorporating retrospective adjustments. Our testing of the May 2023 data highlighted more breaches reported to WG for PCH and RGH than the adjusted figures recorded on each site's spreadsheet. We understand that management are undertaking work to determine the cause of this possible error. **(Matter Arising 5)**

2.24 At PoW the focus of the validation process is to apply a breach reason code or breach exemption code to all cases where the 4-hour target is exceeded. This

process is carried out by administration staff the following day. The CAS cards of all breach patients are reviewed in order to determine the breach code. Unlike PCH and RGH the validation process does not seek to verify the times input to WPAS. Again, the process at PoW is time consuming, especially as the CAS cards of all patient's exceeding 4-hours are reviewed.

2.25 Similar to PCH and RGH, PoW receives a spreadsheet from information services of cases that need validation. The PoW spreadsheet differs to the other sites as additional information is reported for validating due to different WPAS used. However, the PoW staff have fallen behind in reviewing and validating the entries on the spreadsheet. At the time of our fieldwork, while there were no validation delays at PCH and RGH, there were 1,860 outstanding entries that needed to be validated, of which 1,633 were over a month old at PoW. **(Matter Arising 5)**

Conclusion:

2.26 While there are data validation process, they vary between sites, and there are concerns that data being reported to WG may not be accurately capturing the adjustments made during the validation process. We have provided limited assurance against this objective.

Objective 5: Timely monitoring and review of performance takes place at appropriate forums within the Health Board, with escalation where necessary.

2.27 A monthly integrated performance dashboard is prepared by management that includes 4-hour performance data. The dashboard is reported to both the Board and Planning, Performance and Finance (PP&F) committee.

2.28 At a Care Group level, 4-hour targets are discussed at the monthly Unscheduled Care (USC) Clinical Service Group (CSG) performance review meetings. These meetings are chaired by the USC Service Director and attended by the ED CSG managers, deputies, and business partners.

2.29 Weekly USC performance meetings take place involving the Head of Performance and Information and the CSG managers and deputies from all three sites.

2.30 We understand that performance is also monitored at the Operational Management Board via the USC highlight reports, although we did not see minutes or papers for these meetings so we were unable to evaluate the level of scrutiny against the 4-hour performance.

2.31 At a CSG level we evidenced weekly ED senior team meetings taking place at RGH where the 4-hour ED performance metric was discussed. We were informed similar meetings used to take place at POW, but recent staffing changes has meant a pause, in the meantime daily 'catch ups' take place with the senior management team. PCH have recently introduced a weekly performance meeting where they will review ED performance data. **(Matter Arising 6)**

2.32 Monitoring of the 4-hour performance also forms part of the daily 'Safe 2 Start' meetings, that are held several times a day, across sites.

2.33 Whilst we were able to establish a reporting structure, from ED CSGs up to Board, the lack of availability of agendas and action logs for some meetings has made it difficult to evidence the scrutiny and escalation process in operation. However, we note that the CSG managers, who have site specific knowledge, are in attendance at the weekly USC performance meeting and at the monthly Care Group performance, providing continuity. **(Matter Arising 6)**

2.34 From the review of the agendas and action logs that we obtained we observed that at Board and PP&F meetings reporting is on a Health Board wide level. Similarly, the data presented at the USC performance meeting Health Board wide and not broken down by site. However, the action log from the meeting did suggest site specific discussions took place. It is only at the CSG weekly meetings that site specific performance information is presented. **(Matter Arising 6)**

2.35 We note from our review of the data presented, that it only contains information on the number and / or percentage of patients who were reported as being treated within the 4-hour target. There is no breakdown of the reported non-breaches that were as a result of having breach exemption codes applied. There is also no data reported in relation to the patients that 'did not wait', but were still classed as treated within the 4-hour period. Finally, we have not seen reporting in relation to breaches and the reasons for them, as captured with the local breach reason codes. We acknowledge that management will have access to this data as part of their interactive dashboard. **(Matter Arising 6)**

Conclusion:

2.36 Monitoring and review of 4-hour performance data is timely and a clear reporting structure is in place from CSGs up to Board, with varying degree of detail available at each level. However, in the absence of some agendas and action logs, we have not always been able to clearly evidence the degree of monitoring that is taking place or the escalation between the tiers. Reporting could be enhanced with additional information. We have provided reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Lack of standardised operating procedures (Design)	**Potential Impact**
There is no Health Board wide Standard Operating Procedure (SOP) in place to provide guidance to ensure a consistent approach to capture and record 4-hour ED data. As such, there is no document setting out for staff the reason why they are capturing this data, the importance of its accuracy and how that information is then used to monitor performance and inform decision making. We note: • For PoW whilst there are some guidance documents there is not one for completion of the CAS card the transfer of that data to WPAS. • RGH has a single page breach validation guidance document that lists the breach and exemption codes but gives no information on how to apply these codes and capturing of times. A draft SOP has been created, and that does provide additional information on completion of the CAS card and input to WPAS, but this has never been finalised or circulated to staff and was under review at the time of our fieldwork. • PCH informed us they have a one-page guidance document, but a copy could not be provided. We believe the same validation guidance document used RGH. There are differences across the sites that may be impacting on the ability to accurately report performance data in relation to the 4-hour target. We found: • The method used for identifying the treatment complete times is inconsistent across the three sites. PoW uses the time of discharge, and RGH and PCH use the time a clinical decision is made regarding the patients ongoing treatment. However, the interpretation of when a clinical decision is made is different between RGH and PCH. • PoW have applied stricter criteria in relation to the breach exemption codes. • The responsibility for interpreting and transferring the data on CAS cards to WPAS varies across sites. At PCH and RGH this process is carried out by the nurse in charge as soon as possible after discharge, whereas at PoW the administration staff carry out this process the following day.	Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed. Inability to effectively monitor performance across sites if different approaches to capturing information are in place.

• The breach reason codes that identify where delays occur in the EDs are different in POW to PCH and RGH. This impacts on the number of clinical exceptions that POW report, who recorded less clinical exceptions than their counterparts due to the way in which they capture the data. It also impacts the Health Boards ability to fully compare data across sites in relation to ED delays.		

Recommendations		Priority
1.1a	A standardised approach to the application of the 4-hour performance clinical exception guidance should be established by the Health Board.	**High**
1.1b	A 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.	
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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Develop standardised approach to application of 4 hour clinical exception to include a pan CTM SOP for application of WG guidance.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
1.2	Develop a standardised set of codes to be used across all sites.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine

Matter Arising 2: CAS Cards completion (Operation)	**Potential Impact**
The CAS cards require the key times from the patient's journey to be recorded. For example, the treatment start time, treatment complete time and discharge time, should all be recorded for transferring into WPAS. Our review of the CAS cards at each of three sites identified that they are designed slightly differently, and in some cases the need to capture key time data was not explicit. Our testing of a sample of 60 cards, across the three sites, identified that cards are not completed in a consistent way and often do not include all of the time data. (See Matter Arising 4). For example, the PoW card includes a table summarising the key time information. However, 0/20 of the PoW CAS cards in our sample had this table completed. In cases where key time data is missing, the person inputting the data into WPAS will have to attempt to determine key times based on the patient notes and other information written on the card.	Inaccurate and incomplete capture of information resulting in inaccurate reporting within the Health Board and to Welsh Government.

	Recommendations	**Priority**
2.1	Staff 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.	**High**
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.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
2.1	Communicate through safety briefings the importance of fully completing CAS Cards and review implementation of summary table across all sites.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
2.2	Develop standardised CAS card for all sites in conjunction with Clinical Director and Lead Nurse.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine

Matter Arising 3: Training (Operation)	**Potential Impact**
The WPAS system is used to capture the 4-hour performance for the EDs. PCH and RGH are part of the Health Board's WPAS, whereas PoW is uses the Swansea Bay University Health Board WPAS. We visited the three sites to establish if staff had been trained in the use of the system including the recording of the data required to calculate the 4-hour performance metric. The key points we identified were: • At PCH and RGH, training is provided by the WPAS team on use of the system. New users are not given access to the system until training has been completed. However, at PoW staff are either trained by the Digital Services team or in-house training will be provided. The WPAS team do not train staff on the application of rules in relation to breach exemptions or breach reasons. The lack of a SOP means there are variations in approach across sites, therefore training has to at a local level. • At PCH and RGH, nursing staff are trained on the application breach exemptions and reasons by the senior nurses within the department. As there is no Health Board wide standard process, the on-site-training is based on the knowledge of the nurse who provided the training. • At POW admin staff are responsible for the input of data to WPAS. Staff will follow user guides to establish where and when to apply the breach codes and existing admin staff will provide future staff with training.	• Inaccurate reporting within the Health Board and to Welsh Government if correct processes are not followed.

	Recommendations	**Priority**
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.	**High**

	Agreed Management Action	Target Date	Responsible Officer
3.1	Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine

Matter Arising 4: Accuracy and consistency in capturing information (Operation)	**Potential Impact**
We tested a sample of 20 patients from each of the three sites who attended the ED units on a day in May 2023. Our sample included patients that met the 4-hour target and a number that exceeded the 4-hour target and had a breach exemption code applied, or were classed as breaches. We reviewed the information captured on the CAS card to ensure completion, and compared this to the information recorded in WPAS to ensure accurate transfer. We also considered the impact on being able to correctly report 4-hour information. Data Capture We looked for the treatment start time, treatment completion time and discharge time on a sample of 60 CAS cards. We note that treatment start time was missing from 16% of cards, treatment completion time was missing from 65% of cards and discharge time was missing from 57% of cards. Only 26% of the cards contained data for the three key times. (See table 1, page 24 for breakdown of missing data across the three sites.) As noted, the treatment completed time was missing from 65% of the sample. This information must be captured for a breach exemption to be applied as it demonstrates that the treatment completed time was within 4-hours. However, all three sites apply different criteria for what the completion time should be. • RGH use clinical decision time, but only if the CAS card clearly shows that a treatment plan was in place for the patient. Alternatively, a time the same as, or shortly after the treatment start time can be used, as it is assumed that if treatment has started, a plan will have been established. • PCH apply the same principles as RGH, however they may also use the time the patient is referred to a speciality as the treatment completed time. • PoW guidance says the treatment completed time and discharge time should always be the same. If a patient is still in the ED department, then they will continue to receive treatment by the A&E staff until they have been discharged. Data Accuracy For the 54% of CAS cards where treatment data was captured, we compared the data to the information held on WPAS. We identified 22 variations, which is an error rate of 23%. The majority (86%) of the variations related to the treatment start time.	• Where data is inaccurate, areas of poor performance may not be properly identified, and corrective action taken. • Exposure to reputational issues for the Health Board, should reported data found to be inaccurate or incomplete.

Correct reporting of a breach • PoW identify a patient as a breach exemption if the patient has been seen by an ED doctor within 2.5 hours and, if needed, referred to a speciality within 3 hours. This is stricter criteria than used elsewhere. As such, 7/10 patients we sampled that were classed as a breach, may have been reported as an exemption if the criteria used at RGH and PCH were applied. • 9/21 sample patients where a breach exemption code was recorded were reported as a breach. In three of these cases the incorrect treatment time had been input on WPAS, so these should not have been a breach. In the remaining six cases, we were unable to identify how the treatment completed time recoded in WPAS had been derived. If this information had been clear on the CAS card then there may have been the opportunity to apply a breach exemption code. More broadly, 177/594 (30%) of patients across the three sites on our sample date were reported as breaching the 4-hour target. 41/177 had a breach exemption code applied yet were still reported as a breach. We understand that this may be due to a lack of data on the CAS card to support the application of a breach exception code or incorrect input of a breach exemption code.	

Recommendations		Priority
4.1	The 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.	**High**
4.2	The 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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
4.2	• 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.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine

Matter Arising 5: Validating data and adjustments (Operation)	**Potential Impact**
We observed the process for data validation at each site and note: • At PCH and RGH the purpose of retrospective validation is to ensure accuracy of the data input on the previous day, specifically patients recorded as having breach exemption codes applied yet reporting as a breach. The Senior Nurse traces these to the CAS card, to ensure the treatment complete time has been correctly captured or ensures that the breach exemption is valid. Adjustments are made to WPAS to rectify errors. For the May 2023 data that we analysed, at RGH an average of 7 adjustments were made per day, whereas at PCH the average is 15 per day. Both sites had an average of 171 people presenting each day. • A note is made of staff member who incorrectly input the data and informal feedback is provided. No record is retained of this. • Records of which entries are amended within WPAS and the justification for the change are not held. We acknowledge the audit trail within WPAS will capture some information. Management are concerned that the adjusted figures for breach exemptions are not the daily figures reported to WG. Management maintains a spreadsheet of the total number of adjustments made and the revised breach exemption figure for the day. Our analysis of May 2023 data as shown in table 2, page 24 identified that the data submitted to WG showed more breaches than had been recorded in the post-validation figures. We are aware that some work has started to determine the cause of the reporting differences. At POW, a different validation process is followed. Breach reasons and exemptions are applied by administrative staff the following day, when the CAS cards of patients that had exceeded the 4-hour target are reviewed. As a result, more CAS cards are reviewed than at the other two sites, who only review cards of patients breaching and where an exemption code has been applied. The approach taken at PoW is to validate the reason for a breach, as opposed to validating the accuracy of the data entered. PoW receive a daily report from the information team, of cases awaiting validation. However, at the time of our audit there were 1,860 outstanding entries to be validated, with 1,633 over a month old.	• Inaccurate reporting of performance or inappropriate decisions made based on poor data. • Resource unnecessary to rectify errors.

Recommendations		Priority
5.1	A 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.	**Medium**
5.2	Further 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.	**High**
5.3	A 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.	**Medium**
5.4	A 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.	**Low**

Agreed Management Action		Target Date	Responsible Officer
5.1	Implement a standardised approach to capturing any changes to records, monitor through Directorate Performance reviews.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
5.2	Undertake regular "snapshot" audits to ensure validation is correctly captured and monitor through Directorate Performance reviews.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
5.3	Review validation approaches across all ED's and implement a standardised approach to reporting.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine

5.4	Undertake review of outstanding cases at POW and determine if validation is required.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine

Matter Arising 6: Monitoring and reporting (Operation)	**Potential Impact**
A clear structure is in place for monitoring of the 4-hour performance target, from individual CSGs up to Board. While at PoW weekly CSG performance meetings were not taking place at the time of our review due to staffing changes, daily 'catch ups' were happening. We requested copies of the agendas and action logs of the committees and groups where monitoring takes place. However, in most instances we were only provided with one set of papers, therefore making it difficult to evidence the level of monitoring and escalation between groups. From the information that was available we note: • Monitoring of site-specific data only appears to take place within CSG weekly performance meetings. The slide deck taken to the USC Care Group meeting reported Health Board wide data, as such there was no ability to identify sites that may be more of a concern than others. • The data reported at the various groups and committees focusses on the percentage of patients that were seen within the 4-hour target. We saw no breakdown of the proportion of reported non-breaches that were as a result of a breach exemption code being applied. Through our testing we also saw cases of a number of patients that did not wait to be treated, but this data does not appear to be reported. Finally we saw no reporting against the local breach reason codes that the Health Board has in place. However, we acknowledge that this information is available to managers via their performance dashboards and therefore can be used to inform decision making.	• Poor decision making based on inaccurate or incomplete data. • Management action not taken to rectify issues if reporting is inadequate.

Recommendations		**Priority**
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.	**Medium**
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.	**Medium**

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.	**Medium**
6.4	Consideration 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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
6.1	Re-instate weekly SM meetings at POW.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
6.2	Ensure agenda and action logs are retained.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
6.3	Site specific slide deck in place, ensure used to underpin discussions.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine
6.4	Develop a more detailed report to include analysis of breach codes.	June 2024	Lee Collins- Directorate Manager, Emergency and Acute Medicine

Information relating to matters arising

Matter Arising 4: Table 1 – Missing data from CAS cards split by site:

A random sample of 60 CAS cards reviewed, 20 from each site. 25% of the sample related to patients that were not reported as exceeding the 4-hour target. The remaining 75% exceeded the target and were either reported as a clinical exemption or as a breach.

Data missing from sample of 60 completed CAS cards	**Data missing by site**			**TOTAL**
	PoW	**RGH**	**PCH**	
Treatment start time	3	3	4	10/60
Treatment complete time	17	6	16	39/60
Discharge time	18	1	15	34/60

Matter Arising 5: Table 2 -Analysis of variation between breach numbers reported to WG and breach numbers recorded on departmental spreadsheets pre and post validation.

	Total no. of attendees May 2023	**No. and % of breaches from WG data submission**	**No. and % of breaches from site records pre-validation**	**No. and % of breaches from site records post-validation**
RGH	5,319	1,550 / 29%	1,560 / 29%	1,347 / 25%
PCH	5,299	2,012 / 40%	2,150 / 41%	1,710 / 32%

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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IT Service Management
Final Internal Audit Report

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Cwm Taf Morgannwg University Health Board

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Auditors:	Martyn Lewis (Senior IM&T Audit Manager) Sian Harries (IM&T Audit Manager)
Executive sign-off:	Stuart Morris (Director of Digital)
Distribution:	Steve Macdonald (Assistant Director for Digital Delivery); Brett Thomas (Head of End User Computing); Paul Chilcott (Lead Infrastructure Architect / Interim Head of Cyber)
Committee:	Audit & Risk Committee

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

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

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place for IT Service Management.

Overview

We have issued reasonable assurance on this area. We note the positive progress made in redesigning the service catalogue, developing the service desk function, and improving knowledge management. Whilst some processes are in place for relationship and supplier management, they are unstructured and inconsistent. The matters requiring management attention include:

- incomplete Service Catalogue;
- delay in progress of developing ITIL-aligned processes;
- inconsistent arrangements for relationship management;
- lack of defined process for contract and supplier management;
- pre-defined call types not always utilised, resulting in some requests recorded as incidents, and duplicate classifications;
- lack of defined process for Problem Management.

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

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.	 2021/22

Assurance summary[1]

Objectives		Assurance
1	IT services are appropriately designed, agreed, provided, and managed.	Reasonable
2	Relationships with services are maintained to review and evaluate to improve service quality.	Reasonable
3	Appropriate supplier management is in place.	Limited
4	Appropriate processes are in place for incident, event, and problem management.	Reasonable
5	Processes are in place to gather, analyse, store, and share knowledge and information.	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	Service Catalogue	1	Operation	Medium
2	IT Service Management Processes	1	Operation	Medium
3	Relationship Management	2	Design	Medium
4	Contract / Supplier Management	3	Operation	High
5	Pre-defined calls and classifications	4	Design	Low

6	Problem Management	4	Design	Medium

1. Introduction

1.1 In line with the 2023/24 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or 'organisation') we reviewed IT service management.

1.2 Best practice for IT service management is set out within ITIL, formally an acronym for Information Technology Infrastructure Library. This is a set of detailed practices for IT service management that focuses on aligning IT services with the needs of a business. ITIL describes processes, procedures, and tasks which are not organisation-specific, but can be applied by an organisation for establishing integration with the organisation's strategy, delivering value, and maintaining a minimum level of competency.

1.3 The potential risk considered in this review is as follows:

- IT services provided do not suit the needs of the organisation.

2. Detailed Audit Findings

Objective 1: IT services are appropriately designed, agreed, provided and managed with reference to an appropriate framework (ITIL), and which fit the needs of the organisation.

2.1 An appropriate ICT staffing and governance structure is in place, which is subject to continuous review and revision. Progress has been made to conform to ITIL and use ITIL methodologies since we last undertook work in this area (CTM-2021-20 and CTM-2122-24).

2.2 As part of the Network and Information Systems Regulations of 2018 (NIS Regulations), NHS Wales organisations were required to identify all services deemed critical to business continuity. The ICT department used the opportunity to redesign and update their service catalogue and publish it to the intranet. Whilst the service catalogue has been improved and clearly indicates critical systems and time critical services, there are gaps in the Service Level Agreements (SLAs) information. We also note that there is no identification of which services are supported either nationally or locally, which would provide clarity to users. **See Matter Arising 1 at Appendix A.**

2.3 Good progress has been made regarding change management with a process that ensures changes are appropriately assessed, approved, and actioned, and a weekly Change Advisory Board to monitor the process.

2.4 Approximately 25 ICT staff have undertaken ITIL training over the last two years, which demonstrates an appetite and intent to conform to ITIL, and to foster a framework that meets the needs of the Health Board. We understand that there has been instability in the Head of Service Management role in the last few years, which has impacted the rate of progress in developing the framework. However, areas such as operational knowledge management have developed by maturing the ICT KnowledgeBase repository and authoring new policies, processes, user guides and work instructions. Whilst KnowledgeBase has a dedicated area for IT

Service Management, the development of related processes and procedures has been hindered by the instability of the Head of Service Management role. We acknowledge that some progress has been made by the ICT Configuration Manager where more urgent gaps were identified, such as developing service desk processes. **See Matter Arising 2 at Appendix A.**

2.5 We positively note the development of the service desk function. Previously known as CTM Operational Support, which had the same staff covering both 1st and 2nd line support on a rotational basis. The restructured service desk was fully established in 2022 when the 1st and 2nd line support functions were split into two entities with dedicated support for each, and a Service Desk Manager was placed in post. The new structure was developed to better suit the needs of the organisation and to provide an improved service to Health Board staff. The service desk operates normal business hours, and staff can log a request or incident ('calls') through channels such as e-mail and telephone, or via the ICT Portal, where calls can be self-logged at any time.

2.6 ServicePoint, the call management system used to log, resolve, and report on calls, has a link to the Digital Health Care Wales (DHCW) Support SharePoint, where call handlers can find comprehensive user guides that cover the lifecycle of a call, from initial logging, creating a related problem or change, to call closure. ServicePoint has modules encompassing incident and request management, problem management, change and release management and integrated configuration management that allows for a managed service that links with ITIL service management best practice.

Conclusion:

2.7 Our review highlighted good progress in developing an ITIL focused framework. Whilst there are gaps in the service catalogue, we acknowledge the improvements made to date, which have been hampered by the instability of the Head of Service Management role. There has been significant training provision for ITIL within the ICT department to support the restructured and improved service desk function. Accordingly, we have concluded **reasonable** assurance for this objective.

Objective 2: Digital Services ensures relationships with services are maintained in order to review and evaluate services on a regular basis to improve service quality.

2.8 Links and service agreements between ICT and services are established in some areas, but not all. Improvements are being made where possible, for example, services that were previously paper based are undergoing digital transformation, and as part of this work ICT have recognised the need to assign ICT leads to engage with the service to understand and develop requirements. Further to this, there are embedded system managers within ICT for local services, and dedicated desktop support is available within hospital sites.

2.9 While there are areas of good practice, there is no overall structure or defined process to both relationship or service management, therefore, no consistent approach across services or clear monitoring of service levels compared to agreed targets as a basis for measures to improve service quality and add value. As

referenced in objective 1, the instability of the Head of Service Management role has delayed overall progress in these areas. **See Matter Arising 3 at Appendix A.**

Conclusion:

2.10 There is a lack of overall structure and defined process to detail the expectations, responsibilities, and performance standards for ICT service delivery. However, there are areas of good relationship management, such as embedded ICT System Managers, which could be used as examples to develop a relationship management framework. Consequently, we have concluded **reasonable** assurance for this objective.

Objective 3: Appropriate supplier management is in place that ensures digital services are aware of their suppliers, contracts and the performance of these.

2.11 ICT suppliers are split into those managed by ICT, those managed by other departments of which ICT are aware, and those of which ICT are unaware. Health Board policy is that ICT are responsible for all ICT services. We note that ICT have a record of suppliers and are generally aware of contracts, however, there is no central full record of both. National IT services are managed by DHCW, and include Service Management Boards (SMB), which are attended by relevant Health Board ICT staff. The aim of the SMBs is to provide governance and stewardship to ensure that the IT services within their control are fit for purpose.

2.12 Within the Health Board there are areas of good supplier management, which correlate to where contracts are in place and which are managed by ICT, and with long-standing suppliers, where there are close working relationships and regular meetings between parties. For example, there appears to be very good relationships with suppliers relating to the boundary change with Swansea Bay University Health Board, with service leads in place, weekly meetings and defined service level agreements which are closely monitored. However, supplier management is generally *ad hoc* with no consistent approach across local services and no central repository of supplier and contract information.

2.13 We identified that there is no overarching framework or policy for the management of suppliers and contracts that ensures value is gained and to drive efficiencies. Poor and inconsistent supplier management poses the risks of delays, defects, cost overruns, financial penalties, and reputational damage. Similarly, poor contract management can result in suppliers having undue control over cost and performance, and without appropriate scrutiny, can deviate away from contract terms, and reporting and invoices may not continue to reflect the original contract terms. We note that this was an area to be developed by the Head of Service Management, however, the instability of the role has delayed progress in this area. **See Matter Arising 4 at Appendix A**.

Conclusion:

2.14 Whilst there are some elements of supplier management being undertaken, the lack of centralised data in addition to the absence of an overarching framework

exposes the Health Board to financial and reputational damage. Consequently, we have concluded **limited** assurance for this objective.

Objective 4: Appropriate processes are in place for incident, event and problem management in order to minimize the impact on users.

2.15 Incidents and requests are logged on ServicePoint and service level agreements (SLA), such as response times, are recorded within the system as part of the service categories arrangements. Our review of a sample of calls highlighted that generally, calls are picked up quickly after being logged and appropriate actions are taken to resolve. Monthly '1-2-1s' are conducted with call handlers where a sample of their calls are scored on call quality and discussed, providing an environment of continuous learning and improvement.

2.16 When logging a call within ServicePoint, certain services have pre-defined calls to deal with common standard requests. There are 313 pre-defined call types in total. If an appropriate pre-defined option is available for the affected service, once selected, the call type, details, and priority fields will pre-populate accordingly. We reviewed all calls logged between July and the end of September 2023 and identified that 50% of calls used the pre-defined functionality. This indicates that call handlers either do not follow the process, or that the functionality is too complex due to the large number of available call types.

2.17 In addition, classifications are not configured for all services, and there are several duplicates which impacts the ability to perform meaningful analysis. For example, '648' calls are split between two separate classifications relating to the same matter: 'Email – Release'; and 'Email – Release of Email'. In addition, for 466 instances where online staff termination forms were incorrectly recorded as incidents rather than requests, a call type of 'unclassified' was used, which indicates that the pre-defined functionality was not used. Mis-recording requests as incidents may affect related metrics including SLAs as response times differ for standard requests (240 minutes) compared with incidents (30 minutes). We understand that work is being undertaken with system managers to remap arrangements according to service as opposed to department. **See Matter Arising 5 at Appendix A**.

2.18 We also reviewed all of the incidents logged in the July - September period and note that 99% had been closed. In October 2022 an 'ICT 3 Strike Closure' procedure was published which sets out the process of closing calls if confirmation cannot be obtained from the staff member who logged the incident or request. At the time of our fieldwork, 18 calls remained open with a 'Awaiting User' status. Of these, 8 calls have since been closed using the above process. While we note that 10 calls remained open which had limited or no updates since initially logged, there has been significant improvement to the reviewing and updating calls process since we last looked at this area.

2.19 Problem management is a process to reduce the likelihood and impact of incidents by identifying actual and potential causes, and to manage workarounds and known errors. During our fieldwork we saw problems recorded within ServicePoint, but there was no defined procedure and therefore, no consistent approach to logging

or management. We note that a draft procedure has been developed, but due to the instability of the Head of Service Management role, this has not been progressed. **See Matter Arising 6 at Appendix A**.

Conclusion:

2.20 Our testing identified that calls are generally well handled, and there have been improvements since we last looked at this process. However, there are some areas of weakness such as the use of pre-defined call types, classifications not configured for all services, duplications of classifications and mis-recording of requests as incidents. While problems are recorded in ServicePoint, there is no defined procedure in place to ensure a consistent approach is taken. Consequently, we have concluded **reasonable** assurance for this objective.

Objective 5: Processes are in place to gather, analyse, store and share knowledge and information within the organisation in order to improve efficiency by reducing the need to rediscover knowledge.

2.21 ICT staff have access to KnowledgeBase, a SharePoint library containing a wide range of information such as system links, work instructions, ServicePoint training and technical guides. Clinical systems have specific knowledge pages which include information in relation to known device issues, troubleshooting guides, and kit requirements. We confirmed that the ordering of information on the pages was easy to navigate. As we note above, ServicePoint call handlers can access DHCW's suite of guides in operating the system. Whilst some areas within KnowledgeBase are more developed than others, there has been progress since we last looked at this area in 2022.

Conclusion:

2.22 The ICT KnowledgeBase continues to mature, with logical ordering of information that is easy to find. Whilst there are areas still under development, we can see that effort is being made to update the library. Accordingly, we have concluded **substantial** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Service Catalogue (Operation)			**Potential Impact**
As part of the Network and Information Systems Regulations of 2018 (NIS Regulations), NHS Wales organisations were required to identify all services deemed critical. The ICT department used the opportunity to redesign and update their service catalogue and publish it to the intranet. Whilst the service catalogue has been improved and clearly indicates critical systems and time critical services, it is not complete with gaps in information such as service and support availability. We also note that there is no identification of which services are nationally or locally supported, which would provide clarity to users.			• IT services provided do not suit the needs of the organisation.
Recommendations			**Priority**
1.1	Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	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.	Q2 24/25	Lead Infrastructure and Security Architect
1.2	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 recoverability.	Q2 24/25	Lead Infrastructure and Security Architect

Matter Arising 2: IT Service Management Processes (Operation)			**Potential Impact**
Whilst KnowledgeBase has a dedicated area to IT Service Management, we note that the development of processes and procedures has again been delayed due to the instability of the Head of Service Management role. We acknowledge that some progress has been made by the ICT Configuration Manager where more urgent gaps were identified, such as working with the Service Desk Manager to develop Service Desk processes.			• IT services provided do not suit the needs of the organisation.
Recommendations			**Priority**
2.1	Management should ensure that knowledge management is progressed through the creation and development of ITIL aligned processes and procedures.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	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.	Q3 24/25	Assistant Director of Digital Delivery

Matter Arising 3: Relationship Management (Design)			**Potential Impact**
There is no overall structure or defined process to relationship management between ICT and services, therefore, no consistent approach across the Health Board and no tangible monitoring of service levels compared to agreed targets as a basis for measures to improve service quality and add value. We note that the instability of the Head of Service Management role has delayed overall progress of these areas.			• IT services provided do not suit the needs of the organisation.
Recommendations			**Priority**
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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	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.	Q4 24/25	Assistant Director of Digital Delivery

Matter Arising 4: Contract / Supplier Management (Design)			**Potential Impact**
Our review identified that there is no overall structure or defined process to contract or supplier management, therefore, no consistent approach or tangible monitoring of service level agreements. Poor and inconsistent supplier management poses the risks of delays, defects, cost overruns, financial penalties, and reputational damage. Similarly, poor contract management can result in suppliers having undue control over costs and performance, and without appropriate scrutiny, can deviate away from contract terms and reporting and invoices may not continue to reflect the original contract terms. We note that the instability of the Head of Service Management role has delayed overall progress of these areas.			• IT services provided do not suit the needs of the organisation. • Financial risk. • Reputational risk.
Recommendations			**Priority**
4.1	Management 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.		**Medium**
4.2	Management 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.		**High**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	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.	Q3 24/25	Assistant Director of Digital Delivery

4.2	Creation of a tiered framework categorising high, medium and low value/importance suppliers and contracts, and the appropriate level of governance and level of management given to each category.	Q3 24/25	Assistant Director of Digital Delivery
4.3	This action is closely tied to action 4.2 and the appropriate controls will need to be placed with supplier and contract management framework	Q3 24/25	Assistant Director of Digital Delivery

Matter Arising 5: Pre-defined and classifications (Operation)	**Potential Impact**
We reviewed all of the calls logged July and September 2023 and identified that 50% of calls used the pre-defined functionality. This indicates that call handlers are either not following the process or that the functionality is too complex, due to the large number of available call types. In addition, classifications are not configured for all services and we identified that there are several duplicate classifications which could impact the ability to perform meaningful analysis. In addition, there were 466 instances where online staff termination forms were incorrectly recorded as incidents rather than requests and a call type of 'unclassified' was used, which indicates that the pre-defined functionality was not used. Mis-recording requests as incidents may effect related metrics including SLAs, as response times differ for standard requests (240 minutes) versus incidents (30 minutes).	• IT services provided do not suit the needs of the organisation.

Recommendations		**Priority**
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.	**Low**
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.	**Low**
5.3	Management should ensure that requests such as staff termination forms are accurately logged.	**Low**
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.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	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	Q1 25/26	Assistant Director of Digital Delivery

	DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25		
5.2	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	Q1 25/26	Assistant Director of Digital Delivery
5.3	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	Q1 25/26	Assistant Director of Digital Delivery
5.4	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	Q1 25/26	Assistant Director of Digital Delivery

Matter Arising 6: Problem management (Design)			**Potential Impact**
Problem management is a process to reduce the likelihood and impact of incidents by identifying actual and potential causes, and to manage workarounds and known errors. Whilst we observed problems being recorded within ServicePoint, there is no defined procedure and therefore, no consistent approach to logging or management. We note that there is a draft procedure, but due to the instability of the Head of Service Management role, this has not been progressed and finalised.			• IT services provided do not suit the needs of the organisation.
Recommendations			**Priority**
6.1	Management should ensure that a defined problem management process and procedure is finalised, published, and adopted.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Once a Digital Service Management function has been created (Action 2.1) complete process and procedures for Problem Management.	Q4 24/25	Assistant Director of Digital Delivery

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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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
5.3.4

Audit & Risk Committee

Internal Audit Follow Up Review – Facilities Governance – Progress Update on Action Plan

Dyddiad y Cyfarfod / Date of Meeting	22/02/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business (on behalf of Jill Venables)
Cyflwynydd yr Adroddiad / Report Presenter	Gethin Hughes, Chief Operating Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 At the October 2023 Audit & Risk Committee, Members received an Internal Audit Follow Up Review on Facilities Systems which received a Limited Assurance Rating.

1.2 The Deputy Chief Operating Officer and Divisional Director of Facilities attended the October 2023 meeting to provide Members with an update on the progress being made in relation to reviewing the recommendations and to advise that the action plan that had been developed in response to the audit was being strengthened given that the assurances that had been provided were insufficiently robust. It was noted that the review of the action plan would be completed by February 2024.

2. Specific Matters for Consideration

2.1 The action plan which has been reviewed and updated by the Divisional Director of Facilities is attached at Appendix 1.

2.2 Within the revised action log there are 21 actions which were identified through the audit. Of these, 4 of the actions have been closed and the remaining 17 remain in action. Good progress on closing these remaining actions is being maintained.

2.3 Robust routine monitoring of ongoing compliance is in place

3. Key Risks / Matters for Escalation

3.1 As outlined within Appendix 1.

4. Assessment

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

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

5. Recommendation

5.1 The Committee are requested to NOTE the updated action plan.

6. Next Steps

6.1 The Divisional Director will continue to monitor progress. Committee Members will continue to monitor progress via the Audit Recommendations Tracker.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

	Percent Closed
	Actions
	Closed

A

Actions

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

24%	Percent Closed
17	Actions
4	Closed

			Owner	Date Recorded/ Meeting	Date Due	Date Closed	STATUS
	Indicators	icators to ensure compliance with all Procurement and Finance Procedures/Policy/Financial Standards	Jill Venables, Divisional Director of Facilities	16/10/2023	20/01/2024	03/01/2024	Closed
N/A	Management Discussion	Meet with Senior Facilities Managers. Discuss Key Performance Indicators. Conduct Training and Procedures.	Jill Venables, Divisional Director of Facilities	16/10/2023	04/01/2024	04/01/2024	Closed
N/A	Performance and Governance Meeting	Meet with the Performance and Governance Lead - Facilities and Team to discuss further Auditing Processes	Jill Venables, Divisional Director of Facilities	16/10/2023	26/01/2024	26/01/2024	Closed
N/A	Management Performance Audit	Design Monthly Management Audit	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities	16/10/2023	26/01/2024	30/01/2024	On Track
N/A	Governance Audit	Monthly Audit - Commences on 31/01/24	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities	16/10/2023	31/01/2024		On Track
N/A	Management Performance Audit	Monthly Audit - Commences on 24/02/24	Senior Facilities Management Team	16/10/2023	24/02/2024		On Track
MA 1	Training	Ensure all staff who require P2P training attend a training session	• Claire Masters, Performance and Governance Lead - Facilities • Procurement support	16/10/2023	12/02/2024		On Track
MA 1 and MA 5	Training	Ensure all staff who require Qlik system training attend a training session	• Claire Masters, Performance and Governance Lead - Facilities • Finance Support	16/10/2023	20/02/2024		On Track
MA 2.2a	Oracle Process	Develop comprehensive guidance for staff on all Procurement processes to ensure compliance at all stages of the process.	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities	16/10/2023	31/10/2023		Closed
MA2.2a	Oracle Process	Share the comprehensive guidance with other admin teams in Facilities who process goods ordering through Oracle to reflect recent structure change and ensure consistency.	• Claire Masters, Performance and Governance Lead - Facilities	16/10/2023	31/01/2024		On Track
MA2.2a	Oracle Process	Monitor orders on a regular basis to ensure correct use of call/off value orders. Where retrospective orders have been used evaluate if call off/value order would have been more appropriate Monitoring should include all admin teams who process goods ordering and reflect revised structure	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities • Senior Facilities Management Team	16/10/2023	31/01/2024		On Track
MA 2.3	Oracle Process	Ensure notes section of Oracle is utilised where a retrospective order is deemed appropriate s to explain the reason for the use of a retrospective order, including details of who requested the goods and services to be procured.	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities • Senior Facilities Management Team	16/10/2023	31/01/2024		On Track
MA 2.4	Oracle Process	Develop a process to ensure documentation to support all orders is retained and made available if required. Complete regular monitoring to ensure process adhered to	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities • Senior Facilities Management Team	16/10/2023	31/01/2024		On Track
MA3.2	Procurement Process	Ensure that staff retain documentation to evidence that 3 quotes have been obtained for orders under £5k	Claire Masters	16/10/2023	31/01/2024		On Track
MA 4	Accounts payable	Review Invoice on hold report and take appropriate action to 'release' the hold.	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities • Senior Facilities Management Team	16/10/2023	31/01/2024		On Track
MA 4	Accounts payable	Regular review of IOH report to ensure appropriate action is taking place to release invoices on hold in a timely manner	• Jill Venables, Divisional Director of Facilities • Claire Masters, Performance and Governance Lead - Facilities • Senior Facilities Management Team	16/10/2023	31/01/2024		On Track
MA 6	Budget control	Management should review and clarify purchasing and budgetary arrangements and responsibilities for Facilities and ensure that they align to the Health Board's revised Operational Structure.	Jill Venables	16/10/2023	On-Going		On Track

Closed - all actions complete; sustainability being monitored for 6 months	
On track- timescale for completion not due; no immediate risk of non-delivery	
Not on track - but with action plan in place to mitigate immediate risk now	1-4 days over

Closed - all actions complete; sustainability being monitored for 6 months	
On track- timescale for completion not due; no immediate risk of non-delivery	
Not on track - but with action plan in place to mitigate immediate risk now	1-4 days over
Not on track, no action plan; not delivering outcomes within timescale	5 days or more over

Outcome / Update	Comments
Governance Key Performance Indicators have been prepared and will be implemented on 31st January 2024	
Initial Training Complete	
Auditing Processes Complete	
All staff who require training have been identified and included on the Training Master record. As at 9 th Febuary 2024 94% of staff are now compliant with Training. Additional training date planned as follows 6th February 2024. **NB: Employees who fail to complete this training will be removed from the system until training is complete.**	
All staff who require training have been identified and included on the Training Master record. As at 26th January 2024 88% of staff are now compliant with Training. Additional training date planned for 12th February 2024. **NB: Employees who fail to complete this training will be removed from the system until training is complete.**	
Facilities have worked with procurement and finance business partners to co-produce an agreed process compliant with All Wales No PO No Pay Policy. Audit and Governance Key Performance Indicators.	Procurement colleagues asked to review Action cards and if acceptable action can be closed
Audit and Governance Key Performance Indicators.	
Monthly Monitoring/Audit	
The correct use of the Oracle notes section for retrospective orders have been added to the Facilities Key Performance Indicators and monitored monthly	
Monthly Monitoring/Audit	
Include monitoring/Audit of quotation exercise and document retention as part of Facilities Key Performance Indicators to be monitored monthly	
	Once IOH report confirmed as covering all of Facilities, action can be closed
Action to release IOH to be included as part of Facilities Key Performance Indicators and monitored monthly	
An action plan has been put in place and we are working with the Acute Services General Manager's (ASGM's) at each Care Group Clinical Services locality to capture spend against activity and demand generated by a number of contract services used by the Care Group Clinical Services and that the Facilities Hub have limited control over. The aim being to mitigate and reduce the spend where possible. Systems are now in place to track and monitor, however further review is required to reduce activity and achieve budget as the services areas are significantly overspent. Further control measures need to be determined, implemented and monitored.	

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Issues

Average	0.00
High	0
Medium	0
Low	0

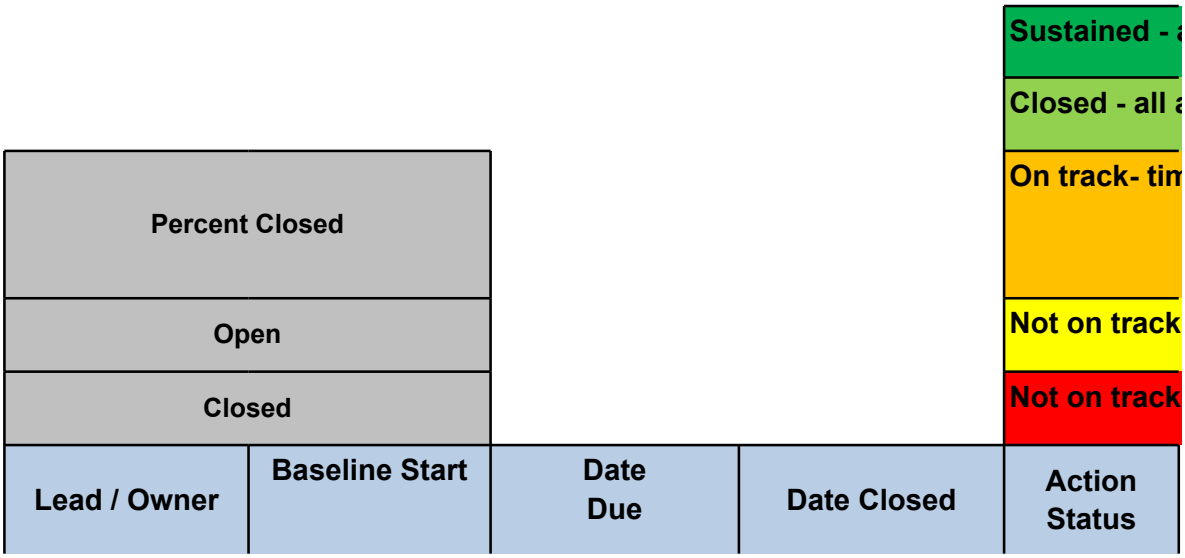
Nbr	Theme	Discussed	Issue Description	Action Required / Taken / Recommendation	Escalation Level	Owner	Date Opened	Date Due	Date Closed

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board					Owner	Likelihood	Consequence	Risk Rating	Actions being taken	Original Deadline	New Deadline	Date last updated	Comments
END OF WORKSHEET (INSERT ADDITIONAL ROWS ABOVE THE GREY LINE ONLY)													

Milestone	Sub Nbr	Scheme

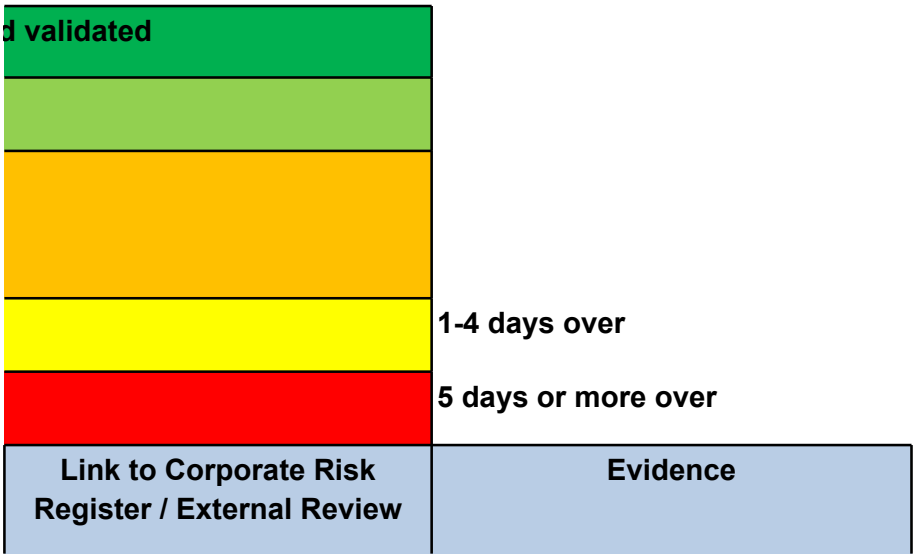
ɔd Iechyd Prifysgol
ı Taf Morgannwg
ersity Health Board

Action / Note Description	Executive SRO


Sustained -
Closed - all
On track- tim
Not on track
Not on track
Percent Closed
Open
Closed
Lead / Owner
Baseline Start
Date Due
Date Closed
Action Status

actioned sustained over 6 months and delivering required outcome and
actions complete; sustainability being monitored for 6 months
nescale for completion not due; no immediate risk of non-delivery
- but with action plan in place to mitigate immediate risk now
, no action plan; not delivering outcomes within timescale

Sustained and Validated	Findings: Current Status / Position statement after each meeting


d validated
1-4 days over
5 days or more over
Link to Corporate Risk Register / External Review
Evidence

Comments

Archwilio Cymru
Audit Wales

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

Date issued: February 2024

Document reference: 3313A2023

This document has been prepared for the internal use of Cwm Taf Morgannwg University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

About this document

1 This document provides the Audit and Risk Committee with an update on our current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board.

2 We also provide additional information on:

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

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

4 A summary of the accounts and performance audit work completed in 2023 is provided separately in the 2023 Annual Audit Report.

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Certification
The Health Board's Charity's 2022-23 Annual Report and Account	Executive Director of Finance	The statutory audit of the Report and Account.	Completed.	The Auditor General certified them on 26 January 2024.
The Health Board's 2023-24	Executive Director of Finance	The statutory audit of the Annual Report and Accounts.	We expect to start our audit planning in March 2024.	By 12 July 2024.

Annual Report and Accounts				

Performance audit update

6 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 will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge	Part 1 – Regional report drafting Part 2 – Project brief to be issued in February 2024	April 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 also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).		
All-Wales thematic on workforce planning arrangements	Executive Director of People	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Report Drafting	April 2024
Primary Care Services - Follow-up Review (Local Work 2023)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We	Report Drafting	April 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		made several recommendations to the Health Board. This work will follow-up progress against these recommendations.		
Structured Assessment 2023 – Deep Dive	Executive Director of Finance	We had previously indicated an intention to undertake deeper dive work to examine digital arrangements. However, given the significantly challenging financial position across NHS Wales, we are now looking at replacing the work on digital with focused work examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Fieldwork	June 2024
Review of the Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries - Follow up	Director of Nursing, Midwifery and Patient Care & Chief Operating Officer	This work will focus on reviewing the Health Board's progress in implementing the four recommendations made in our 2022 review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit.	Scoping	June 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Quality Governance Arrangements Joint Review Follow-up - Progress update	Chief Executive	In our joint report published in August 2023, we signalled our intention to ask the Health Board for a written update on its progress in addressing the areas the joint review follow-up team felt that further work was necessary. These areas were set out in the report. We will assess the Health Board's progress jointly with Healthcare Inspectorate Wales with the aim of determining whether the outstanding recommendations can be closed.	Scoping	June 2024
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from our 2022 review. The specific focus of this work is to be confirmed.	Scoping	To be confirmed

Other relevant publications

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

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

Title	Publication Date
Corporate Joint Committees – commentary on their progress	November 2023

Additional information

8 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

9 There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Equality Report	November 2023

Audit Wales

1 Capital Quarter

Tyndall Street

Cardiff CF10 4BZ Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Annual Audit Report 2023 – Cwm Taf Morgannwg University Health Board

Audit year: 2022-23

Date issued: January 2024

Document reference: 3986A2024

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report summarises the findings from my 2023 audit work at Cwm Taf Morgannwg University NHS Trust (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts; and
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources.

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible using technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 28 July 2023, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have commented on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments. I have also published an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges

that need to be gripped locally and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit and Risk Committee on 22 February 2024. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Health Board's 2022-23 accounts[2] were properly prepared and materially accurate and I therefore issued an unqualified true-and-fair opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

13 However, I qualified my regularity opinion because the Health Board breached its revenue resource limit. For the three-year period 2020-21 to 2022-23 the Health Board expended £24.221 million over the three-year revenue limit that the Welsh

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

[2] I audit and certify the Health Board's Performance Report, Accountability Report and Financial Statements. 'Accounts' is a generic term.

Government had authorised. The Health Board did not exceed its authorised capital resource-limit for the for the three-year period 2020-21 to 2022-23.

14 I found no other regularity matters of a material adverse nature. I did however report that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in place for the period 2022-23 to 2024-25. This financial duty requires Health Boards to prepare, and have approved by the Welsh Ministers, a rolling three-year integrated medium-term plan.

15 I reported nine audit recommendations for improvement to the Health Board's Audit and Risk Committee. Management fully accepted seven of the nine recommendations and they have put actions in place to implement them. I will review the Health Board's progress with the actions as part of my 2023-24 audit.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- Urgent and sustainable action is needed to tackle the long waiting times for orthopaedic services. There's a clear commitment to improve waiting times, however, it could take three years or more to return the orthopaedic waiting list to pre-pandemic levels.
- From an all-Wales perspective, despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.
- The Health Board has generally effective arrangements to ensure good governance; however, opportunities exist to improve some of these arrangements further. Addressing the financial challenges currently facing the Health Board and preparing a long-term Clinical Services Plan and an approvable Integrated-Medium Term Plan remain key priorities for the Board.
- The Health Board had made significant progress in addressing the substantial concerns and recommendations set out in our 2019 joint review of Quality Governance arrangements with Healthcare Inspectorate Wales.

17 These findings are considered further in the following sections.

Detailed Report

Audit of accounts

18 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

19 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

20 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

21 I concluded that the Health Board's accounts were properly prepared and materially accurate (true and fair), and I issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

22 I reported nine audit recommendations, to management and to the Health Board's Audit and Risk Committee. Management fully accepted seven of the nine recommendations and formally agreed management actions and dates of implementation.

23 I must report issues arising from my work to those charged with governance (the Members of Board), for their consideration before I issue my audit opinion on the accounts. My audit team reported these issues to the Board on 27 July 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit and Risk Committee

Issue	Auditors' comments
Uncorrected misstatements	There was one non-trivial uncorrected misstatement that related to the reversal of prior-year impairments that had been accounted for incorrectly. The error resulted in the understatement of the value of four properties and the overstatement of in-year expenditure. The misstated totalled £1,648,097, which is not material to the 2022-23 accounts and therefore did not adversely affect my audit opinion.

Corrected misstatements	I reported the six most significant areas of corrected misstatements. They related mainly to accounting classifications and disclosures.
Other significant issues	I reported nine recommendations for improvement, with management's formal responses. The Health Board's Audit and Risk Committee considered them on 19 December 2023.

24 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2023 and the return was prepared in accordance with the Treasury's instructions.

25 I also audit the Health Board's Charity's annual report and accounts, which I reported to Trustee Members on 25 January 2024 and certified on 26 January 2024. The Charity Commission's deadline is 31 January.

Regularity of financial transactions

26 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

27 Where a Health Board does not achieve financial balance, its revenue and/or capital expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

28 I qualified my regularity opinion because the Health Board breached its revenue resource limit. For the three-year period 2020-21 to 2022-23 the Health Board expended £24.221 million over the three-year revenue limit that the Welsh Government had authorised.

29 The Health Board did not exceed its authorised capital resource-limit for the for the three-year period 2020-21 to 2022-23. For the three-year period 2020-21 to 2022-23 the Health Board expended £132,000 below the three-year capital limit that the Welsh Government had authorised.

30 I have the power to place a substantive report on the Health Board's accounts, alongside my opinions, where I want to highlight an issue(s). Due to the regularity issue set out above, I issued a substantive report setting out the factual details of my qualification of my regularity opinion.

31 My substantive report also highlighted that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in

place for the period 2022-23 to 2024-25. This financial duty requires Health Boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. The duty is an essential foundation to the delivery of sustainable quality health services.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

32 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- commenting on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments;
- reviewing the Health Board's progress in implementing the 14 recommendations made in our 2019 Joint Review of Quality Governance Arrangements with Healthcare Inspectorate Wales;
- publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally; and
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

33 My conclusions based on this work are set out below.

Orthopaedic Services in Wales

34 In March 2023, I commented on orthopaedic services across Wales. My national report 'Orthopaedic Services in Wales – Tackling the Waiting List Backlog' sets out the scale of orthopaedic waits, changes in demand, aspects of service capacity, and some of the nationally co-ordinated work to modernise services. My report also set out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services.

35 My work found that securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with the COVID-19 pandemic making this significantly worse. Previous monies allocated by Welsh Government have resulted in short term improvements but have not achieved the sustainable changes to services that were necessary with orthopaedic waiting list targets not met since they were first established in 2009.

36 Since the impact of the pandemic has lessened, orthopaedic services have been slow to restart, and while necessary infection control regimes will continue to have an impact on throughput, there is scope for current capacity to be used more efficiently. My scenario modelling indicates that it could take between three to five years to return orthopaedic waits to pre-pandemic levels across Wales. This is based on both a significant drive on community-based prevention and an increase in capacity and activity. Without this, services may never return to pre-pandemic levels.

37 My work found that there is a clear commitment to improve orthopaedic services. NHS Wales commissioned efficiency and effectiveness reviews both nationally and locally, which set out a suite of recommendations. A national clinical strategy for orthopaedics was also commissioned which sets out service options and a clear clinical voice on what needs to be done. However, urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

38 In addition to my national report, my team set out how the Health Board's orthopaedic services compare to other health boards across Wales. My comparative report highlighted that the Health Board has:

- an orthopaedic waiting list that is just below the all-Wales average in terms of total number of people waiting, patients waiting longer than a year for a first outpatient appointment, and patients who have been on the waiting list for longer than two years;
- higher than average levels of potential latent 'lost' demand as an impact of patients not going to their GP during the pandemic;
- higher than average levels of orthopaedic bed and medical workforce capacity;
- the longest waits for radiology services, but some of the shortest waits for physiotherapy; and
- very low uptake of new initiatives to reduce unnecessary follow-up outpatient appointments.

39 My scenario modelling indicates that optimistically the waiting list for the Health Board could return to pre-pandemic levels by 2029, but without concerted effort may take many years to return to pre-pandemic levels, if at all.

40 My local report sets out a series of prompts and questions for Board members to inform debate and obtain assurance that improvement actions at a local level are having the desired effect.

Quality Governance Arrangements Joint Review Follow-up

41 In August 2023, I published jointly a report with Healthcare Inspectorate Wales which describes the progress made by the Health Board in strengthening its quality

governance arrangements following our original joint review work in 2019. We published a summary of progress against our 2019 recommendations in May 2021.

42 Our work found that the Health Board had made significant progress in addressing the substantial concerns and recommendations set out in our 2019 report. Of the 14 recommendations we made in 2019, we found that the Health Board had fully implemented 9 recommendations and partially implemented 4 recommendations. 1 recommendation had been superseded.

43 The Health Board has a stronger strategic focus on quality and patient safety compared to 2019. The Health Board's new three-year Quality Strategy clearly articulates the organisation's quality vision, mission, pledge, ambitions, and goals. It also sets out clearly the Health Board's approach to quality, as well as what success will look like. The strategy, together with the new three-year Quality and Patient Safety Framework, provides a good foundation to support the delivery of the new Duty of Quality and Duty of Candour, which came into effect in April 2023. There is also greater clarity on roles, responsibilities, accountability, and governance in relation to quality and patient safety compared to 2019, and the Health Board has significantly increased capacity to support its quality and patient safety arrangements.

44 The organisational scrutiny of quality and patient safety has improved considerably, with greater openness and transparency evident in comparison to 2019. The Health Board's Quality and Safety Committee is operating effectively. The Health Board has also established new arrangements to oversee, scrutinise, and escalate quality and patient safety matters at an operational level. Whilst this is a positive development and a clear improvement on the situation in 2019, the Health Board still has more to do to ensure the arrangements are fully embedded and operating effectively as intended across the new Care Group structure.

45 The Health Board has significantly improved its risk management arrangements, with greater awareness of risk management across the organisation, and clearer processes in place for identifying, managing, and escalating risks. The Health Board has an approved Board Assurance Framework (BAF), which is operating well. It is underpinned by a comprehensive risk management strategy and a suite of risk management policies and procedures, which have been updated to reflect the new operating model. The organisational (corporate) risk register has also been strengthened, and there is good evidence of corporate risks being actively reviewed and managed. Operational risks are captured in the Care Group risk registers. However, opportunities remain to strengthen the content of these risk registers, particularly around the identification of mitigating actions.

46 The Health Board has improved its approach to the management of concerns and complaints since 2019. The concerns and complaints process is clear, and new corporate roles have been created to support implementation and ensure consistency. There is also an improved culture of learning within the Health Board, with a range of arrangements now in place to support the identification and sharing of learning and improvement. However, the Health Board is still dealing with a

significant concerns legacy as it has failed to submit a number of Learning From Events Reports (LFERs) within the mandatory timescales. The Health Board needs to address the situation as a matter of urgency, and improve its processes to ensure LFERs are submitted on a timelier basis in future.

47 The Health Board has also taken a number of steps to improve the culture of the organisation since 2019. The Health Board has a clear Values and Behaviours Framework in place, which appears to be well embedded across the organisation. Staff report that the Health Board's culture is much improved, and they also feel that senior leaders are more visible and accessible. However, responses to our staff survey indicate that there are still pockets of poor behaviour within operational teams that need to be addressed, particularly in relation to bullying and harassment. We also found early evidence of the new operating model supporting further improvements in organisational culture. The staff we spoke to were positive about the changes. In their view, the new operating model should reduce silo working and strengthen the "one CTM" ethos. However, there is still work to be done to fully integrate the Princess of Wales hospital into the organisation's operational arrangements following the change to the Health Board's geographical footprint in 2019.

48 Overall, we felt that this is a positive achievement and a clear demonstration of the Health Board's commitment, drive, and desire to address our concerns in full and put things right. Nevertheless, it still needs to take further action to fully embed its revised quality governance arrangements across the organisation and implement all remaining recommendations in full. However, we do not feel it necessary to schedule any further detailed follow-up work. Where we have identified the need for continued action, we will maintain oversight of the Health Board's progress in these areas through our respective routine work programmes

NHS workforce data briefing

49 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that in some instances, the growth in staff levels, particularly in nursing and some medical specialties hasn't kept up with increasing demand.

50 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23. Wales is growing its own workforce, with increased nurses and doctors in training.

51 Despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies can recruit sufficient graduates once they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer.

52 The data briefing provides context for the local review of workforce planning my team are currently undertaking at the Health Board.

Structured assessment

53 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

54 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations. At the time of my structured assessment work, the Health Board had been placed by Welsh Government under 'enhanced monitoring' for planning and finance; 'enhanced monitoring' for maternity and neo-natal services; 'enhanced monitoring' for quality and governance, leadership and culture, trust and confidence; and 'targeted intervention' for quality issues relating to performance.

Board transparency, effectiveness, and cohesion

55 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- public transparency of Board business;
- arrangements to support the conduct of Board business;
- Board and committee structure, business, meetings, and flows of assurance;
- Board commitment to hearing from staff, users, other stakeholders; and
- Board skills, experiences, cohesiveness, and commitment to improvement.

56 My work found that the Board and its committees operate effectively, cohesively, and transparently, but opportunities to further enhance some arrangements remain.

57 The Board continues to conduct its business in an open and transparent manner. Agendas and papers for Board and committee meetings continue to be published on the Health Board's website in a timely manner. The Health Board makes good use of social media to promote Board meetings, which continue to be livestreamed and recorded. But it should provide more guidance on how members of the public can request to attend meetings in person should they wish to do so.

58 The Board and committees are operating well. Board meetings are generally well chaired, with members and attendees observing the necessary etiquette. Board and committee work programmes and agendas cover all aspects of their respective terms of reference and are shaped by the Board Assurance Framework. Board and committee oversight of the Health Board's estate is improving. Papers for Board and committee meetings are generally well written and clear. The Board and committees receive good support from the Corporate Governance Team despite the significant capacity challenges the team faced during 2023.

59 The Board acts cohesively with Independent Members providing a good balance of scrutiny, support, and challenge. The Health Board has continued to make effective use of self-assessments, appraisals, and Board Development Sessions to support learning, development, and continuous improvement. The Board also continues to demonstrate a strong commitment to hearing from staff and patients.

Corporate systems of assurance

60 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- overseeing strategic and corporate risks;
- overseeing organisational performance;
- overseeing the quality and safety of services; and
- tracking recommendations.

61 My work found that the Health Board's risk, performance, and quality governance arrangements continue to strengthen, but further work is required to ensure they are fully embedded across the organisation and achieving the desired impact.

62 The Health Board's Board Assurance Framework is well embedded. There is an appropriate Board-approved risk management framework in place, with the risk management strategy, risk statement, and risk domains up-to-date and reflecting the organisation's new operating model. Whilst the Health Board has appropriate arrangements in place to manage performance, it lacks a documented framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at all levels of the organisation.

63 The Health Board's Integrated Performance Dashboard continues to provide a detailed overview of its performance, and now appropriately focusses on the key challenges facing the organisation. The Health Board's arrangements for quality governance have improved significantly. The Health Board has a stronger strategic focus on quality and patient safety. There is greater clarity on roles, responsibilities, accountability, and governance in relation to quality and patient safety. Organisational scrutiny of quality safety has also improved considerably, with greater openness and transparency evident. This is a positive development, and the Health Board is aware that some further action is required to fully embed its revised quality governance arrangements across the organisation.

64 The Health Board's arrangements for monitoring internal and external audit recommendations have improved, and positive steps have been taken to track recommendations from other inspectorates and regulators. However, opportunities exist to better identify and analyse key themes arising from audits and inspections.

Corporate approach to planning

65 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan (IMTP); and
- overseeing the delivery of corporate strategies and plans.

66 My work found that the Health Board's corporate planning arrangements continue to mature. It has a clear Board-approved vision and strategic goals, which are being used to shape its Clinical Services Plan. There is a clear timeline in place for developing the Clinical Services Plan, and progressing this work at pace remains a priority for the Health Board. The Health Board has effective arrangements in place for preparing its Integrated Medium-Term Plan (IMTP). However, in common with other Health Boards in Wales, it has been unable to produce a Welsh Government approved IMTP for 2023-26 and is instead working to an Annual Plan. Further work is still required to develop clear milestones, targets, and outcomes for corporate plans and strategies to enable the Board and its committees to ensure effective monitoring, assurance, and scrutiny of progress.

Corporate approach to managing financial resources

67 My work considered whether the Health Board's has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- achieving its financial objectives;
- overseeing financial planning;
- overseeing financial management; and
- overseeing financial performance.

68 My work found that despite a clear process for financial planning, and good arrangements for managing and monitoring the financial position, the Health Board's financial position is extremely challenging for 2023-24.

69 The Health Board has a clear process for financial planning, with good involvement from the Board. However, the Health Board did not meet its statutory duties in 2022-23 in respect of achieving financial balance and having an approvable Integrated Medium-term Plan. The financial position for 2023-24 is extremely challenging with the Health Board working to a planned financial deficit of £79.6m million. The Health Board reported a £36.0 million year-to-date deficit against is core revenue plan in Month 5 2023-24, which was £2.8 million worse than plan. In

October 2023 additional allocations were made available to Health Boards, alongside a requirement for a 10% stretch saving delivery. As a result, the Health Board now has a break-even planning position for 2023-24. Arrangements to oversee and scrutinise financial management are effective, and the Health Board has updated several of its financial control procedures. However, the delivery of its savings plan is a challenge. The Health Board requires savings of £22.9 million but was reporting a gap of £4.4 million in its savings plans at Month 5 2023-24.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2023.

Report	Month
Financial audit reports	
Audit of Accounts Report	July 2023
Opinion on the Financial Statements	July 2023
Audit of Accounts Addendum Report	December 2023
Charitable Funds Audit of Accounts Addendum Report (2021-22 Accounts)	January 2023
Charitable Funds Audit of Accounts Addendum Report (2022-23 Accounts)	January 2024
Performance audit reports	
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog: A comparative picture for Cwm Taf Morgannwg University Health Board	March 2023
Quality Governance Arrangements Joint Review Follow-up	August 2023

Report	Month
NHS Workforce Data Briefing	September 2023
Structured Assessment 2023	December 2023
Other	
2023 Audit Plan	May 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Unscheduled Care: Flow out of Hospital	February 2024
Discharge Planning: Progress Update	February 2024
Review of Financial Efficiencies	March 2024
Review of Workforce Planning Arrangements	March 2024
Primary Care Follow Up Review	March 2024
Unscheduled Care: Arrangements for Managing Access	June 2024
Review of Planned Care Services Recovery	July 2024

Appendix 2

Audit fee

My 2023 Audit Plan set out my fee estimate of £467,328 (excluding VAT, which is not chargeable). I also set a fee estimate of £28,750 in the 2023 Audit Plan for my audit of the Health Board's Charity's annual report and accounts. My staff will determine the final audit costs once all audits are fully concluded. My audit team will then notify management of the closing position, which I will set out as usual in my 2024 Audit Plan.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2023 Audit Plan set out the risks for the audit of the Health Board's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	I reviewed numerous accounting estimates and samples of transactions that included journal entries. The results of my testing were satisfactory.
Under the NHS Finance (Wales) Act 2014, health boards moved to a rolling three-year resource limit for both revenue and capital. For 2022-	I monitor the Health Board's financial position for 2022-23 and the cumulative three-year position to 31 March 2023. My review will also consider the impact of	As set out in this report, my audit confirmed that the Health Board met its three-year capital resource limit but did not meet its three-year resource limit

Audit risk	Proposed audit response	Work done and outcome
23 the Health Board has exceeded its revenue resource limit by £24.481 million; and by £24.221 million for the three financial years to 31 March 2023. This outcome could affect my regularity opinion.	any relevant uncorrected misstatements over the three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2022-23 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.	and I therefore qualified my regularity opinion.
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date of 31 March 2023.	I will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Welsh Government's Manual for Accounts; and • consider whether the carrying value of assets at 1 April 2022 remains materially	The results of my prescribed audit testing were satisfactory. I reported one material adjustment of £16.120 million, to correct a misclassification of valuation indexation between asset categories.

Audit risk	Proposed audit response	Work done and outcome
	appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	
A new accounting standard, IFRS16 Leases, has been introduced from 2022-23. The standard significantly changes how most leased assets are to be accounted for, with leased assets needing to be recognised as assets and liabilities in the Statement of Financial Position (the balance sheet). There are also significant additional disclosure requirements specific to leased assets that need to be reflected in the financial statements.	I will: • consider the completeness of the lease portfolios identified by the Health Board, as needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the new requirements; and • ensure that all material disclosures have been made. As part of my audit planning, I have liaised with officers and provided them with the main audit questions to be raised.	The results of my prescribed audit testing were satisfactory.
I audit some of the disclosures in the remuneration report to a far lower level of materiality, as set out on page 8. The	I will examine all entries in the remuneration report to verify that they are materially accurate, and that remuneration is at the appropriately	The results of my prescribed audit testing were satisfactory. I found and reported some important, albeit immaterial, corrections.

Audit risk	Proposed audit response	Work done and outcome
disclosures are therefore more prone to material misstatement. In some of the past audits I have identified material misstatements in the remuneration report, which the Health Board corrected. I therefore judge the 2022-2023 disclosures to be at risk of misstatement. There is also the regularity risk that the Health Board remunerates a senior officer(s)5 above the Welsh Government's approved pay bands, but without the Welsh Government's formal approval for any salaries that exceed its bandings.	Welsh Government approved levels.	All senior appointments (i.e. those relevant to the remuneration report) had been approved by the Welsh Government where necessary.
I also audit the disclosure of related party transactions and balances to a far lower level of materiality. In some of my past audits I have identified omitted or incorrect disclosures, which were material and required correcting.	I will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations also include other means of testing, such as my review of Companies House records using data analytics.	I identified numerous material omissions and misstatements, all of which were corrected and reported as such. I made recommendations for improvement.

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[drwy e-bost]

Cyfeirnod: 4037A2024

Dyddiad cyhoeddi: 5 Chwefror 2024

I: Cyfarwyddwyr Cyllid y GIG
Cadeiryddion pwyllgorau archwilio'r GIG
Ysgrifenyddion Bwrdd y GIG
Aelodau o Grŵp Cyfrifeg Technegol y GIG
Hywel Jones – Cyfarwyddwr Cyllid y GIG Llywodraeth Cymru
John Evans – Llywodraeth Cymru
Jacqui Salmon – Llywodraeth Cymru

Annwyl gydweithiwr

GIG – Archwilio Cyfrifon 2023-24

1 Cyn bo hir, byddwn yn dechrau ar ein gwaith archwilio cyfrifon ar gyfer holl gyrff y GIG. Felly, rydym yn cymryd y cyfle i ysgrifennu atoch gyda gwybodaeth bwysig am sut y byddwn yn cynnal eich archwiliad 2023-24.

2 Yn y llythyr hwn, byddwn yn ystyried y canlynol:

- yr amserlen archwilio arfaethedig ar gyfer 2023-24;
- adolygiad o archwiliada cyfrifon 22-23;
- diweddariad ar ffioedd archwilio; ac
- edrychwn ymlaen at faterion allweddol sy'n effeithio ar gyfrifon 2023-24 a datblygiadau eraill.

Yr amserlen archwilio arfaethedig ar gyfer 2023-24

3 Ysgrifennom atoch ym mis Mawrth 2023 yn nodi ein hamserlen arfaethedig ar gyfer 2022-23 ynghyd â'n rhesymeg. Rydym yn nodi amserlen arfaethedig a oedd yn adlewyrchu:

- yr adnodd ychwanegol sydd ei angen i weithredu ein dull archwilio newydd wedi'i yrru gan ISA 315 (DU) Nodi ac Asesu Risgiau Camddatganiad Perthnasol (Diwygiwyd Gorffennaf 2020);

- yr oedi a gawsom wrth gwblhau cyfrifon Llywodraeth Leol 2021-22 a oedd mewn rhai achosion yn rhedeg ymhell y tu hwnt i 31 Mawrth 2023; a

- y prinder byd-eang o weithwyr archwilio a chyllid proffesiynol, a effeithiodd ar ein gallu i recriwtio a chadw staff cymwys.

4 Gan ystyried yr uchod, gwnaethom gynnig y dyddiadau cau ardystio archwilio canlynol:

- Archwilio Cyfrifon 2022-23 – ardystio erbyn 31 Gorffennaf 2023;

- Archwilio Cyfrifon 2023-24 – ardystio erbyn 30 Mehefin 2024; a

- Archwilio Cyfrifon 2024-25 – ardystio erbyn 15 Mehefin 2025.

5 Rydym yn ddiolchgar am gefnogaeth cydweithwyr ym mhob corff GIG, a alluogodd holl archwiliadau 2022-23 ac eithrio un Bwrdd Iechyd Lleol (BILl) i gael ei ardystio erbyn y dyddiad targed arfaethedig sef 31 Gorffennaf 2023.

6 Rydym bellach wedi ailasesu'r sefyllfa ar gyfer archwiliad cyfrifon 2023-24. Mae ein sefyllfa wedi gwella y llynedd. Rydym wedi gwneud cynnydd yn ymgorffori'r fethodoleg archwilio newydd ac rydym ymhellach ymlaen gyda'n harchwiliad o Lywodraeth Leol eleni na'r llynedd. Fodd bynnag, rydym yn dal i ddadlau â heriau recriwtio a chadw sy'n golygu nad ydym yn rhagweld gallu bodloni ein dyddiad cau ardystio archwilio gwreiddiol ar gyfer archwiliad cyfrifon 2023-24 ar 30 Mehefin 2024 (fel yr uchod).

7 Felly, rydym yn cynnig y dyddiadau cau ardystio archwilio diwygiedig canlynol:

- Archwilio Cyfrifon 2023-24 – ardystio erbyn 15 Gorffennaf 2024; ac

- Archwilio Cyfrifon 2024-25 – ardystio erbyn 15 Mehefin 2025.

8 Fel y gwelwch o'r uchod, ein bwriad yw dal i geisio gweithio i'n hamserlen wreiddiol ar gyfer archwilio cyfrifon 2024-25. Credwn fod hyn yn gyraeddadwy pan fyddwn yn ystyried mai hon fydd ein trydedd flwyddyn yn cyflwyno archwiliadau o dan ein dull newydd a ddylai gynhyrchu effeithlonrwydd. Wedi dweud hynny, nid yw cyflawni'r amserlen ar gyfer 2024-25 heb ei heriau, yn enwedig os yw amodau'r farchnad yn parhau o ran recriwtio a chadw archwilwyr cymwys.

9 Rydym yn cydnabod, ar gyfer archwilio cyfrifon 2023-24, fod ein dyddiad cau ychydig yn hwyrach nag y byddai llawer o gyrff yn ei hoffi, ond credwn ei bod yn bwysig gosod amserlenni realistig o ystyried ein safbwynt presennol a rhybuddio'r Gwasanaeth am ein cynigion cyn gynted ag y bo modd.

10 Byddwn yn gweithio'n agos gyda Llywodraeth Cymru a thimau cyllid y GIG dros y misoedd nesaf i gytuno ar yr union amseriadau ar gyfer cyflwyno cyfrifon drafft. Mae'n anochel y bydd materion logistaidd i'w hystyried ym mhob corff, ac rydym yn ymwybodol o'r angen i'w hystyried ar ddyddiadau'r Pwyllgor Archwilio, Bwrdd a'r Cyfarfod Cyffredinol Blynyddol (CCB), yn enwedig gan fod yn rhaid i Fyrddau Iechyd ac Ymddiriedolaethau gynnal Cyfarfod Cyffredinol Blynyddol erbyn 31 Gorffennaf bob blwyddyn yn unol â'r Rheolau Sefydlog.

11 O ran yr archwiliad Cronfeydd Elusennol neu'r archwiliad annibynnol, rydym yn bwriadu cwblhau'r rhain erbyn y dyddiad cau a bennwyd gan y Comisiwn Elusennau.

Adolygiad o archwiliad cyfrifon 2022-23

12 Cynhaliwyd ein harchwiliadau o gyfrifon y GIG ar gyfer y flwyddyn a ddaeth i ben ar 31 Mawrth 2023 o dan Safon Archwilio ddiwygiedig, ISA 315. Wrth gynllunio ein harchwiliad mewn Cyrff Iechyd unigol, roedd yn ofynnol i ni ymgymryd â gweithdrefnau asesu risg manylach a helaeth i nodi risgiau camddatganiad perthnasol a datblygu dull archwilio a gynlluniwyd i fynd i'r afael â'r risgiau hynny.

13 Cafodd y safon ddiwygiedig hon effaith sylweddol a phellgyrhaeddol ar ein methodoleg archwilio, ac rydym yn ddiolchgar i'r Timau Cyllid am eu hymgysylltiad a'r gefnogaeth a ddarparwyd ganddynt i'n timau archwilio.

14 Ardystiwyd pob archwiliad ac eithrio un Bwrdd Iechyd Lleol (BILl) gan y dyddiad ardystio gweinyddol y cytunwyd arno - 31 Gorffennaf 2023. Roedd yr oedi ar gyfer y BILl terfynol o ganlyniad i faterion a gododd yn ystod yr archwiliad. Ardystiwyd holl gyrff y GIG cyn dyddiad cau statudol y GIG sef pedwar mis ar ôl cyflwyno'r cyfrifon drafft (dechrau Medi 2023).

15 O ran ein barn a'n hadroddiadau archwilio, ni chafodd yr un o Ymddiriedolaethau'r GIG nac Awdurdodau Iechyd Strategol unrhyw gymwysterau. Roedd gan bob un ac eithrio un o'r BILl gymwysterau rheoleidd-dra am dorri dyletswydd torri. Yn ogystal, roedd gan nifer o'r BILl adroddiad sylweddol am fethu â chyflawni'r ail ddyletswydd ariannol (diffyg cynllun ariannol cymeradwy). Gellir gweld crynodeb o'n barn a'n hadroddiadau GIG yn **Atodiad 1**.

16 Roedd 2022-23 yn flwyddyn heriol yn dechnegol oherwydd prisiad pumedol ystâd y GIG a gweithredu'r safon brydlesu newydd - Safon Adrodd Ariannol Ryngwladol (IFRS) 16. O ganlyniad, gwnaethom nodi addasiadau archwilio mwy wedi'u haddasu a heb eu haddasu nag mewn blynyddoedd blaenorol. Gwnaethom hefyd barhau i weld addasiadau archwilio yn ofynnol i ddatgeliadau adroddiadau am dâl, ynghyd â materion yn ymwneud â chymeradwyo tâl uwch swyddogion. Mewn llawer o achosion, gwnaethom hefyd nodi materion gyda balansau taladwy diwedd blwyddyn a gynyddodd brofion archwilio. Byddwn yn parhau i weithio gyda chyrff unigol a gwneud argymhellion ar gyfer gwella.

17 Gwnaethom gynnal nifer o gyfarfodydd gyda grwpiau cyllid allweddol y GIG yn ystod y flwyddyn ac rydym yn bwriadu parhau â'r cyfarfodydd hyn wrth symud ymlaen. Yn benodol, croesawom ein gwahoddiad i gwrdd â Chadeiriau y Pwyllgor Archwilio a Risg fel grŵp a byddem yn awyddus i wneud hynny eto eleni.

Y wybodaeth ddiweddaraf am ffioedd archwilio

18 O ganlyniad i ISA 315, roedd y dull archwilio diwygiedig a ddefnyddiwyd yn 2022-23 yn gofyn i ni gyflogi staff mwy profiadol, cymwys yn broffesiynol, ar yr archwiliadau, gan arwain at y cynnydd mwy na'r arfer yn eich ffi archwilio y llynedd. Amcangyfrifwyd y byddai'r cynnydd mewn ffioedd sy'n ofynnol i gefnogi'r gwaith o weithredu'r dull newydd hwn oddeutu 10.2%. Yn ogystal, gwnaethom hefyd ddefnyddio cynnydd o 4.8% mewn ffioedd y llynedd mewn perthynas â chwyddiant gan arwain at gynnydd cyfartalog mewn ffioedd cyfunol o 15%.

19 Ar ôl cwblhau ein harchwiliadau 2022-23, gwnaethom gychwyn adolygiad ffioedd fel rhan o'n proses ddysgu ôl-brosiect. I grynhoi, daethom i'r casgliad nad oedd y codiad penodol o 10.2% i gefnogi gweithredu'r safon archwilio ddiwygiedig yn eithaf digonol ar draws holl archwiliadau y GIG. Cyfanswm y gorwariant costau archwilio pellach ar gyfer archwiliadau'r GIG oedd 10.1%, sy'n cyfateb i £234,000.

20 Gan gydnabod y pwysau cost sy'n gyffredin ledled GIG Cymru, rydym wedi penderfynu peidio ag anfonebu am y gorrediadau hyn lle nad oedd unrhyw faterion sylweddol yn codi yn ystod y broses archwilio. Mae hyn yn golygu y byddwn yn amsugno gorwariant o dros £100,000. Mae ein gallu i amsugno'r gorrediadau hyn wedi bod yn bosibl eleni trwy nodi arbedion 'unwaith ac am byth' ychwanegol yn fewnol ac ni ddylid ei ystyried yn gynsail ar gyfer y blynyddoedd i ddod.

21 O ran eleni, mae ein Cynllun Ffioedd ar gyfer 2024-25 bellach ar gael Cynllun Ffioedd 2024-25 | Archwilio Cymru. Mae ein cyfraddau ffioedd yn cynyddu 6.4%

ar gyfartaledd y flwyddyn nesaf. Darperir rhywfaint o gyd-destun pellach yn rhagair yr ymgynghoriad, ond rydym wedi ymgorffori'r neges allweddol yn y llythyr hwn.

22 Fel gweddill y sector cyhoeddus, rydym yn wynebu pwysau sylweddol ar gostau staff. Fel y nodwyd uchod, mae'r rheini'n cael eu gwaethygu gan brinder byd-eang o weithwyr archwilio a chyllid proffesiynol, yr ydym yn eu gweld yn cael eu hadlewyrchu yn ein gallu i recriwtio a chadw staff cymwys.

23 Mae'n bwysig ein bod yn gwneud popeth o fewn ein gallu i fynd i'r afael â'r heriau recriwtio a chadw os ydym am barhau i gyflwyno terfynau amser archwilio yn unol â'r amserlen ddiwygiedig a nodir uchod. Er mwyn helpu i wrthbwyso costau staff cynyddol, rydym yn gwneud penderfyniadau anodd i leihau ein gwariant nad yw'n staff. Rydym wedi symud i swyddfeydd llai, rhatach yn Ne a Gogledd Cymru, wedi lleihau ein costau teithio a'n costau cysylltiedig yn sylweddol, ac wedi dileu lwfansau ariannol a dalwyd yn flaenorol i staff.

24 Mae'n werth nodi bod ffioedd archwilio wedi cynyddu'n sylweddol ar draws y proffesiwn archwilio cyfan mewn ymateb i bwysau rheoleiddio, safonau archwilio newydd (gan gynnwys, ond heb fod yn gyfyngedig i, ISA 315) a chostau staff cynyddol. Mae'r tabl yn **Atodiad 2** yn crynhoi cyfraddau Penodi Archwilio'r Sector Cyhoeddus (PSAA) cyfredol ac yna'n eu cymharu â chyfraddau ffioedd presennol Archwilio Cymru. Mae'r tabl yn dangos y newid sylweddol iawn yng nghyfraddau PSAA dros y pedair blynedd diwethaf (yn dilyn Adolygiad Redmond) ac yn tynnu sylw at y gwahaniaeth amlwg iawn rhwng cyfraddau llywodraeth leol cyfredol yn Lloegr a rhai Archwilio Cymru. Er ein bod yn canolbwyntio ar gyfraddau ffioedd o fewn yr arena llywodraeth leol, mae hyn yn arwydd o'r costau archwilio cynyddol dros y ffin.

25 Mae deddfwriaeth yn ei gwneud yn ofynnol na fydd y ffioedd a godir gennym yn fwy na'r gost lawn o arfer y swyddogaeth y mae'r ffi yn ymwneud â hi. Rydym yn pennu ein ffioedd archwilio yn seiliedig ar ein sail amcangyfrif o gostau, y gymysgedd sgiliau amcangyfrifedig ar gyfer gwaith archwilio a'r nifer amcangyfrifedig o ddiwrnodau sydd eu hangen i gwblhau'r gwaith. Nid ydym, ac ni allwn wneud elw o'n gwaith. Mae ein ffioedd wedi'u gosod ar lefel i adennill y gost lawn amcangyfrifedig ond dim mwy.

26 Rydym hefyd yn ymwybodol ein bod yn symud i ail flwyddyn ein dull archwilio a'n methodoleg newydd. Ar y sail ein bod yn fwy cyfarwydd â'r dull newydd, rydym yn disgwyl gweld rhywfaint o effeithlonrwydd. Fel y nodwyd uchod, gan fod ein ffioedd wedi'u gosod ar lefel i adennill y gost lawn yn unig, lle mae'r gost lawn yn llai na'r ffi amcangyfrifedig, byddwn yn rhoi ad-daliad i gyrff unigol. Yn y cyd-destun hwn, rydym yn parhau i fod yn benderfynol o leihau ffioedd archwilio wrth sicrhau bod ansawdd ein harchwiliad yn parhau i fodloni safonau trylwyr.

27 Bydd eich Cyfarwyddwr Ymgysylltu yn trafod y ffi arfaethedig ar gyfer eich archwiliad unwaith y bydd yr archwiliad yn dechrau a bod yr asesiad risg ar gyfer eich sefydliad wedi'i gwblhau.

Edrych ymlaen at faterion allweddol sy'n effeithio ar archwiliad cyfrifon 2023-24 a datblygiadau eraill

28 Yn ogystal â myfyrio ar y llynedd, mae'n bwysig edrych ar rai o'r materion a allai effeithio ar gyfrifon 2023-24.

29 **Diffygion diwedd blwyddyn a ragwelir** – rydym yn ymwybodol o ddiffygion targed o £123 miliwn a osodwyd gan Lywodraeth Cymru ar draws y GIG cyfan a pha mor heriol fydd hyn i gyrff y GIG ei fodloni. O ystyried y disgwyliadau hyn, byddwn yn canolbwyntio ar rai meysydd, yn enwedig croniadau a gwariant tua diwedd y flwyddyn.

30 O ran ein cyfrifoldebau archwilio ehangach, mae'r sefyllfa wedi ein hysgogi i barhau i ganolbwyntio ar themâu fel cynaliadwyedd ariannol, realaeth cynlluniau arbedion a'r angen parhaus i'r GIG ddarparu gwerth am arian. Ochr yn ochr â'r themâu hyn, mae Archwilydd Cyffredinol Cymru yn rhoi pwysigrwydd sylweddol i weld safonau uchel o lywodraethu a rheolaeth ariannol a bydd yn parhau i daflu goleuni ac adrodd ar wendidau yn y meysydd hyn.

31 **Pwyntiau cyflog gweithredol** – mae hon wedi bod yn thema barhaus i'w harchwilio dros y blynyddoedd diwethaf lle talwyd cyflogau gweithredol yn ychwanegol at y pwynt cyflog diffiniedig a bennwyd gan Lywodraeth Cymru a lle na cheisiwyd na darparu cymeradwyaeth y Llywodraeth i wneud hynny. Bydd hyn eto yn faes ffocws fel rhan o'n gwaith archwilio ar yr adroddiad ar gydnabyddiaeth. Yn ogystal, treulir swm anghymesur o amser yn ceisio cysoni taliadau i gontractau cyflogaeth ar gyfer uwch staff. Yn gyffredinol, mae hwn yn faes lle gallai cyrff iechyd geisio gwella tystiolaeth archwilio.

32 **Newidiadau technegol eraill** – ar hyn o bryd, nid ydym yn rhagweld unrhyw faterion arwyddocaol newydd, ond byddwn yn parhau i gysylltu â Grŵp Iechyd a Gwasanaethau Cymdeithasol (HSSG) a Grŵp Cyfrifo Technegol y GIG (TAG).

33 **Ailgyflwyno archwiliad interim** – ar gyfer 2022-23, ni wnaethom gymhwyso ychydig neu ddim archwiliad dros dro. Roedd hwn yn benderfyniad bwriadol oherwydd ein bod yn dechrau archwiliadau GIG yn llawer hwyrach na'n hamseroedd arferol. Wrth i ni geisio adfer ac o bosibl ddod â'r amserlen yn ôl, rydym yn rhagweld y byddwn yn symud yn ôl i archwiliad dros dro eleni. Gobeithio y bydd hyn yn tynnu pwysau oddi ar dimau Cyllid ac archwilio, yn

enwedig yn ystod y cyfnod archwilio terfynol a drefnwyd ar gyfer mis Mai a Mehefin 2024.

34 **Ansawdd data / Archwiliad â Chymorth Analytics (AAA)** – ers cylch archwilio 2020-21, rydym wedi bod yn defnyddio data cyfriflyfr cyffredinol a gafwyd gan Bartneriaeth Cydwasanaeth GIG Cymru (NWSSP) yn ein cais Archwilio â Chymorth Analytics i gefnogi ein gwaith archwilio. Mae hyn wedi gwireddu sawl mantais gydag archwilwyr yn cael mynediad mwy hygyrch ac amserol i'r data, gwell asesiadau risg ac awtomeiddio rhai profion archwilio. Fodd bynnag, rydym wedi nodi sawl proses aneffeithlon a rhwystrau i'n gweledigaeth o archwiliad sy'n cael ei yrru gan fwy o ddata, gan gynnwys:

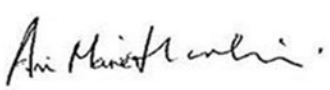
- addasiadau a ddyfynnwyd ar bapurau gwaith nad ydynt yn cael eu postio drwy'r system ariannol ;
- nifer o ddogfennau mapio a dulliau anghyson ar gyfer paratoi'r nodiadau unigol i'r cyfrifon; a
- phapurau gwaith lluosog i gefnogi nodiadau unigol i'r cyfrifon.

35 I ddechrau, rydym yn gweithio gyda rhai cyrff peilot y GIG i geisio dileu'r materion hyn gyda'r disgwyliad y bydd yn creu manteision sylweddol i wella ansawdd data ac effeithlonrwydd arbed amser ar gyfer cyrff ac archwilwyr archwiliedig. Byddwn yn ymgysylltu â'r sector ar y datblygiadau hyn yn gynnar yn 2024.

36 Rydym yn parhau i fod yn ymrwymedig i weithio ar y cyd â chi i lywio'r heriau a nodir yn y llythyr hwn yn llwyddiannus, gan adeiladu ar ein profiadau a rennir. Byddwn yn sicrhau ein bod yn mynychu'r holl GIG perthnasol er mwyn trafod cynnwys y llythyr hwn gyda chi a byddwn yn trefnu cyfarfodydd gyda holl Gyfarwyddwyr Cyfarwyddwyr Cyllid ac Arweinwyr Pwyllgorau Archwilio y GIG i roi cyfle i chi gwrdd â phob un ohonom.

37 Diolch i chi a'ch tîm am weithio'n dda gyda ni.

Yn gywir



Ann-Marie Harkin
Cyfarwyddwr Gweithredol Gwasanaethau Archwilio

Atodiad 1 – Crynodeb o farn ac adroddiadau archwilio'r GIG ar gyfer 2022-23

Bwrdd Iechyd	Adroddiad Cymhwyster/Subs
Aneurin Bevan	Rheoleidd-dra Cymwysedig – torri dyletswydd ariannol gyntaf (egwyl)
Bae Abertawe	Rheoleidd-dra Cymwysedig – torri dyletswydd ariannol gyntaf (egwyl)
Powys	Rheoleidd-dra Cymwysedig – torri dyletswydd ariannol gyntaf (egwyl)
Caerdydd a'r Fro	Rheoleidd-dra Cymwysedig – torri dyletswydd ariannol gyntaf (egwyl) Adroddiad Sylweddol – methu â chytuno ar gynllun ariannol cymeradwy (ail ddyletswydd ariannol)
Cwm Taf Morgannwg	Rheoleidd-dra Cymwysedig – torri dyletswydd ariannol gyntaf (egwyl) Adroddiad Sylweddol – methu â chytuno ar gynllun ariannol cymeradwy (ailddyletswydd ariannol)
Hywel Dda	Rheoleidd-dra Cymwysedig – torri dyletswydd ariannol gyntaf (egwyl) Adroddiad Sylweddol – methu â chytuno ar gynllun ariannol cymeradwy (ail ddyletswydd ariannol)
Betsi Cadwaladr	Barn Wir a Theg Gymwysedig – effaith ansicrwydd yn dod ymlaen o 21-22 (gwariant a thaladwy) Rheoleidd-dra Cymwysedig – taliad i gyfarwyddwr gweithredol dros dro uwchben graddfa gyflogau cymeradwy Llywodraeth Cymru heb ei gymeradwyo'n iawn. Adroddiad Sylweddol – methu â chytuno ar gynllun ariannol cymeradwy (2il ddyletswydd ariannol) Nodyn – dyletswydd ariannol cyntaf (mantoli'r cyfrifon) **diamod**
Felindre	Dim cymwysterau

Bwrdd Iechyd	Adroddiad Cymhwyster/Subs
Iechyd Cyhoeddus Cymru	Dim cymwysterau
Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru	Dim cymwysterau
Iechyd a Gofal Digidol Cymru	Dim cymwysterau
Addysg a Gwella Iechyd Cymru	Dim cymwysterau

Atodiad 2 – Cymhariaeth o gyfraddau ffioedd cyfredol Penodi Archwilio Sector Cyhoeddus (PSAA) gydag Archwilio Cymru

Gradd	Cyfraddau ffioedd Archwilio Cymru	Cardiau Cyfradd Penodiadau Archwilio Sector Cyhoeddus (PSAA)	
	2023-24 £	2023-24 £	2018-20 £
Partner / Cyfarwyddwr	168	414	132
Uwch Reolwr / Rheolwr	129	228	73
Arweinydd Archwilio	106	148	47
Arall	40 - 85	113	36

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[by-email]

Reference: 4037A2024

Date issued: 5 February 2024

To: NHS Directors of Finance
NHS Audit Committee Chairs
NHS Board Secretaries
Members of the NHS Technical Accounting Group
Hywel Jones – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Dear colleague

NHS – Audit of Accounts 2023-24

1 We will shortly commence our accounts audit work for all NHS bodies. We are therefore taking the opportunity to write to you with some important information on how we will undertake your 2023-24 audit.

2 Within this letter, we consider the following:

- the proposed audit timetable for 2023-24;
- a review of the 22-23 audit of accounts;
- an update on audit fees; and
- a look forward to key issues impacting on the 2023-24 accounts and other developments.

The proposed audit timetable for 2023-24

3 We wrote to you in March 2023 setting out our proposed timetable for 2022-23 coupled with our rationale. We set out a proposed timetable which reflected:

- the additional resource required to implement our new audit approach driven by ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020);
- the delays we had experienced in completing the 2021-22 Local Government accounts which in some cases ran well beyond 31 March 2023; and
- the global shortage of audit and finance professionals, which impacted on our ability to recruit and retain qualified staff.

4 Taking the above into account, we proposed the following audit certification deadlines:

- Audit of Accounts 2022-23 – certification by 31 July 2023;
- Audit of Accounts 2023-24 – certification by 30 June 2024; and
- Audit of Accounts 2024-25 – certification by 15 June 2025.

5 We are grateful for the support of colleagues in all NHS bodies, which enabled all 2022-23 audits except for one Local Health Board (LHB) to be certified by the proposed target date of 31 July 2023.

6 We have now reassessed the position for the 2023-24 audit of accounts. Our position has improved on last year. We have made progress embedding the new audit methodology and are further ahead with our audit of Local Government this year than last. However, we are still contending with recruitment and retention challenges which mean we do not envisage quite being able to meet our original planned audit certification deadline for the 2023-24 audit of accounts of 30 June 2024 (as per above).

7 We are therefore proposing the following revised audit certification deadlines:

- Audit of Accounts 2023-24 – certification by 15 July 2024; and
- Audit of Accounts 2024-25 – certification by 15 June 2025.

8 As you can see from the above, our intention is to still try and work to our original timetable for the audit of accounts 2024-25. We believe this is achievable when we take into account it will be our third year delivering audits under our new approach which should generate efficiencies. That said, the achievement of the timetable for 2024-25 is not without its challenges, particularly if market conditions persist in respect of the recruitment and retention of qualified auditors.

9 We recognise that for the forthcoming audit of accounts 2023-24, our deadline is slightly later than many bodies would like but we believe it is important to set realistic timescales given our current position and alert the Service to our proposals as soon as practically possible.

10 We will be working closely with the Welsh Government and NHS finance teams over the next few months to agree the precise timings for submission of draft accounts. There will inevitably be logistical matters to take into account at each body, and we are conscious of the need to factor in Audit Committee, Board and Annual General Meeting (AGM) dates, particularly as Health Boards and Trusts must hold an AGM no later than 31 July each year as per Standing Orders.

11 In respect of the Charitable Funds audit or the independent examination, we intend to complete these by the deadline set by the Charities Commission.

Review of the 2022-23 audit of accounts

12 Our audits of NHS accounts for the year ended 31 March 2023 were carried out under revised Auditing Standard, ISA 315. In planning our audit at individual Health Bodies, we were required to undertake more detailed and extensive risk assessment procedures to identify the risks of material misstatement and to develop an audit approach designed to address those risks.

13 This revised standard had a significant and far-reaching impact on our audit methodology, and we are grateful to Finance Teams for their engagement and the support they provided to our audit teams.

14 All audits except for one Local Health Board (LHB) were certified by the agreed administrative certification date - 31 July 2023. The delay for the final LHB was as a result of issues arising during the audit. All NHS bodies were certified before the NHS statutory deadline which is four months after submission of the draft accounts (early September 2023).

15 With regards to our audit opinions and reports, none of the NHS Trusts or Strategic Health Authorities received any qualifications. All except one of the LHBs had regularity qualifications for breach of break-even duty. In addition, a number of the LHBs had a substantive report for a failure to meet the second financial duty (lack of an approved financial plan). A summary of our NHS opinions and reports can be seen in **Appendix 1**.

16 2022-23 was a technically challenging year due to the quinquennial valuation of the NHS estate and implementation of the new leasing standard - International Financial Reporting Standard (IFRS) 16. As a result, we identified more

adjusted and unadjusted audit adjustments than in previous years. We also continued to see audit adjustments being required to remuneration report disclosures, along with issues relating to the approval of senior officer remuneration. In many cases, we also identified issues with year-end payables balances which increased audit testing. We will continue to work with individual bodies and make recommendations for improvement.

17 We held a number of meetings with key NHS finance groups during the year and we intend to continue with these meetings going forward. In particular, we welcomed our invitation to meet with the Audit and Risk Committee Chairs as a group and would be keen to do so again this year.

Update on audit fees

18 As a result of ISA 315, the revised audit approach applied in 2022-23 required us to employ more experienced, professionally qualified, staff on the audits, resulting in the larger than usual increase in your audit fee last year. We estimated that fee increase required to support the implementation of this new approach would be around 10.2%. In addition, we also applied a 4.8% fee increase last year in respect of inflation resulting in a combined average fee increase of 15%.

19 On the completion of our 2022-23 audits, we initiated a fee review as part of our post-project learning process. In summary, we concluded that the specific uplift of 10.2% to support the implementation of the revised auditing standard was not quite sufficient across all NHS audits. The total amount of further audit cost overrun incurred on NHS audits amounted to 10.1% which is equivalent to £234,000.

20 Recognising the cost pressures prevalent across NHS Wales, we have decided not to invoice for these overruns where there were no significant issues arising during the audit process. This means that we will be absorbing overspends of over £100,000. Our ability to absorb these overruns has been made possible this year by identifying additional 'one-off' efficiencies internally and should not be seen as creating a precedent for future years.

21 In terms of this year, our Fee Scheme for 2024-25 is now available Fee Scheme 2024-25 | Audit Wales. Our fee rates are increasing on average by 6.4% next year. Some further context is provided in the consultation foreword, but we have incorporated the key message into this letter.

22 Like the rest of the public sector, we are facing significant staff cost pressures. As stated above, those are exacerbated by a global shortage of audit and

finance professionals, which we are seeing reflected in our ability to recruit and retain qualified staff.

23 It is important that we do all that we can to address the recruitment and retention challenges if we are to continue to bring audit deadlines forward in accordance with the revised timetable set out above. To help offset increasing staff costs, we are taking difficult decisions to reduce our non-staff expenditure. We have moved to smaller, cheaper offices in both South and North Wales, have significantly reduced our travel and associated costs, and removed financial allowances previously paid to staff.

24 It is worth pointing out that audit fees have increased significantly across the whole audit profession in response to regulatory pressures, new auditing standards (including, but not limited to, ISA 315) and rising staff costs. The table in **Appendix 2** summarises current Public Sector Audit Appointment (PSAA) rates and then compares them to current Audit Wales fee rates. The table illustrates the very substantial change in PSAA rates over the past four years (following the Redmond Review) and highlights the very marked difference between current local government rates in England and those of Audit Wales. Whilst we are focusing on fee rates within the local government arena, this is indicative of the rising audit costs across the border.

25 Legislation requires that the fees we charge may not exceed the full cost of exercising the function to which the fee relates. We set our audit fees based on our estimated cost base, the estimated skills mix for audit work and the estimated number of days required to complete the work. We do not, and cannot, make a profit from our work. Our fees are set at a level to recover the estimated full cost but no more.

26 We are also mindful of us moving into the second year of our new audit approach and methodology. On the basis that we are more familiar with the new approach, we are expecting to see some level of efficiency. As stated above, as our fees are set at a level to only recover the full cost, where the full cost is less than the estimated fee, we will issue a refund to individual bodies. In this context, we remain determined to minimise audit fees whilst ensuring that our audit quality continues to meet rigorous standards.

27 Your Engagement Director will discuss the proposed fee for your audit once the audit commences and the risk assessment for your organisation has been completed.

A look forward to key issues impacting on the 2023-24 accounts audit and other developments

28 As well as reflecting on last year, it is important to have a look at some of the issues that could impact on the 2023-24 accounts.

29 **Projected year-end deficits** – we are mindful of the control total deficit of £123 million set by Welsh Government across the whole of the NHS and how challenging this will be for NHS bodies to meet. Given these expectations, we will focus on certain areas, particularly accruals and expenditure around year-end.

30 In terms of our wider audit responsibilities, the situation has prompted us to remain focused on themes such as financial sustainability, the realism of savings plans and the continued need for NHS to deliver value for money. Alongside these themes, the Auditor General for Wales places significant importance to seeing high standards of governance and financial management and will continue to shine a light and report on weaknesses in these areas.

31 **Executive salary pay points** – this has been a recurring theme for audit over the past few years where executive salaries have been paid over and above the defined salary point determined by the Welsh Government and where Government approval to do so has not been sought or provided. This again will be an area of focus as part of our audit work on the remuneration report. In addition, a disproportionate amount of time is spent seeking to reconcile payments to contracts of employment for senior staff. This is generally an area where health bodies could seek to improve audit evidence.

32 **Other technical changes** – at this point in time, we are not anticipating any new significant issues, but we will continue to liaise with Health and Social Services Group (HSSG) and the NHS Technical Accounting Group (TAG).

33 **Reintroduction of an interim audit** – for 2022-23, we applied little or no interim audit. This was a deliberate decision due to us commencing NHS audits much later than our normal timings. As we aim to recover and potentially bring the timetable back, we are envisaging moving back to an interim audit this year. This will hopefully take pressure off both Finance and audit teams, particularly during the final audit period scheduled for May and June 2024.

34 **Data quality / Analytics Assisted Audit (AAA)** – since the 2020-21 audit cycle, we have been using general ledger data obtained from the NHS Wales Shared Service Partnership (NWSSP) in our Analytics Assisted Audit application to support our audit work. This has realised several benefits with auditors having more accessible and timely access to the data, enhanced risk

assessments and automation of some audit tests. However, we have identified several inefficient processes and barriers to our vision of a more data driven audit, including:

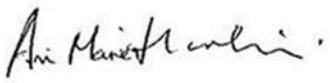
- adjustments cited on working papers not posted through the financial system;
- multiple mapping documents and inconsistent approaches for preparing the individual notes to the accounts; and
- multiple working papers to support individual notes to the accounts.

35 We are initially working with some pilot NHS bodies to try and eradicate these issues with the expectation that it will generate considerable benefits to improving data quality and time saving efficiencies for both audited bodies and auditors. We will engage with the sector on these developments during the early part of 2024.

36 We remain committed to working collaboratively with you to successfully navigate the challenges set out in this letter, building on our shared experiences. We will ensure we attend all the relevant NHS fora to discuss the content of this letter with you and will be arranging meetings with all NHS Directors of Finance and Audit Committee Chairs to provide you with an opportunity to meet with us all.

37 Thank you to you and your teams for working so well with us.

Yours sincerely



Ann-Marie Harkin
Executive Director Audit Services

Appendix 1 – A summary of NHS audit opinions and reports for 2022-23

Health Board	Qualification/Subs Report
Aneurin Bevan	Qualified Regularity – breach of first financial duty (break-even)
Swansea Bay	Qualified Regularity – breach of first financial duty (break-even)
Powys	Qualified Regularity – breach of first financial duty (break-even)
Cardiff & Vale	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Cwm Taf Morgannwg	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Hywel Dda	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Betsi Cadwaladr	Qualified True and Fair opinion – impact of uncertainty coming forward from 21-22 (expenditure and payables) Qualified Regularity – payment to interim executive director above WG approved pay scale not properly approved. Substantive Report – failure to agree an approved financial plan (second financial duty) Note – first financial duty (break-even) **unqualified**
Velindre	No qualifications
Public Health Wales	No qualifications

Health Board	Qualification/Subs Report
Welsh Ambulance Services NHS Trust	No qualifications
Digital Health and Care Wales	No qualifications
Health Education and Improvement Wales	No qualifications

Appendix 2 – A comparison of current Public Sector Audit Appointment (PSAA) fee rates with Audit Wales

Grade	Audit Wales Fee Rates	Public Sector Audit Appointments (PSAA) Rate Cards	
	2023-24 £	2023-24 £	2018-20 £
Partner / Director	168	414	132
Senior Manager / Manager	129	228	73
Audit Lead	106	148	47
Other	40 - 85	113	36