CTMUHB Audit & Risk Committee

Thu 20 June 2024, 12:30 - 14:00

Virtual Via Teams

Agenda

12:30 - 12:35
5 min

1. PRELIMINARY MATTERS

Patsy Roseblade, Chair

1.1. Welcome and Introductions

Patsy Roseblade, Chair

1.2. Apologies for Absence

Information *Patsy Roseblade, Chair*

1.3. Declarations of Interest

Information *Patsy Roseblade, Chair*

12:35 - 12:45
10 min

2. CONSENT AGENDA

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 18 April 2024

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

2.1.1 Unconfirmed Minutes ARC 18 April 2024 v1 KD - GW edit_SM.pdf (13 pages)

2.1.2. Unconfirmed In Committee Minutes of the Meeting held on 18 April 2024

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

2.1.2 Unconfirmed IC Minutes 18 April 2024 v1 KD.pdf (2 pages)

2.2. Items for Noting

2.2.1. Annual Cycle of Business 2024-25

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

2.2.1 Annual Cycle of Business Cover Report ARC 20 June 2024.pdf (4 pages)
2.2.1a Appendix 1 - Annual Cycle of Business ARC 20 June 2024.pdf (4 pages)

2.2.2. Forward Work Plan

Discussion *Patsy Roseblade, Chair*

2.2.2 Forward Work Plan Audit & Risk Committee 20 June 2024.pdf (3 pages)

12:45 - 12:45
0 min

3. MAIN AGENDA

3.1. Action Log - to follow

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

3.2. Matters Arising Not Contained Within the Action Log

Discussion *Patsy Roseblade, Chair*

12:45 - 12:45
0 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

Discussion *Matthew Evans, Local Counter Fraud Officer*

- 4.1 Local Counter Fraud Update Cover Report ARC 20 June 2024.pdf (3 pages)
- 4.1a Local Counter Fraud Update Report ARC 20 June 2024.pdf (3 pages)
- 4.1b Appendix 1 Counter Fraud Benchmark Report ARC 20 June 2024.pdf (5 pages)
- 4.1c Appendix 2 -Counter Fraud Investigations Update ARC 20 June 2024.pdf (14 pages)
- 4.1d CTMUHB Counter Fraud Annual Report 2023-24.pdf (20 pages)

4.2. Losses & Special Payments Report

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

- 4.2 Losses & Special Payments Report ARC 20 June 2024.pdf (9 pages)
- 4.2a Losses & Special Payments Appendices Mar 24 ARC 20 June 2024.pdf (10 pages)

4.3. Procurement & Scheme of Delegation Report

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

- 4.3 Procurement & SOD Report ARC 20 June 2024.pdf (12 pages)
- 4.3a Appendix 1Change to the Scheme of Delegation - CHC placements.pdf (1 pages)

4.4. Post Payment Verification Annual Report

Discussion *Post Payment Verification Manager*

- 4.4 PPV End of Year Report 2023-2024 ARC 20 June 2024.pdf (6 pages)

12:45 - 12:45
0 min

5. IMPROVING CARE

5.1. Organisational Risk Register

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

- 5.1 Org RR May 24 Cover Report ARC 20 June 2024.pdf (7 pages)
- 5.1b Appendix 1 Org RR May 2024 ARC 20 June 2024.pdf (8 pages)

5.2. Audit Recommendations Tracker

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

- 5.2a Audit Tracker Recommendations Cover Report ARC 20 June 2024.pdf (9 pages)
- 5.2b Appendix 1 - AMaT Audit Rec Tracker ARC 20 June 24 (002).pdf (15 pages)
- 5.2c Appendix 2 -Audit Tracker Devpt Work Programme LIVE as at 05062024 (002).pdf (2 pages)

5.3. National Clinical Audit Annual Plan

Discussion *Dom Hurford, Medical Director*

- 5.3 Clinical Audit Annual Plan 2024-25 ARC 20 June 2024.pdf (4 pages)

5.3.1a Appendix 1 National Clinical Audit Annual Plan CTMUHB 2024_25Ver1_0.pdf (12 pages)

5.4. Internal Audit

5.4.1. Internal Audit Progress Report

Discussion *Internal Audit*

There will be no progress report on this occasion as the IA Annual Report and Opinion being presented to the In Committee session will provide the status on all the 2023/24 work.

5.4.2. IA Review - Workforce - Leadership and Management Development

Discussion *Internal Audit*

5.4.2 IA Review Leadership and Management Development Final ARC 20 June 2024.pdf (18 pages)

5.4.3. IA Review - Welsh Risk Pool

Discussion *Internal Audit*

5.4.3 IA Review WRP Final ARC 20 June 2024.pdf (18 pages)

5.4.4. IA Review - Technical Resilience

Discussion *Internal Audit*

5.4.5. IA Review - Risk Management

Discussion *Internal Audit*

5.4.5 Ia Review Risk Management Final ARC 20 June 2024.pdf (18 pages)

5.4.6. IA Report - Revised Decarbonisation Audit

Discussion *Internal Audit*

5.4.6 Decarbonisation Update Cover Report ARC 20 June 2024.pdf (4 pages)
5.4.6a Decarbonisation Internal Audit Report (Revised Final).pdf (22 pages)

5.4.7. IA Review - Adult Mental Health - CSG Review

Discussion *Internal Audit*

5.4.7 IA Review Adult Mental Health CSG Final ARC 20 June 2024.pdf (41 pages)

5.5. Audit Wales

5.5.1. Audit Wales - Audit & Risk Committee Update

Discussion *Audit Wales*

5.5.1 Audit Wales Update Report ARC 20 June 2024.pdf (12 pages)

5.5.2. Audit Wales CTMUHB Detailed Audit Plan 2024

Discussion *Audit Wales*

5.5.2 Audit Wales 2024 Detailed Audit Plan ARC 20 June 2024.pdf (24 pages)

12:45 - 12:45
0 min

6. CLOSE OF BUSINESS

Patsy Roseblade, Chair

6.1. Any Other Urgent Business

Patsy Roseblade, Chair

6.2. How did we do in the meeting?

Patsy Roseblade, Chair

6.3. Committee Highlight Report to Board

Patsy Roseblade, Chair

12:45 - 12:45
0 min

7. PRIVATE/IN COMMITTEE SESSION

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

- CTMUHB – Draft Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2023-2024
- WHSSC Draft Annual Governance Statement 2023-2024
- National Collaborative Commissioning Unit Annual Governance Compliance Statement for 2023-2024
- EASC Draft Annual Governance Statement 2023-2024
- National Imaging Academy Governance Compliance Statement
- CTMUHB Draft Accounts 2023-2024 - **Draft Subject to Final Audit Review**
- CTMUHB Audit Enquiries Letter
- WHSSC and EASC Draft Accounts 2023-2024
- WHSSC Audit Enquiries Letter
- EASC Audit Enquiries Letter
- Audit Wales: Audit of the Financial Statements (ISA 260) Report (Including the Letter of Representation and Audit Opinion)
- Organisational Risk Register - Cyber Security Risks
- Audit Recommendations Tracker
- Financial Control Procedure – Medical Variable Pay

12:45 - 12:45
0 min

8. DATE AND TIME OF NEXT MEETING

Ian Wells, Chair

10 JULY 2024 TO APPROVE THE ANNUAL ACCOUNTS AND ACCOUNTABILITY REPORT

Agenda Item Number:

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

18 April 2024

Members Present:	
Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member (Vice Chair)
Rachel Rowlands	Independent Member
Geraint Hopkins	Independent Member
In Attendance:	
Sally May	Executive Director of Finance & Procurement
Gethin Hughes	Chief Operating Officer (in-part)
Sallie Davies	Deputy 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
Nathan Crouch	Audit Wales
Owen James	Head of Corporate Finance
Gareth Watts	Director of Corporate Governance/Board Secretary
Claire Brown	Head of Quality Assurance and Compliance
Kelly Eddington	Quality Assurance & Compliance Officer
Emma Walters	Head of Corporate Governance & Board Business
Kathrine Davies	Corporate Governance Manager (Secretariat)

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

	The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.
1.2	**Apologies for Absence** There were no apologies received.
1.3	**Declarations of Interest** There were no interests declared.
2.	**CONSENT AGENDA**
2.1	**FOR APPROVAL**
2.1.1 Resolution	**Unconfirmed Minutes of the Meeting held on 22 February 2024** The Minutes were **APPROVED** as a true and accurate record.
2.1.2 Resolution	**Unconfirmed Minutes of the In Committee Meeting held on 22 February 2024** The Minutes were **APPROVED** as a true and accurate record
2.2	**FOR NOTING**
2.2.1 Resolution	**Audit & Risk Committee Annual Cycle of Business for 2024-25** The Committee **NOTED** the Annual Cycle of Business.
2.2.2 Resolution	**Annual Report Timetable 2023-24** The report was **NOTED**.
2.2.3 Resolution	**Declarations of Interest and Gifts and Hospitality Report** The report was **NOTED**.
2.2.4	**Breaches To The Standing Orders** G. Watts presented the report that reported on a breach of the standing orders. The Chair referred to the timing of papers and queried whether it was within their gift to change the standing orders to provide more flexibility with preparation of reports. G. Watts advised that it would not be within the Committee's remit to change the standing orders as they were set out by Welsh Government. He advised that they were having ongoing discussions with the new Governance Lead at Welsh Government with regard to this

	issue and would provide a further update back to a future meeting of the Committee.
Resolution:	The Committee **NOTED** the report and **APPROVED** the Breach to Standing Orders being reported
2.2.5	**Committee Forward Work Plan**
Resolution	The Committee **NOTED** the forward work plan.
3.	**MAIN AGENDA**
3.1	**GOVERNANCE**
3.1	**Audit & Risk Committee Action Log** The Committee reviewed the Action Log and noted the following updates: G. Watts advised on the completed actions that had come out of the last meeting, which included the action arising from the Procurement and Scheme of Delegation report in relation to agency non-receipting and that it was proposed that there would be some joint workforce and finance work on agency processes supported by some further and advised that those discussions had taken place. He advised that the cross referral between the Committee and People and Culture Committee with regard to the Counter Fraud Report had now taken place and received by the People & Culture Committee on the 15th April 2024. G. Watts advised that there was one outstanding action highlighted in Amber with regard to Stroke and Ophthalmology reports and advised that this had been picked up with the Chief Operating Officer outside of the meeting with a detailed report being presented to the Quality & Safety Committee, which would be shared with Members once received. Resolution The Action Log was **NOTED.**
3.1.1	**Matters Arising not Contained within the Action Log** There were no matters arising.
3.2	**Committee Annual Self-Effectiveness Survey Outcome & Improvement Plan** G Watts presented the outcome of the survey and highlighted key updates. The Chair commented that it was disappointing that there had only been 5 responses received but noted that this was probably due to the transition of Committee Membership changes. The Chair suggested that when the year-end papers were presented to the June 2024 meeting it would be helpful to provide an explanation of the

Resolution Action	statement of internal control and the Assurance Framework for new members of the Committee. G. Watts advised that it was a low response but there were other opportunities to provide real time feedback, for example, at the end of the meeting. The Committee **NOTED** the report. To provide an explanation of the Statement of Internal Control and Assurance Framework at the next meeting of the Committee in June 2024.
4.	**SUSTAINING OUR FUTURE**
4.1 Resolution Action	**Local Counter Fraud Annual Report** M. Evans presented Members the report provides detail on tasks and actions undertaken with the four strategic counter fraud work areas. The Chair referred to the components in the Annual Report that were reporting everything as green and advised that there had been one amber component in relation to risk assessments for last year and one red. M. Evans confirmed that there had been and advised that he would amend the report to reflect this. The Chair suggested that the report, once amended, could be received on the Consent Agenda for the next meeting. I Wells advised that it was good to see the more informal involvement of staff and queried what the uptake was when they undertook these activities. M. Evans advised that they were seeing more contact from staff now when previously there was not a lot of uptake. He advised that they have been tracking contact made by staff across NHS Wales however, the data was not currently available, but they would be able to bring this back within the Key Performance Indicators for the August 2024 meeting. The Chair advised that the red item related to the Board Champion for Fraud that was the previous Director of Corporate Governance and the fact that there had been a gap in recruitment whilst waiting to appoint the new Director of Corporate Governance. The report was **NOTED.** Annual Report to be amended to reflect the previous red and amber components and brought back to the next meeting of the Committee.
4.2	**Local Counter Fraud Update Report** M. Evans presented Members the report that provides detail on tasks and actions undertaken with the four strategic counter fraud work areas.

Commented [SM(TMED1]: Please check with Gareth - I would assume that we are presenting the Statement of Internal Control rather than explaining it?

	M. Evans drew Members attention to the impending trial scheduled for early summer and noted that this might possibly attract media attention and would be resource intensive during that period of time. He advised that the National Counter Fraud Team would be working closely with the Communications Team on this. M. Evans advised that the staff survey had just been completed, the results of which would be included in the benchmarking report for the August 2024 meeting.
Resolution	The report was **NOTED.**
4.3	**Procurement & Scheme of Delegation Report** S. May presented the report for Committee and highlighted the position on procurement matters for the period 1st February 2024 to 31st March 2024. S. May drew Members attention to the list of single tender actions relating to Capital which largely reflected the significant additional capital funding had been received towards year end. S. May referred to the number of PO No Pay invoices on hold and advised that whilst there had been an improvement in recent months, this still remained a concern. She advised that the Finance and Procurement teams were continuing to engage with appropriate officers to communicate the importance of this process to meet the 95% target. The Chair referred to the Public Sector Payment Policy (PSPP) and queried whether the UHB would meet the 95% target. O. James confirmed that they had and advised that the report was up to the end of March 2024 so they did not have the most up to date data and this was due to the focus on year end and staffing capacity challenges within the team. The Chair congratulated the team on meeting the target.
Resolution	The Committee **NOTED** the position on procurement matters for the period 01.02.24 to 31.03.24; and **NOTED** the update regarding Purchase to Pay and achievement of PSPP target for period of 2023/24.
4.4	**Post Payment Verification Annual Report** The Chair advised members that this item had been deferred to the meeting to be held on the 20th June 2024.
4.5	**Progress Update on Grant Thornton Recommendations** V. Wallace presented the report that provided an overview of progress to date in delivery of the recommendations. S. May reminded the committee that they had just gone through the annual planning process for the Integrated Medium Term Plan (IMTP) in terms of

	agreeing investments. At this point in time there was no further money set aside for some priorities such as children's weight management service. S. May advised that it was important that all areas of the Health Board work within the context of the IMTP is approved by Board. V. Wallace advised that she would ensure that the comments were passed on. I Wells thanked S. May for clarifying the position. He referred to paragraph 3.5 and advised that the wording of this could be more positive and added that Wales had the worst child obesity in Britain and possibly Europe. S. May advised that it was worth noting that there were a range of other services available in regard to child obesity and they could amend this to reflect that. The Chair referred to 2.8 defining the Born Well Strategy where it stated that it was no longer appropriate and was amber. However, in 2.9 it described the workforce plan and was showing as green. She advised that the two were linked and that there was an inconsistency that required to be reviewed. She added that it also referred to Integrated Locality Groups rather than Care Groups. In response, V. Wallace advised that they did not have a Born Well Strategy but a Starting Well and Growing Well Strategy and confirmed that they would review the wording of this.
Resolution	The Committee **NOTED** the overview set out within the report and the progress made against each of the recommendations from the Grant Thornton review.
Action	To feedback the comments made by the Committee and to review the wording on 2.8 and 2.9 with regard to the Born Well strategy.
5.	**IMPROVING CARE**
5.1	**Annual Review: Risk Management Framework** G. Watts presented Members with the report and highlighted key updates to members. G. Watts extended his thanks to the Assistant Director of Governance and Risk for undertaking this work.
Resolution	The Committee **ENDORSED FOR BOARD APPROVAL.**
5.2	**Organisational Risk Register** G. Watts presented Members with the report and highlighted key updates to members.

	G. Watts extended his thanks to the Assistant Director of Governance and Risk for keeping the risk register up to date and for undertaking the risk training which had now reached over 600 staff across the organisation. I Wells commented that it was pleasing to see the Information Governance risk had reduced to a score of 9. He also referred to the risk 4632 with regard to stroke and the update that was providing more clarity. I Wells requested an update on risk 5276 with regard to the LIMS software. C. Hamblyn advised that she was unable to provide an update but would take this away as an action with digital and pathology colleagues and would provide an update for the May iteration. The Chair referred to risk 4103 with regard to the Ophthalmology Business Case Business Case completed for expansion of Ophthalmic Diagnostic and Treatment Centre community services in Maesteg and Ysbyty Cwm Cynon and queried whether this was a Capital Business Case aimed for Welsh Government rather than an internal Business Case and requested further narrative on this. C. Hamblyn advised that she had spoken to the Planned Care Group with regard to this and would take this back and request further detail. The Chair referred to the new risk 5417 on dental where it referred to ad hoc lists and advised that the narrative on the mitigating actions was not providing assurance to the Committee. C. Hamblyn advised that they had pushed back on this during the last iteration when they were working on the mitigating actions and this would be more robust for the next iteration.
Resolution	The Committee **NOTED** the report
Action	To review risks 5276 LIMS Software, 4103 Ophthalmology Business Case and 5417 Community Dental outside of the meeting for the next iteration of the Risk Register.
5.3	**Audit Recommendations Tracker** G Watts presented an update to the Audit & Risk Committee on reported progress of audit report recommendations and actions in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module. I Wells referred to page 4 of the report where it referred to the Audit Recommendations that had been completed or proposed for completion. He advised that the Bridgend Transfer of Service had not been completed as yet and queried why it had been closed. G. Watts advised that he would take this away as an action and review the detail on that. He added that anything that was proposed for closure would have to be taken to the Executive Lead.

	The Chair referred to recommendations that were fully completed awaiting approval but then stated that there is no update. She queried who the recommendations were awaiting approval from. C. Hamblyn advised that they would try to remain clearer moving forward and that they had taken on board the comments raised so that when it is presented to the Committee they are assured and that the recommendations would not be formally closed until the Committee can seek assurance that it has gone through the appropriate due diligence and governance processes.
Resolution	The Audit & Risk Committee **NOTED** the report.
Action	To review the Bridgend Transfer of Services closed recommendation outside of the meeting.
5.4	**Medical Rostering Report** S Davies provided the Committee with an update on the progress achieved in relation to the audit report on Medical Rostering. S. Davies advised that there were two outstanding recommendations, both of which were in hand. The Policy was being updated and would be presented to the Local Medical Council (LMC) in June 2024. She advised that the Study Leave policy was more complex due to staff in the Bridgend area having a different study leave policy to those staff in Rhondda Cynon Taff and Merthyr Tydfil. She added that they were proposing a single policy but due to the Transfer of Undertakings of Employment (TUPE) Regulations they were not currently able to do that. The Chair queried that even if the LMC approve could the staff who transferred over by TUPE remain on their existing terms and conditions of employment. S. Davies confirmed that this was correct.
Resolution	The Committee **NOTED** the report and the update provided.
5.5	**INTERNAL AUDIT**
5.5.1	**Internal Audit Progress Report** P. Dalton presented the progress report that provided the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at 10 April 2024. P. Dalton referred to page 3 of the report and the performance indicators and advised that the time taken for management response to draft report within 15 working days was showing as red. He advised that it was taken longer to move this forward and would remain red for longer than anticipated. The Chair referred to table 2 where the position had deteriorated from the last report received. P. Dalton advised that it was not anticipated that it would improve at this current time.

Resolution	The report was **NOTED.**
5.5.2	**Internal Audit Review – PCH Financial Management and Change Control Progress Report** E. Jones presented the report that had been given a 'reasonable' assurance rating. E. Jones drew Members attention to page 3 of the report that summarised the opinion for each objective and key recommendations within which were with regard to improved information to allow accurate payments and ensuring the Project bank account was operating as intended.
Resolution	The report was **NOTED.**
5.5.3	**Internal Audit Review – Management of Controlled Drugs** E Samways presented the review of the management of controlled drugs process that was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board. E. Samways referred to page 3 of the report and that the Executive Summary had provided an overall assurance opinion of 'reasonable'. The Chair queried why most of the recommendations were due to be completed over the summer months except for two and that the recommendation for the authorised signatory lists was not due to be reviewed until September. E. Samways advised that it was linked to the quantity of the lists as every ward and theatre has its own list and there is quite a volume of them that need reviewing. S. May, in response, referred to the red action in terms of the signatory lists and advised that it required a bit more urgent focus and suggested that she takes this away as an action outside of the meeting and will raise with the Chief Operating Officer and seek to provide more assurance to the Committee.
Resolution	The reported was **NOTED.**
Action	To raise the red risk re controlled drugs authorised signatories with the Chief Operating Officer to request further assurance that this is being urgently addressed
5.5.4	**Internal Audit Review – Gastro Intestinal (GI) Pathways** E. Samways presented the report on Audit of Gastro-Intestinal (GI) pathways demand management that was undertaken in line with the 2023/24 Internal Audit Plan for the Cwm Taf Morgannwg University Health Board.

	E. Samways advised that the review had received a 'reasonable' assurance opinion. She added that that there had been some concern with regard to the lack of policy in terms of operating procedures across the three sites, many of which were still in draft form and related to pockets of services as opposed to the service as a whole. G Hughes advised that they often had three ways of working within CTM due to historic models. He added that they had 9 different ways of working in GI due to them having both surgical pathways and medical pathways. However, they were receiving good clinical engagement and they were seeing improvements in the GI pathways which was helping to build the Directorate on a more stable ground. I Wells referred to the Welsh Patient Administration System (WPAS) integration on page 12 of the report where he advised that the narrative on the management response seemed a bit weak and had expected to see more detail on that. G. Hughes advised that he would take this back as an action outside of the meeting.
Resolution	The Committee **NOTED** the report.
Action	To review the management response with regard to the WPAS integration outside of the meeting.
5.5.5	**Internal Audit Review – Decarbonisation** E Samways presented the report on Audit of Decarbonisation was undertaken in line with the 2023/24 Internal Audit Plan for the Cwm Taf Morgannwg University Health Board. E. Samways advised that the Deputy Director of Strategy & Partnerships had been working closely with them on the audit. The review had provided a 'limited' assurance rating and they were now looking at the action plan and associated targets. She added that there were a number of areas where there was a mixed range of assurance and this was due to staff undertaking this work alongside their day jobs. However, a person had now been appointed and was dedicated to that role. The Chair referred to recommendation 4.1 in the management response were it stated that a fully costed plan should be developed. She advised that the practicality of doing that made it almost impossible and queried how this was going to sit on the Audit Tracker and where. S. May in response, advised that this was the first time she had seen this recommendation which was attributed to one of her staff whose role was to manage the Corporate Directorate of Planning and Partnerships. She added that this was a much broader issue and therefore the recommendation could do with a further review as there was a complex mix of revenue and capital issues to be addressed which asks the question whether there is a sufficiently detailed plan that can be costed, as in her

	opinion the current answer is probably did not. S. May suggested that V. Wallace should review the proposed actions at 4.1 and 4.2 with Internal Audit colleagues and that S May would contract her in this regard
Resolution	The Committee **NOTED** the report.
Action	To review the management response on recommendation 4.1 and bring back to a future meeting.
5.5.6	**Internal Audit Review – Digital Operating Model Follow Up Review** Paul Dalton presented the review of the Digital Operating Model that was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board. P. Dalton referred to page 3 of the report that showed good progress made and the large majority of actions completed with two waiting to be closed down. The review provided a 'reasonable' assurance opinion. The Chair commented that it was pleasing to see the progress being made.
Resolution	The Committee **NOTED** the report.
5.5.7	**Internal Audit Annual Audit Plan 2024-2025** P Dalton presented the report that sets out the internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. P. Dalton advised that the Internal Audit Plan also included the Internal Audit Charter. He referred to page 10 of the report that identified the high level areas that they would be looking to review during the next year. P. Dalton confirmed that the Plan was flexible and could be changed during the course of the year and would take a steer from the Committee on that. P. Dalton also referred to Appendix C and the standardised document setting out the relationship between Internal Audit and the Health Board. I Wells referred to other activities and in particular, the newly formed Joint Commissioning Committee and whether there were any previous audits from the previous three organisations that could be included in this. P. Dalton advised that there was one in 2023 that had been deferred and confirmed that they would be working with the Chief Commissioner and the team to discuss what they would be including within the Plan.
Resolution	The Committee: • **APPROVED** the Internal Audit Plan for 2024/25 • **APPROVED** the Internal Audit Charter; and • **NOTED** the associated Internal Audit resource requirements and Key Performance Indicators.

5.6	**AUDIT WALES**
5.6.1	**Audit Wales Audit & Risk Committee Update** M. Jones and N. Couch updated Members on Audit Wales current and planned accounts and performance audit work at Cwm Taf Morgannwg University Health Board. M. Jones advised on the process for receiving the Health Board Accounts and confirmed that an Extra Ordinary meeting of the Committee would be held on the 10th July 2024 to consider the position and a Special Board Meeting would be held on the 11th July 2024 to receive the audited documents for onward approval by the Auditor General on the 12th July 2024. The Chair referred to the accounts for the three former CTM Hosted Bodies that had now been amalgamated into the Joint Commissioning Committee, and queried whether they would have to be presented to the Health Board first for consolidation. M. Jones confirmed that they did and the team would consolidate them into the Health Board accounts. S. May advised that they would follow the normal process for the close down of the accounts and if there were any issues that arose they would be flagged to the Committee. Resolution The report was **NOTED.**
5.4.2	**Audit Wales Workforce Planning Audit** D. Murphy presented the report and highlighted key findings for Members attention. D. Murphy advised that the findings of the audit overall was that the Heath Board was focussed on significant workforce challenges. There was an improved understanding of current and future service demand and improved arrangements for engaging with internal and external stakeholders. D. Murphy advised that there was reasonable oversight of operational issues and that the People and Culture Committee were sighted on this. He thanked the Director for People and his team for their assistance with the audit. Resolution The report was **NOTED.**
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.
6.3	**Highlight Report To Board** The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.
7.	**PRIVATE/IN COMMITTEE SESSION** Members noted the following items were be discussed at the In Committee session: • Organisational Risk Register – Business Sensitive Risks • Audit Recommendations Tracker
8.	**DATE AND TIME OF NEXT MEETING 20 June 2024 at 10:15AM**

Agenda Item Number:

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

AUDIT AND RISK In-Committee Meeting

18 APRIL 2024

Members Present:

Patsy Roseblade	Independent Member (Chair)
Ian Wells	Independent Member (Vice Chair)
Geraint Hopkins	Independent Member

In Attendance:

Sally May	Executive Director of Finance & Procurement
Paul Dalton	NWSSP- Internal Audit and Assurance
Emma Samways	NWSSP- Internal Audit and Assurance
Gethin Hughes	Chief Operating Officer
Gareth Watts	Director of Corporate Governance/Board Secretary
Mark Jones	Audit Wales
Nathan Couch	Audit Wales
Kathrine Davies	Corporate Governance Manager

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:

- Kath Palmer, Independent Member
- Cally Hamblyn, Assistant Director of Governance & Risk

1.3 Declarations of Interest

There were no declarations declared.

2. MAIN AGENDA

2.1 Organisational Risk Register – Cyber Security Risks

G Watts presented the report for the Audit & Risk Committee to review and discuss the organisational risk register and consider whether the risks escalated to the Organisational Risk Register are in accordance with the Risk Management Strategy

I Wells commented that it was pleasing to see the updates to the red risks and that the Cisco ISE project had commenced in March 2024 to upgrade the wireless authentication system and also increase capacity for WiFi.

The Chair requested an update on risk 5602 which was now passed its review date. In response, G Hughes provided assurance to the Committee on the mitigating actions being taken to manage the risk and will provide further updates as required via the organisational risk register, including the impact on staff in terms of access arrangements.

Resolution: The Committee **REVIEWED** the risks escalated to the Organisational Risk Register at Appendix 1 and **CONSIDERED** assurance from the report that all that can be done is being done to mitigate the risks.

2.2 Audit Recommendations Tracker

G. Watts presented an update on the recommendations on the tracker with regard to the audit of accounts addendum review included within the report. He advised that this had been received by the Executive Leadership Group on the 15 April 2024 who supported the closure of the actions in the tracker as outlined.

M. Jones confirmed that Audit Wales will undertake a further follow up on all of these recommendations as part of the audit of the annual accounts.

Resolution: The Committee **NOTED** the report and **CONSIDERED** that sufficient assurance has been provided that due process in terms of the updates and closure of recommendations has been followed.

3. ANY OTHER URGENT BUSINESS

There was no urgent business to report on this occasion.

4. DATE AND TIME OF NEXT MEETING

20 June 2024 at 10:15am

Agenda Item
2.2.1

Audit & Risk Committee

Audit & Risk Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

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

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

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

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

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

4. Assessment

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

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

5. Recommendation

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

6. Next Steps

6.1 There are no next steps required.

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				⚑				⚑				⚑
National Clinical Audit Annual Plan	Medical Director	Annually						⚑						
Governance														
Action Log	Director of Corporate Governance	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑
Annual Financial Accounts	Director of Finance	Annually						⚑ Draft	⚑ Final					
Accountability Report (Including the Governance Statement)	Director of Corporate Governance	Annually						⚑ Draft	⚑ Final					
Annual Review of the Risk Management Strategy / Board Assurance Framework	Director of Corporate Governance	Annually				⚑								
Sustaining our Future														
Losses & Special Payments Report	Director of Finance	Quarterly		⚑				⚑		⚑				⚑
Procurements & Scheme of Delegation Report	Director of Finance	All Regular meetings		⚑		⚑		⚑		⚑		⚑		⚑

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**
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Patient Pathway Follow Up	Internal Audit	Further work required so now scheduled for presentation to the **15 August 2024 meeting.**
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.
Deferred from April 2024 Meeting	Deferred item	Financial Control Procedure – Medical Variable Pay (In Committee)	Medical Director	20 June 2024

Annual Cycle of Business – Deferred from April 24 Meeting	Annual Item (deferred)	National Clinical Audit Programme Update 2023 – 2024	Medical Director	20 June 2024
Deferred from April 2024 Meeting	Deferred item	Internal Audit Review - Mental Health Clinical Service Groups Review	Internal Audit	20 June 2024
Requested via email	IA Item	Internal Audit Review – Risk Management	Internal Audit	20 June 2024
Requested via email	IA Item	Internal Review – Medical Variable Pay Follow Up	Internal Audit	20 June 2024
Requested via email	IA Item	Internal Audit Review – Revised Decarbonisation Audit	Internal Audit	20 June 2024
Requested via email	IA Item	Internal Audit Review – Supply Chain Partner	Internal Audit	15 August 2024
Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – Quality Framework	Internal Audit	15 August 2024
Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – Reasonable Officer	Internal Audit	15 August 2024
Deferred from June 2024 meeting	Deferred Item	Internal Audit Review – PCH Key Project Objectives	Internal Audit	15 August 2024

COMPLETED ITEMS

Email from Director of	Additional Item	Progress update on Grant Thornton Recommendations	Executive Director of Strategy & Transformation	18 April 2024 – **Completed**

Strategy & Transformation				
Email from Director of People	Additional Item	Workforce Management – Audit Wales Report	Audit Wales	18 April 2024 – **Completed**
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – PCH Financial	Internal Audit	18 April 2024 - **Completed**
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Controlled Drugs	Internal Audit	18 April 2024 – **Completed**
Requested via email	Additional item	Progress Update on Grant Thornton Recommendations	Executive Director of Strategy & Transformation	18 April 2024 – **Completed**
Deferred from February 24 Meeting	Deferred Item	Internal Audit Report – Patient Pathway Follow Up	Internal Audit	18 April 2024

Agenda Item
4.1

Audit & Risk Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
Statws Cyhoeddi / Publication Status	Open/ Public Choose an item.
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

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

5. Recommendation

5.1 The 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 – 20 June 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	48	10
Ensuring that anti-crime measures are embedded at all levels across the organisation		
Inform and Involve	100	4
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.		
Prevent and Deter	148	14
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.		
Hold to Account	310	54
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.		
TOTAL	606	82

4. STRATEGIC GOVERNANCE

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

5. INFORM AND INVOLVE

A programme of general fraud awareness sessions has been established for 2024/25 and session date have been released to staff to allow self-booking on a convenience basis.

6. PREVENT AND DETER

A full review of existing fraud risk assessments has been undertaken to identify those assessment due for review. Additionally, risk assessments outstanding for completion have been prioritised for action based on current risk position. All existing and new risk assessments will be recorded on DATIX upon completion which will allow for easier management under existing processes going forward.

7. HOLD TO ACCOUNT

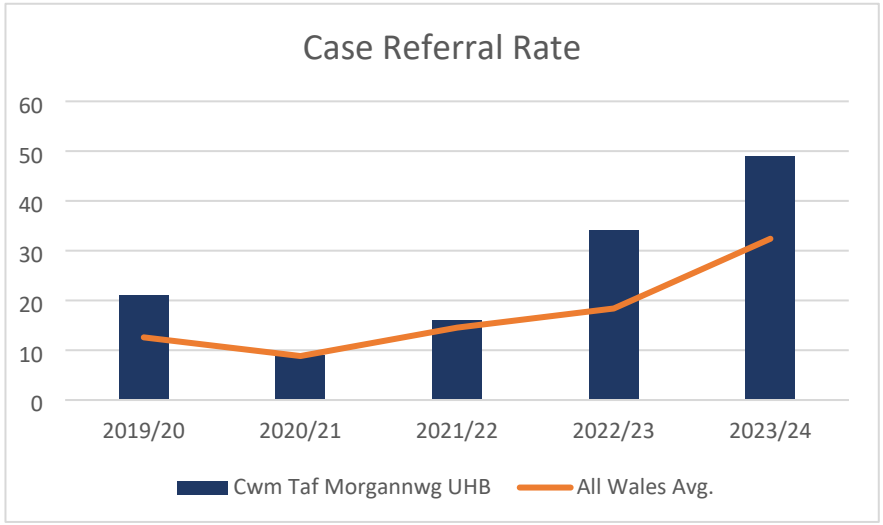
The status of the LCFS investigative caseload is summarised in Appendix 2 to this report. A summary of basic investigation KPI data is presented at outset of the appendix.
Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained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

Item 4.1 – Appendix 1

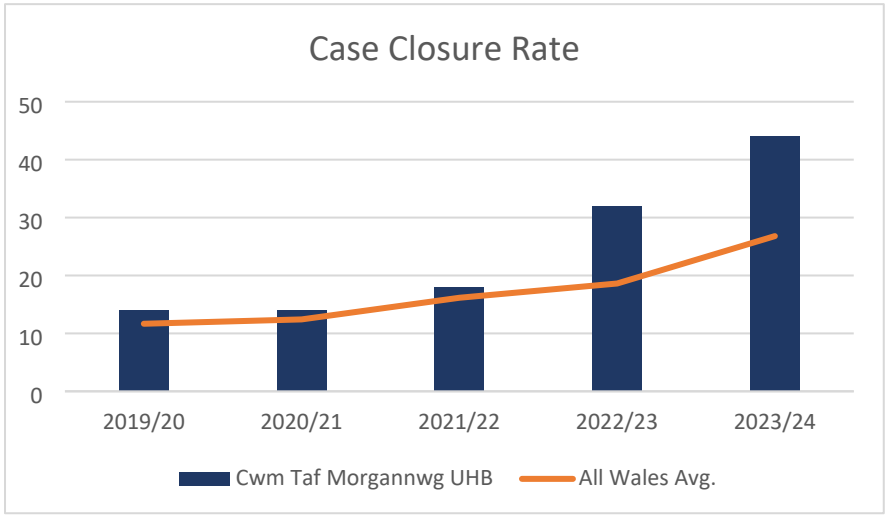
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Full Year

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	21	12.6
2020/21	9	8.8
2021/22	16	14.5
2022/23	34	18.4
2023/24	49	32.4



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	14	11.7
2020/21	14	12.4
2021/22	18	16.2
2022/23	32	18.6
2023/24	44	26.8



Counter Fraud Benchmarking Statistics – Full Year

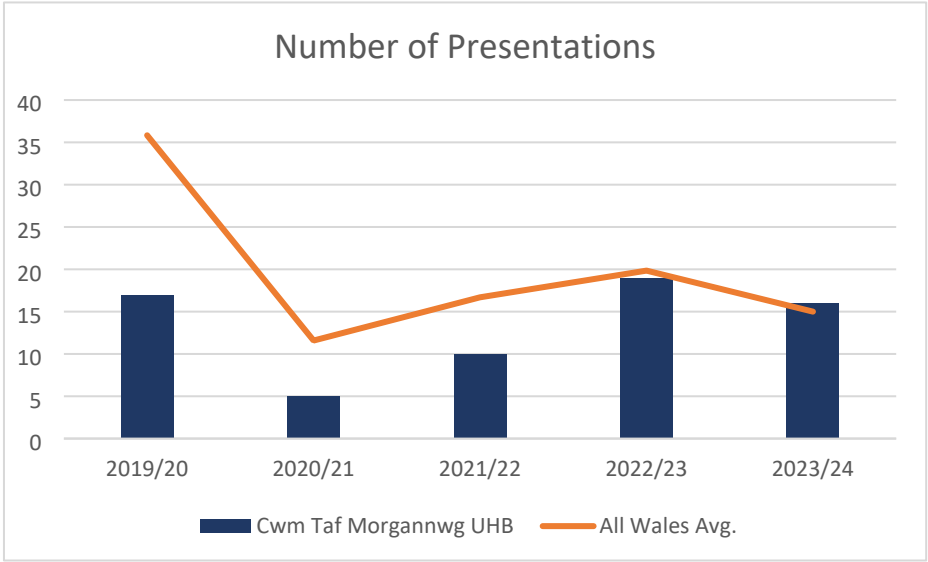
Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2019/20	11	21	14	18
2020/21	18	9	14	13
2021/22	13	16	18	11
2022/23	11	34	32	13
2023/24	13	49	44	14*

***4 Investigations Transferred to other NHS bodies for action**

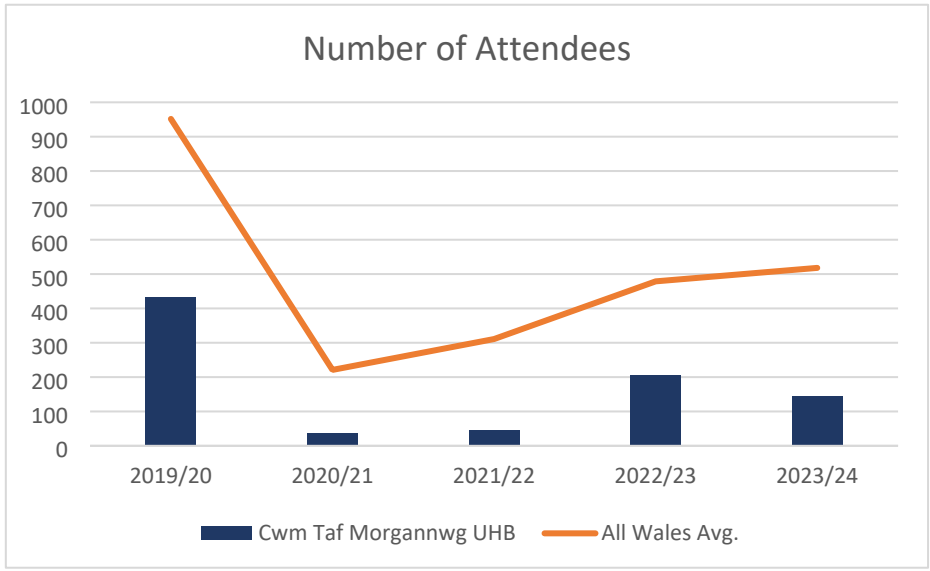
Sanctions	2020/21			2021/22			2022/23			2023/24		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	0	1	1	1	0	6	0	1	6	0	2	2
All Wales Avg.	0.8	1.8	1.6	0.4	4.0	3.0	0.7	2.8	4.6	0.7	2.9	4.9
All Wales Total	9	21	19	5	52	39	9	37	60	8	35	59

Counter Fraud Benchmarking Statistics – Full Year

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	17	36
2020/21	5	12
2021/22	10	17
2022/23	19	20
2023/24	16	15

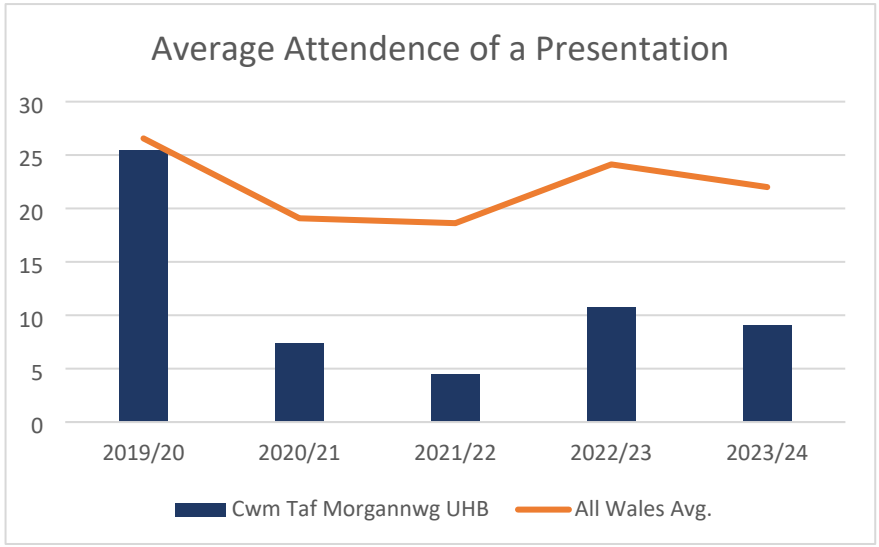


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	432	952
2020/21	37	221
2021/22	45	311
2022/23	204	479
2023/24	143	518

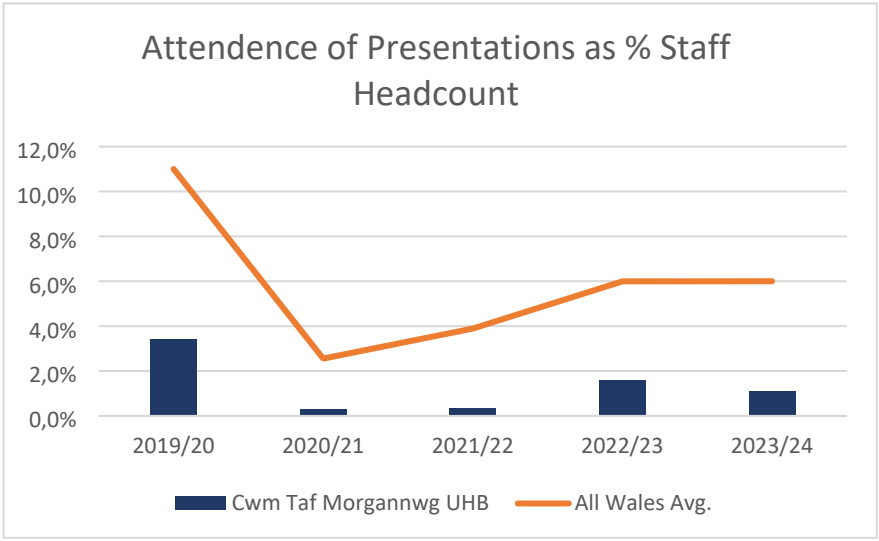


Counter Fraud Benchmarking Statistics – Full Year

Average Attendance of a Presentation	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	25	27
2020/21	7	19
2021/22	5	19
2022/23	11	24
2023/24	9	22



Attendance of Presentations as % Staff Headcount	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	3.4%	11%
2020/21	0.3%	2.6%
2021/22	0.4%	3.9%
2022/23	1.6%	6%
2023/24	1.1%	6%



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Cwm Taf
University Health Board

Item 4.1 – Appendix

Counter Fraud Investigations Update Report

Summary

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

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

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

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

Case Status

Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2024/25
17	0	6

Case Rates

Referrals Received 2024/25	Cases Under Investigation for Over 12 Months
8	2

Sanctions/Outcomes

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

Open Cases			
Reference Number	Date Opened	Allegation	Status
WARO/20/00032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	The subject 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 completed and trial is planned to commence at Cardiff Crown Court on 17 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/22/01136	18/08/2022	Unknown third party attending to complete an agency shift	Enquiries have corroborated referral information with witnesses with statements and documentation gathered. Digital forensics of mobile devices has been undertaken and evidence analysed. An interview under caution has been undertaken and an account gained. This investigaiton forms part of a wider investigative strategy with Home Office immigration and Police involvement. Case review underway to align and assess potential for CPS consideration.

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

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

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00067	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 have established that compensation has been paid previously for the member of public linked to NHS treatment. Enquiries are being undertaken to ascertain the exact nature of that compensation and whether any dishonesty is present in the context of the allegation.

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. Police are leading in this investigation; the Counter Fraud Team are in contact with the Police Drugs Liaison Officer for support and updates.
INV/24/00221	29/01/2024	Timesheet Fraud	Locum Doctor alleged to have been claiming incorrect rate and inflated hours. Allegation refers to claiming of on-site on call rate when actually absent. Additionally there appears to be inflation of hours claimed for weekends. Enquires have gathered timesheets and analysis is being undertaken.
INV/24/00223	29/01/2024	Timesheet Fraud	Locum Doctor alleged to have been claiming incorrect rate and inflated hours. Allegation refers to claiming of on-site on call rate when actually absent. Additionally, there appears to be inflation of hours claimed for weekends. Enquires have gathered timesheets and analysis is being undertaken. Further enquiries are being undertaken with the supplying agency seeking to corroborate and enhance current evidence.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00224	29/01/2024	Non-Completion of Contracted Hours	Allegation that Consultant has not worked job plan sessions following a denied request to drop sessions. Enquiries have established communications confirming what expectations are in relation to sessions. Further enquiries undertaken assess how firm existing job plan arrangements are for this consultant and to attempt to clarify what actual sessions have been completed during the period of concern. Further enquiries are being undertaken with the supplying agency seeking to corroborate and enhance current evidence.
INV/24/00465	23/02/2024	Authorisation of hours not worked	Concerns have been raised regarding bank staff submitting timesheets for hours beyond initially agreed shift hours and outside of hours of operation of unit worked at. Claims have been authorised by managers. Meetings have been held with senior managers and People Services colleagues to discuss concerns. Access has been gained to the allocate system and shift data gathered. Analysis is being undertaken. Enquiries established that staff identified had been uplifted in banding and hours authorised were intended to align with the pay of this higher banding. This appears to be a case of poor process rather than dishonesty.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/00789	25/03/2024	Pharmacy Contract Fraud	Allegation that a Community Pharmacy has provided false information on an application to be included on the Health Board's Pharmaceutical List. The potential false information relates to premises address and appears to be linked to a dispute around freehold/leasehold of the property. General Pharmaceutical Council have previously visited the contractor on two occasions and are satisfied with the operation of the pharmacy. The Pharmacy Team have sought legal advice on the matter from Legal and Risk. Following review this case was assessed as lacking any dishonesty and that the issues raised were technical and administrative with no concerns around the behaviour.
INV/24/00859	05/04/2024	Working elsewhere in receipt of occupational sick pay	Allegation that subject has worked for own photography business whilst absent due to sickness. Enquiries have established one instance of work completed on a weekend day during absence period. This falls under the criminal threshold and information has been shared with manager and People Services for review.

Open Cases			
Reference Number	Date Opened	Allegation	Status
INV/24/01164	07/05/2024	Falsified Sickness	Allegation that a staff member is absent due to workplace injury but has submitted photographs of injury which is believed to not be not them due to lack of a tattoo. Enquiries being undertaken to corroborate this allegation with parallel disciplinary ongoing.
INV/24/01324	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and timesheets obtained for review. Lines of enquiry will be established to cross reference working. A further reference has been created to separate subjects into individual investigations. INV/24/01334 is the linked reference.
INV/24/01334	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and timesheets obtained for review. Lines of enquiry will be established to cross reference working. A further reference has been created to separate subjects into individual investigations. INV/24/01334 is the linked reference.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
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 was not concluded as the subject resigned their position. An assessment concluded that the available evidence did not meet the criminal threshold of realistic prospect of conviction and case closure was sought as a result.
INV/24/00708	19/03/2024	Patient Prescription Fraud	A patient has been alleged to have registered at multiple GP Practices in the area and is seeking prescriptions for immediate need relating to pain. GP Practices have been approached to gather information around the registration of the patient and what information was provided by them to the Practices. Further checks undertaken to ascertain whether any other GP practices have registered this patient.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
			Controlled Drugs Accountable Officer has been made aware and an alert has been requested for dissemination to GP Practices to highlight the concerns. Evidence was established that the patient was unhappy with the service with their original GP and had sought to force the issue by presenting as a temporary patient rather than drug seeking behaviour.
INV/24/00897	10/04/2024	Non-completion of NHS time in Job Plan	Concerns raised that a consultant is not completing job planned activity. Concerns arose as part of job plan review and are centred on a high allocation of SPA in job plan and site referenced as working location was not frequented by subject. Enquiries established that SPA was included in job plan as a placeholder for other activity that was verified as completed. Site location in job plan was incorrect and subject had been attending a different site. Job plan was inaccurate and weak to rely upon. Job plan is being addressed and revised with Clinical Lead as part of review programme.
INV/24/01059	25/04/2024	Working elsewhere in receipt of occupational sick pay	Subject was witnessed to be entering a care home in uniform whilst absent from substantive Health Board role due to sickness. Enquiries with the care home established that no work had been completed by the subject during the absence period.

Closed Cases			
Reference Number	**Date Opened**	**Allegation**	**Outcome**
INV/24/01258	17/05/2024	Working elsewhere in receipt of occupational sick pay	Referral received via Fraud and Corruption Reporting Line alleging that subject tis absent from Health Board role due to sickness but has been working for friends cleaning company. Information supplied was lacking in detail. Enquiries established that subject is undertaking a University course unrelated to NHS role in spare time and had taken holiday in sickness period. No information was established to suggest work at cleaning company. Information was shared with subject's manager who is addressing via the sickness review process and was aware of holiday and course despite no formal declaration being made. Advice provided around this.

Cwm Taf Morgannwg University Health Board

Counter Fraud Annual Report 2023/24

Matthew Evans

18 April 2024

Table of contents

1. Introduction

This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Functional Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.

The Counter Fraud Work Plan for 2023/24 was approved by the Audit Committee in April 2022 and identified a total resource of 616 days for the year. The Counter Fraud Team delivered 604 days of counter fraud activity. The total cost for the provision of local counter fraud services for the year was £157,841.

For ease of reference and in line with the Work Plan, this report is structured under in line with Functional Standards Requirements of Counter Fraud activity. The annual report should be completed in enough detail to enable the responsible officers within the organisation to gain sufficient assurance that the counter fraud, bribery and corruption work undertaken is compliant with the Functional Standard Requirements and has been completed in line with organisations counter fraud workplan.

When the required work has not been completed against the counter fraud work plan or is not fully compliant with the Functional Standard Requirements details of the corrective actions to be undertaken should be reported.

2. Executive summary of organisational compliance

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2023/24 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic risk-based approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud activity. Flexibility contained in the work plan allowed high risk work to be undertaken urgently and dynamically.

Progress against the plan has been monitored during meetings with the Director of Finance, with update reports produced and presented to the Audit Committee in line with its agreed work programme.

The Counter Fraud Team continue to attend meetings and forums organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter Fraud Authority Training Delivery Leads to deliver key skills development sessions, refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. From 2021/22 NHS Wales adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. Counter Fraud work since that introduction has been focussed on building or maintaining compliance with the new standards. Since 2021/22 the Health Board has shown continual annual improvement in ratings against the Standards or maintained ratings. At the conclusion of 2023/24 the Health Board is assessed as Green overall with each of the 12 Components being Green rated for the first time.

3. Declaration of compliance against the Functional Standard Requirements at the end of March 2022

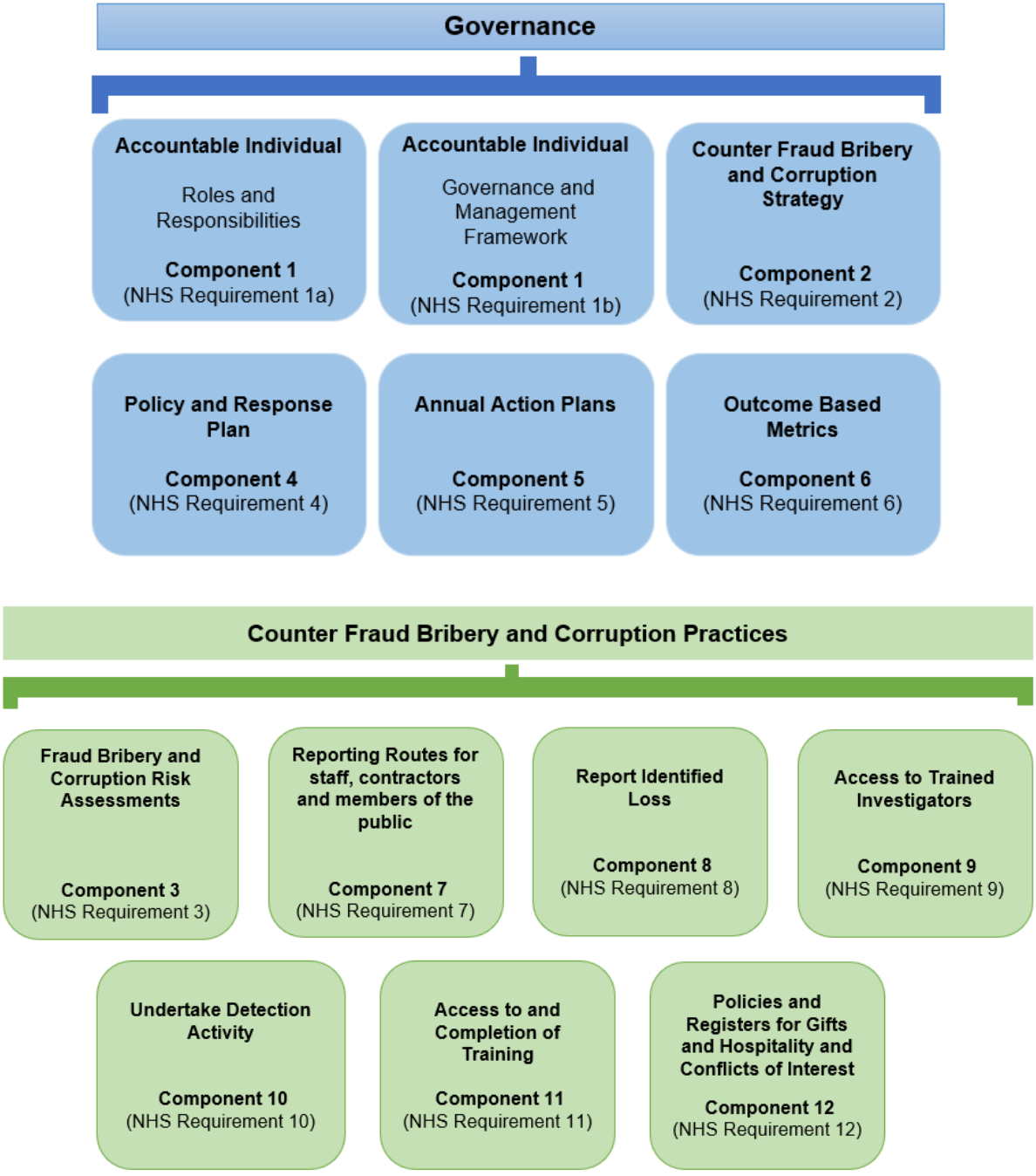
The annual report must contain one of the declarations listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2023/24 has been self-reviewed against the Functional Standard Requirements relating to fraud, bribery and corruption, and that the above rating has been achieved.

Organisation	**Cwm Taf Morgannwg University Health Board**
Accountable Board Member Signature	
Date	

4. Work carried out against the Functional Standard Requirements



Governance

This section of the annual report outlines how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption.

Work relating to each Governance Component of the Functional Standard is summarised and current and previous rating for each Requirement is set out below.

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 1 **Accountable individual**	**NHS Requirement 1A**	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in	RED	GREEN	NHSCFA proactive exercise reports have been presented to the Health Board's Audit

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
		gaining assurance and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.			Committee. A concluding report Quality & Assurance evaluation has also been presented to Audit Committee which highlighted work undertaken in response to findings. The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the template. This includes details of the Functional Standard Return for review. The Director of Corporate Governance has been nominated as the Fraud Champion supported by the Assistant Director of Governance and Risk. Support around the implementation of fraud risk recording via DATIX, furthering counter fraud awareness at induction under Corporate Governance input, and supporting work around Standards of Behaviour Policy fraud proofing.
Component 2 **Counter fraud bribery and corruption strategy**	**NHS Requirement 2**	This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is	GREEN	GREEN	The Health Board's Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
		aligned to the objectives of the strategy and locally identified risks.			fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. The CFP&RP and work plan are agreed by Director of Finance and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.
Component 4 **Policy and response plan**	**NHS Requirement 4**	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy. Staff awareness of these key policy documents is measured using questionnaires and a survey issued in March 2024.
Component 5 **Annual Action Plan**	**NHS Requirement 5**	This Component relates to the development and management of the organisation's annual counter fraud work	GREEN	GREEN	A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
		plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.			allocated in line with this within the context of 4 strategic areas of counter fraud activity; Inform and involve, prevent and deter, hold to account and strategic governance. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance and regular reporting to Audit Committee. Allocated resource is included as part of this regular reporting along with benchmarking of overall resource availability.
Component 6 **Outcome based metrics**	**NHS Requirement 6**	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	GREEN	GREEN	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism.

Counter Fraud Bribery and Corruption Practices

This section of the annual report outlines the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The organisation should report against each Counter Fraud Practice Component, under the Functional Standard and summarise the work completed to meet each Requirement. A high-level summary of each of the Counter Fraud Practice Components is set out below.

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 3 **Fraud bribery and corruption risk assessment**	**NHS Requirement 3**	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	AMBER	GREEN	Comprehensive risk assessments are carried out in line with the GCFP methodology and recording aligns to the Health Board's Risk Management Policy. The annual counter fraud work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments,

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					development of a fraud risk profile around core risk areas, implementation of managing fraud risk via DATIX, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments.
Component 7 **Reporting routes for staff, contractors and members of the public**	**NHS Requirement 7**	This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.	GREEN	GREEN	The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. Reporting routes are also highlighted within counter fraud awareness training, newsletters and communications, included on the Counter Fraud Intranet pages and highlighted in the Counter Fraud Information Booklet available for staff. Reporting routes include a central Counter Fraud email inbox, email and phone directly to LCFSs, a Microsoft Forms Fraud Reporting form, the National Fraud and Corruption Reporting Line as well as alternative reporting

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					routes to Director of Finance and whistleblowing charity Protect-Public Concern at Work. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of new investigations in 2023/24. Surveys have been undertaken in March 2024 to measure effectiveness.
Component 8 **Report identified loss**	**NHS Requirement 8**	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	GREEN	The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis.

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 9 **Access to trained investigators**	**NHS Requirement 9**	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.	GREEN	GREEN	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2023/24 was 2.6 FTE.
Component 10 **Undertake detection activity**	**NHS Requirement 10**	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	GREEN	GREEN	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					assessments are considered as part of this work and completed where necessary. As a result of this information and intelligence review process the Counter Fraud Team have registered local proactive exercises on the case management system in 2023/24.
Component 11 **Access to and completion of training**	**NHS Requirement 11**	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations and e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts. The awareness programme is sufficient to achieve a Green rating but is an area that is continually improvement. Work has been undertaken including risk based training resulting from proactive work, embedding of short from blog style communications which are driving

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					connections with staff with a more informal style. Contact with the Counter Fraud Team has increased and the Team have logged more referrals on the case management system than ever before as a result.
Component 12 **Policies and registers for gifts and hospitality and Conflicts of Interest**	**NHS Requirement 12**	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations. Testing of staff awareness of the Policy has been included in surveys issued in March 2024.

5. Appendices

Appendix 1 – Counter Fraud Activity

This section of the annual report should detail the total counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Area of activity	Days used
Proactive work	312
Reactive work	292
Total days used	604

Appendix 2 – Counter Fraud Costs

This section of the annual report should detail the total costs of the counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Cost of Counter Fraud, Bribery and Corruption Work	Total Costs £
Proactive costs	£81,534
Reactive costs	£76,307
Total costs	£157,841

Appendix 3 – Nominations Overview

This section of the annual report should detail the nominated officers at the organisation during the reporting period, including all supporting LCFS. If any of the nominations have changed during the year, the date of the change should be included.

The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B and 9.

Role	Name of Nominated Person
Accountable Board Member	Sally May
Audit Committee Chair	Patsy Roseblade
Fraud Champion	Gareth Watts
Lead LCFS	Matthew Evans
Supporting LCFS	Beverley Jones
Supporting LCFS	Alison Williams

Appendix 4 – Investigation Information

This section of the annual report should detail all the activity recorded on the CLUE Case Management System. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6, 7 and 8.

Investigation Information	Number
Investigations carried forward from 2022/23	13
Investigations Opened during the period	50
Investigations Closed during period	44
Investigations Transferred	4
Investigations Ongoing	15

Appendix 5 – Risk Based Exercises

This section of the annual report should detail all the Fraud Risk Assessments (FRAs), Local Proactive Exercises (LPEs) and System Weakness Reports (SWRs) undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the NHS Counter Functional Standard NHS Requirement 1B, 3, 5, 6, 8 and 10.

Fraud Risk Assessments	Number
Number of FRAs reviewed in line with the organisations risk management policy	6

Local Proactive Exercises	Number
Number of LPEs conducted during the year	25
Number of LPEs recorded on the NHS CFA Case management system as per component 8	25
Number of LPEs concluded during the year	21

System Weakness Reports	Number
Number of SWRs identified during the year	0
Number of SWRs concluded during the year on the NHS CFA Case management system as per component 8	0
Number of new processes adapted or introduced as a result of SWRs	0

Appendix 6 - Sanction & Redress Overview

This section of the annual report should detail of any sanctions and redress activity undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6 and 8.

Sanction Imposed	Number
Disciplinary	2
Civil	3
Criminal	0
Total Sanctions	5

Redress Imposed	Total Amount £
Fraud identified	£46,446
Fraud Prevented	£11,930
Fraud Recovered	£33,438

Agenda Item
4.2

Audit & Risk Committee

Losses and Special Payments 01.01.24 to 31.03.24

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James – Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May - Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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 3 month period from 1 January 2024 to 31 March 2024, as required by in Standing Financial Instruction.

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

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

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

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

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

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

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

a) 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 March 2024

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

Table 1

	31.03.24	31.12.23	31.03.23	31.03.22	31.03.21
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	94,478	92,859	72,198	65,127	86,029
Redress Medical Negligence claims/costs	372	484	385	235	269
GP Indemnity (Note 1)	612	134	0	0	0
Personal Injury claims/costs	917	794	701	611	436
Recoverable from Welsh Risk Pool	(106,450)	(101,213)	(83,623)	(93,074)	(114,863)
Net claim provision	**(10,071)**	**(6,942)**	**(10,339)**	**(27,101)**	**(28,129)**
Permanent Injury Benefit	3,755	4,252	4,077	6,201	6,320
Net Provision	**(6,316)**	**(2,690)**	**(6,262)**	**(20,900)**	**(21,809)**
Number of live cases on the Losses Register					
	31.03.24	**31.12.23**	**31.03.23**	**31.03.22**	**31.03.21**
Medical Negligence claims	339	343	334	299	309
Redress Medical Negligence claims	279	250	230	213	168
GP Indemnity claims	28	25	18	7	0
Personal Injury claims	113	105	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 March 24

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 (31.12.2023).

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

Table 2

	Year to	Year to	Year ended	Year ended	Year ended
	31.03.24	**31.12.23**	**31.03.23**	**31.03.22**	**31.03.21**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	31,542	25,647	17,386	1,945	13,110
Redress Medical Negligence claims/costs	380	254	711	170	305
GP Indemnity	626	141	6	1	0
Personal Injury claims/costs	831	617	822	772	316
Recoverable from Welsh Risk Pool	(31,173)	(24,870)	(16,858)	(1,210)	(12,449)
Net claim expenditure (Note 1)	**2,206**	**1,789**	**2,067**	**1,678**	**1,282**
Permanent Injury Benefit	132	402	(1,707)	286	470
Other	771	140	1,427	570	609
Total Net expenditure	**3,109**	**2,331**	**1,787**	**2,534**	**2,361**

Note 1: The annual budget for net claim expenditure for 2023-24 is £1,785k, actual expenditure for the year is £2,206k, therefore an overspend of £421k to March 2024. This overspend has a direct impact on the final position of the health board.

c) Cash Write-Offs made for the period 1 January 2024 to the 31 March 2024

Table 3 shows the cash impact to 31 March 2024 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

	01.01.24 - 31.03.24 £000	Previous Months	Total 2023-24 £000
Medical Negligence (Appendix 1)			
Claims	2,912	3,525	6,437
Costs	1,196	1,021	2,217
Defence Fees	167	440	607
Medical Negligence Totals	4,275	4,986	9,261
Redress Medical Negligence (Appendix 2)			
Claims	214	74	288
Costs	10	32	42
Defence Fees	14	49	63
Redress Medical Negligence Totals	238	155	393
GP Indemnity (Appendix 3)			
Defence Fees	7	7	14
GP Indemnity Totals	7	7	14
Personal Injury (Appendix 4)			
Claims	40	152	192
Costs	-12	270	258
Defence Fees	63	103	166
Personal Injury Totals	91	525	616
Permanent Injury Benefit (Appendix 5)	227	227	454
Permanent Injury Benefit Totals	227	227	454
Other (Appendix 6)			
Ex-Gratia	25	112	137
Debt Write Off	1	2	3
WRP Penalty Charge	3	17	20
Ombudsman	4	9	13
Employment Matter/Other	599	0	599
Other Totals	632	140	772
Total	5,470	6,040	11,510
Recovered from Welsh Risk Pool	(1,066)	(7,279)	(8,345)
Net Cash Write-Off	4,404	(1,239)	3,165

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 final revenue position.

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 £421k. 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 *(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: ☐
	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	Yes (Include further detail below)	

(Pobl /Ariannol) / **Resource Impact** *(People / Financial)*	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 January 2024 to 31 March 2024.
- **NOTE** the WRP overspend and the CTM share of overspend; which has been incorporated into the LHB's annual final revenue position.
- **NOTE** the overspend on net claim expenditure and the impact of this on the final in-year revenue position highlighted in Table 2. This expenditure is charged to the Patient Care & Safety revenue position.

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 01/01/2024 - 31/03/2024							Appendix 1
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
05RRSMN0039	0	8	0	0	8	139	147
10RYLMN0014	0	0	0	-84	-84	109	25
12RYLMN0004	0	5	0	0	5	477	482
12RYLMN0035	-850	7	750	0	-93	1 384	1 291
12RYLMN0037	200	1	0	0	201	331	532
13RYLMN0005	0	4	0	0	4	24	28
13RYLMN0096	0	2	0	0	2	750	752
15RYLMN0049	0	0	0	0	0	417	417
15RYLMN0106	65	6	0	0	71	122	192
15RYLMN0143	95	2	95	0	192	1	193
15RYLMN0199	0	8	0	0	8	9	17
17RYLMN0165	0	5	0	0	5	1	6
18RYLMN0029	25	0	0	0	25	6	31
18RYLMN0033	-1	0	0	1	0	25	25
18RYLMN0078	0	7	0	0	7	13	20
18RYLMN0085	0	0	0	-199	-199	224	25
18RYLMN0106	0	1	0	0	1	20	20
19RYLMN0030	0	0	0	-59	-59	84	25
19RYLMN0083	0	0	0	-134	-134	159	25
20RYLMN0009	0	0	0	-86	-86	111	25
20RYLMN0014	0	0	8	-86	-78	103	25
20RYLMN0018	0	0	0	0	0	13	13
20RYLMN0021	0	2	0	-125	-123	148	25
20RYLMN0027	20	0	0	0	20	94	114
20RYLMN0033	150	6	414	0	570	20	589
20RYLMN0037	75	0	418	0	493	817	1 309
20RYLMN0099	0	0	0	0	0	74	74
20RYLMN0108	0	4	0	0	4	7	11
20RYLMN0109	106	0	0	0	106	244	351
20RYLMN0112	0	3	0	0	3	7	10
20RYLMN0125	50	0	0	0	50	116	166
20RYLMN0129	180	1	0	0	181	1 214	1 395
20RYLMN0164	50	2	0	0	52	9	61
20RYLMN0170	0	0	0	0	0	12	13
21RYLMN0014	0	4	0	0	4	9	12
21RYLMN0016	5	0	0	0	5	78	83
21RYLMN0034	0	0	0	0	0	5	6
21RYLMN0035	75	2	0	0	77	9	85
21RYLMN0060	0	1	0	0	1	6	7
21RYLMN0077	100	8	50	0	158	223	381
21RYLMN0098	0	1	0	0	1	83	84
21RYLMN0119	0	1	0	0	1	19	20
21RYLMN0134	0	0	4	0	4	20	24
21RYLMN0136	0	4	0	0	4	0	4
21RYLMN0140	70	0	0	0	70	0	70
21RYLMN0147	38	0	0	0	38	47	85
21RYLMN0148	0	1	0	0	1	9	9
21RYLMN0149	0	1	0	0	1	3	3
21RYLMN0155	5	0	0	0	5	6	11
22RYLMN0008	0	2	0	0	2	6	8
22RYLMN0012	65	0	0	0	66	68	133
22RYLMN0027	0	0	0	-34	-34	59	25
22RYLMN0039	101	0	0	0	101	28	129
22RYLMN0053	0	0	0	-7	-7	32	25
22RYLMN0067	0	0	0	0	0	7	7
22RYLMN0096	0	1	0	0	1	3	3

22RYLMN0103	0	0	0	0	0	1	1
22RYLMN0113	0	3	0	0	3	16	19
22RYLMN0153	0	0	0	0	0	60	60
22RYLMN0159	0	4	0	0	4	4	7
22RYLMN0164	0	0	75	0	75	2	77
22RYLMN0169	0	9	0	-93	-84	118	34
22RYLMN0174	10	0	0	0	10	54	64
22RYLMN0182	0	3	0	0	3	10	12
22RYLMN0188	-9	0	0	0	-9	29	20
22RYLMN0190	45	3	0	0	48	30	78
22RYLMN0191	0	0	0	0	0	0	0
22RYLMN0201	0	2	0	0	2	0	2
23RYLMN0040	0	0	29	0	29	13	42
23RYLMN0042	0	0	0	0	0	3	3
23RYLMN0046	0	0	0	-3	-3	28	25
23RYLMN0051	63	0	175	0	238	9	247
23RYLMN0052	44	0	28	0	72	3	76
23RYLMN0061	33	0	0	0	33	15	48
23RYLMN0064	28	0	0	0	28	1	29
23RYLMN0068	0	4	0	0	4	0	4
23RYLMN0072	0	0	0	-5	-5	30	25
23RYLMN0073	0	0	125	0	125	4	129
23RYLMN0075	46	1	0	0	47	63	110
23RYLMN0079	29	0	0	0	29	126	155
23RYLMN0093	1	0	0	-13	-12	38	26
23RYLMN0095	16	1	0	0	17	46	63
23RYLMN0096	15	0	0	0	15	13	28
23RYLMN0119	0	0	180	0	180	4	184
23RYLMN0127	0	0	0	0	0	3	3
23RYLMN0136	0	2	0	0	2	0	2
23RYLMN0139	15	0	75	0	90	2	92
23RYLMN0141	13	0	0	0	13	9	21
23RYLMN0143	0	4	0	0	4	8	12
23RYLMN0153	0	0	125	0	125	4	129
23RYLMN0156	2	0	0	0	2	86	88
23RYLMN0157	0	2	0	0	2	21	22
23RYLMN0158	0	0	0	0	0	82	82
23RYLMN0170	0	2	0	0	2	4	6
23RYLMN0172	60	0	0	0	60	9	69
23RYLMN0177	10	0	0	0	10	5	15
23RYLMN0180	0	2	0	0	2	8	10
23RYLMN0193	0	0	55	0	55	4	59
23RYLMN0196	0	2	0	0	2	0	2
23RYLMN0202	32	0	17	0	49	16	64
23RYLMN0220	0	1	0	0	1	1	3
23RYLMN0222	0	5	0	0	5	5	10
23RYLMN0236	0	4	0	0	4	0	4
23RYLMN0239	0	3	250	0	253	11	264
23RYLMN0246	0	1	0	0	1	7	8
23RYLMN0247	25	1	20	0	46	0	46
24RYLMN0030	0	4	0	0	4	3	7
24RYLMN0032	35	2	0	0	37	0	37
24RYLMN0052	0	2	0	0	2	5	7
24RYLMN0061	0	0	0	0	0	7	7
24RYLMN0067	0	0	20	0	20	0	20
24RYLMN0082	42	0	0	0	42	0	42
24RYLMN0182	18	0	0	0	18	0	18
Total 01/01/2024 - 31/03/2024	**1 196**	**167**	**2 912**	**-** **928**	**3 348**		
Total						**9 018**	**12 365**

Redress Payments 01/01/2024 - 31/03/2024							Appendix 2
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
18RYLMN0124	2	0	0	0	2	42	44
19RYLMN0090	0	0	1	0	1	9	10
19RYLMN0105	0	0	0	-3	-3	5	2
20RYLMN0051	0	1	5	0	6	2	8
20RYLMN0082	0	0	3	0	3	1	4
20RYLMN0091	0	0	0	-25	-25	25	0
20RYLMN0106	2	4	0	0	6	0	6
20RYLMN0147	2	0	0	0	2	2	4
20RYLMN0183	0	0	2	0	2	3	4
20RYLMN0187	0	0	1	0	1	11	12
20RYLMN0191	0	1	8	0	8	-8	0
21RYLMN0042	0	0	0	-7	-7	7	0
21RYLMN0069	2	0	0	0	2	7	9
21RYLMN0139	0	0	0	-3	-3	3	0
22RYLMN0003	0	0	5	0	5	3	8
22RYLMN0026	0	0	10	0	10	14	24
22RYLMN0043	2	0	3	0	5	0	5
22RYLMN0046	0	0	1	0	1	0	1
22RYLMN0063	0	0	0	-3	-3	5	2
22RYLMN0082	0	0	10	0	10	2	12
22RYLMN0118	0	0	0	-25	-25	27	2
22RYLMN0119	0	0	2	0	2	0	2
22RYLMN0131	0	0	1	0	1	3	4
22RYLMN0137	0	0	-4	0	-4	5	1
22RYLMN0146	0	0	0	-0	-0	2	2
22RYLMN0179	0	0	0	0	0	1	1
22RYLMN0184	0	0	0	-20	-20	21	2
22RYLMN0186	0	0	18	0	18	2	20
23RYLMN0002	2	0	14	0	15	13	28
23RYLMN0020	0	0	1	0	1	0	1
23RYLMN0023	0	0	3	0	3	2	5
23RYLMN0027	0	6	8	0	13	0	13
23RYLMN0030	0	0	0	-1	-1	3	2
23RYLMN0058	0	0	0	-10	-10	10	0
23RYLMN0059	0	0	1	0	1	0	1
23RYLMN0090	0	0	11	0	11	0	11
23RYLMN0108	0	0	22	0	22	0	22
23RYLMN0111	0	0	0	-2	-2	2	0
23RYLMN0134	0	2	0	0	2	0	2
23RYLMN0147	0	0	18	0	18	0	18
23RYLMN0167	0	0	2	0	2	-2	0
23RYLMN0169	0	0	9	0	9	2	11
23RYLMN0229	0	0	0	-1	-1	2	2
23RYLMN0231	0	0	8	0	8	0	8
24RYLMN0001	0	0	0	-14	-14	14	0
24RYLMN0004	0	0	0	0	0	0	0
24RYLMN0005	0	0	1	0	1	0	1

Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
24RYLMN0012	0	0	1	0	1	0	1
24RYLMN0040	0	0	1	0	1	0	1
24RYLMN0073	0	0	7	0	7	0	7
24RYLMN0074	0	0	1	0	1	0	1
24RYLMN0076	0	0	11	0	11	0	11
24RYLMN0078	0	0	0	0	0	0	0
24RYLMN0083	0	0	2	0	2	0	2
24RYLMN0084	0	0	1	0	1	0	1
24RYLMN0107	0	0	3	0	3	0	3
24RYLMN0128	0	0	11	0	11	0	11
24RYLMN0146	0	0	1	0	1	0	1
24RYLMN0181	0	0	8	0	8	0	8
24RYLMN0202	0	0	3	0	3	0	3
24RYLMN0203	0	0	0	0	0	0	0
24RYLMN0205	0	0	5	0	5	0	5
24RYLMN0219	0	0	0	0	0	0	0
Total 01/01/2024 - 31/03/2024	**10**	**14**	**214**	**- 114**	**125**		
Total						**239**	**364**

GP Indemnity Payments 01/01/2024 - 31/03/2024							Appendix 3
Case Reference	**Costs £000**	**Defence Fee £000**	**Claims £000**	**WRP reimbursement £000**	**Total £000**	**Previous Write Offs £000**	**Cumulative £000**
23RYLMN0186	0	1	0	0	1	0	1
23RYLMN0204	1	4	0	0	5	1	6
23RYLMN0208	2	2	0	0	4	0	4
24RYLMN0207	3	1	0	0	4	0	4
Total 01/01/2024 - 31/03/2024	**6**	**7**	**-**	**-**	**13**		
Total						**1**	**15**

Personal Injury Payments 01/01/2024 - 31/03/2024							Appendix 4
Case Reference	Costs £000	Defence Fee £000	Claims £000	WRP reimbursement £000	Total £000	Previous Write Offs £000	Cumulative £000
22RYLPI0029	0	0	0	0	0	0	0
23RYLPI0008	0	0	0	0	0	0	0
20RYLPI0022	0	0	1	0	1	19	20
20RYLPI0030	0	0	7	0	7	0	7
20RYLPI0054	0	3	0	0	3	10	13
20RYLPI0055	0	3	0	0	3	1	3
20RYLPI0061	0	10	0	0	10	95	105
21RYLPI0007	0	1	0	0	1	75	76
21RYLPI0018	0	0	0	0	0	11	11
21RYLPI0025	0	0	0	0	0	1	1
21RYLPI0035	0	2	0	0	2	0	2
21RYLPI0040	0	0	0	0	0	2	2
21RYLPI0041	5	1	11	0	17	2	19
21RYLPI0043	0	1	0	0	1	1	2
22RYLPI0002	0	4	0	0	4	2	7
22RYLPI0005	0	0	0	0	0	34	34
22RYLPI0006	0	0	0	0	0	1	1
22RYLPI0013	0	0	0	0	0	1	1
22RYLPI0015	0	0	0	0	0	1	1
22RYLPI0016	0	0	0	0	0	1	1
22RYLPI0020	0	0	0	0	0	2	2
22RYLPI0023	0	0	0	-25	-25	50	25
22RYLPI0025	0	1	0	0	1	1	2
22RYLPI0030	0	1	0	0	1	27	28
22RYLPI0034	0	1	0	0	1	1	1
22RYLPI0035	0	1	0	0	1	53	54
22RYLPI0036	0	0	0	0	0	1	2
22RYLPI0037	0	0	0	0	0	2	2
22RYLPI0038	0	0	0	0	0	6	6
22RYLPI0042	0	0	0	0	0	1	1
23RYLPI0001	0	1	0	0	1	3	3
23RYLPI0003	0	1	0	0	1	2	3
23RYLPI0006	0	0	1	0	1	25	26
23RYLPI0008	0	4	0	0	4	1	5
23RYLPI0009	0	0	0	0	0	4	5
23RYLPI0010	0	0	0	0	0	1	1
23RYLPI0012	0	0	0	0	0	1	2
23RYLPI0014	0	1	0	0	1	1	2
23RYLPI0016	0	2	20	0	22	1	23
23RYLPI0017	0	0	0	0	0	1	1
23RYLPI0018	0	0	0	0	0	1	1
23RYLPI0019	0	0	0	0	0	1	1
23RYLPI0020	0	0	0	0	0	1	2
23RYLPI0025	0	0	0	0	0	0	1
23RYLPI0027	0	0	1	0	1	4	5
23RYLPI0028	0	0	0	0	0	1	1
23RYLPI0029	0	0	0	0	0	2	3

23RYLPI0032	0	0	0	0	0	1	1
23RYLPI0033	0	0	0	0	0	7	8
23RYLPI0037	-18	0	0	0	-18	141	123
23RYLPI0038	0	0	0	0	0	1	1
23RYLPI0039	0	0	0	0	0	1	1
23RYLPI0040	0	0	0	0	0	2	2
23RYLPI0041	0	0	0	0	0	1	1
23RYLPI0042	0	1	0	0	1	1	1
23RYLPI0044	0	0	0	0	0	1	1
23RYLPI0045	0	0	0	0	0	0	1
23RYLPI0046	0	0	0	0	0	1	1
23RYLPI0048	0	0	0	0	0	0	1
23RYLPI0049	0	1	0	0	1	1	1
23RYLPI0050	0	0	0	0	0	0	1
23RYLPI0052	0	2	0	0	2	1	3
24RYLPI0001	0	0	0	0	0	1	1
24RYLPI0003	0	0	0	0	0	1	1
24RYLPI0005	0	0	0	0	0	1	1
24RYLPI0006	0	1	0	0	1	1	1
24RYLPI0008	0	0	0	0	0	0	1
24RYLPI0009	0	0	0	0	0	0	1
24RYLPI0011	0	0	0	0	0	0	1
24RYLPI0012	0	0	0	0	0	0	1
24RYLPI0014	0	1	0	0	1	1	2
24RYLPI0015	0	0	0	0	0	0	1
24RYLPI0016	0	1	0	0	1	1	2
24RYLPI0017	0	1	0	0	1	0	1
24RYLPI0021	0	1	0	0	1	0	1
24RYLPI0022	0	1	0	0	1	0	1
24RYLPI0023	0	0	0	0	0	0	0
24RYLPI0024	0	0	0	0	0	0	0
24RYLPI0025	0	0	0	0	0	0	0
24RYLPI0026	0	0	0	0	0	0	0
24RYLPI0027	0	1	0	0	1	0	1
24RYLPI0028	0	0	0	0	0	0	0
24RYLPI0029	0	0	0	0	0	0	0
24RYLPI0030	0	0	0	0	0	0	0
24RYLPI0031	0	0	0	0	0	0	0
24RYLPI0033	0	0	0	0	0	0	0
24RYLPI0034	0	1	0	0	1	0	1
24RYLPI0037	0	1	0	0	1	0	1
24RYLPI0040	0	0	0	0	0	0	0
Total 01/01/2024 - 31/03/2024	**- 12**	**63**	**40**	**- 24**	**66**		
Total						**616**	**682**

Permanent Injury Benefit 01/01/2024 - 31/03/2024

Appendix 5

Laspar Number	In period Payments £000	Previous Write-Offs £000	Cumulative £000
01RRSPI0020	8	253	260
02RVEPI0001	4	73	76
02RVEPI0003	6	185	191
02RVEPI0004	4	127	131
03RRSPI0020	28	903	930
03RVEPI0028	7	275	283
04RRSPI0009	8	246	254
04RRSPI0024	7	172	179
05RRSPI0020	3	85	88
05RRSPI0021	7	204	211
05RVEPI0033	11	312	323
05RVEPI0034	3	92	95
08RVEPI0009	7	203	210
10RYLPI0070	4	115	119
11RYLPI0065	12	266	278
12RYLPI0059	4	81	85
13RYLPI0020	2	42	44
13RYLPI0050	7	156	163
98RVEPI0005	0	7	8
19RYLPI0022	24	353	377
20RYLPI0032	6	49	55
20RYLPI0033	3	21	23
20RYLPI0034	1	33	34
20RYLPI0035	12	97	109
20RYLPI0036	8	67	75
20RYLPI0037	3	23	26
20RYLPI0038	7	54	61
20RYLPI0039	5	41	46
20RYLPI0040	13	102	114
20RYLPI0041	8	68	77
20RYLPI0042	4	33	37
Total 01/01/2024 - 31/03/2024	**227**		
Total		**4 736**	**4 963**

Other Payments 01/01/2024 - 31/03/2024			Appendix 6
Case Reference	Type	Details	Amount £000
24RYLBD0008	BD - Bad debts	Inv 101051	0,38
24RYLEG0192	EG - Ex gratia payments	Lost Property	1,41
24RYLEG0194	EG - Ex gratia payments	Lost Property	0,78
24RYLEG0193	EG - Ex gratia payments	Retirement Vouchers	0,20
24RYLEG0195	EG - Ex gratia payments	Retirement Vouchers	0,38
24RYLEG0196	EG - Ex gratia payments	Retirement Vouchers	0,43
24RYLEG0197	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0198	EG - Ex gratia payments	Retirement Vouchers	0,34
24RYLEG0199	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0200	EG - Ex gratia payments	Retirement Vouchers	0,30
24RYLEG0201	EG - Ex gratia payments	Retirement Vouchers	0,28
24RYLEG0202	EG - Ex gratia payments	Retirement Vouchers	0,24
24RYLEG0203	EG - Ex gratia payments	Retirement Vouchers	0,47
24RYLEG0204	EG - Ex gratia payments	Retirement Vouchers	0,26
24RYLEG0205	EG - Ex gratia payments	Retirement Vouchers	0,22
24RYLEG0206	EG - Ex gratia payments	Retirement Vouchers	0,29
24RYLEG0207	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0208	EG - Ex gratia payments	Retirement Vouchers	0,22
24RYLEG0209	EG - Ex gratia payments	Retirement Vouchers	0,39
24RYLEG0210	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0211	EG - Ex gratia payments	Retirement Vouchers	0,41
24RYLEG0212	EG - Ex gratia payments	Retirement Vouchers	0,27
24RYLEG0213	EG - Ex gratia payments	Retirement Vouchers	0,22
24RYLEG0214	EG - Ex gratia payments	Retirement Vouchers	0,39
24RYLEG0215	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0216	EG - Ex gratia payments	Retirement Vouchers	0,39
24RYLEG0217	EG - Ex gratia payments	Retirement Vouchers	0,28
24RYLEG0218	EG - Ex gratia payments	Retirement Vouchers	0,33
24RYLEG0219	EG - Ex gratia payments	Retirement Vouchers	0,33
24RYLEG0220	EG - Ex gratia payments	Retirement Vouchers	0,20
24RYLEG0221	EG - Ex gratia payments	Retirement Vouchers	0,20
24RYLEG0222	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0223	EG - Ex gratia payments	Retirement Vouchers	0,33
24RYLEG0224	EG - Ex gratia payments	Retirement Vouchers	0,36
24RYLEG0225	EG - Ex gratia payments	Retirement Vouchers	0,22
24RYLEG0226	EG - Ex gratia payments	Retirement Vouchers	0,23
24RYLEG0227	EG - Ex gratia payments	Retirement Vouchers	0,41
24RYLEG0228	EG - Ex gratia payments	Retirement Vouchers	0,25
24RYLEG0229	EG - Ex gratia payments	Retirement Vouchers	0,42
24RYLEG0230	EG - Ex gratia payments	Retirement Vouchers	0,10
24RYLEG0231	EG - Ex gratia payments	Retirement Vouchers	0,24
24RYLEG0232	EG - Ex gratia payments	Retirement Vouchers	0,24
24RYLEG0233	EG - Ex gratia payments	Retirement Vouchers	0,24
24RYLEG0234	EG - Ex gratia payments	Retirement Vouchers	0,20
24RYLEG0235	EG - Ex gratia payments	Retirement Vouchers	0,37
24RYLEG0236	EG - Ex gratia payments	Retirement Vouchers	0,39
24RYLEG0237	EG - Ex gratia payments	Retirement Vouchers	0,22

24RYLEG0238	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0239	EG - Ex gratia payments	Retirement Vouchers	0,35
24RYLEG0240	EG - Ex gratia payments	Retirement Vouchers	0,28
24RYLEG0241	EG - Ex gratia payments	Retirement Vouchers	0,23
24RYLEG0242	EG - Ex gratia payments	Retirement Vouchers	0,38
24RYLEG0243	EG - Ex gratia payments	Retirement Vouchers	0,23
24RYLEG0244	EG - Ex gratia payments	Retirement Vouchers	0,36
24RYLEG0245	EG - Ex gratia payments	Retirement Vouchers	0,29
24RYLEG0246	EG - Ex gratia payments	Retirement Vouchers	0,38
24RYLEG0247	EG - Ex gratia payments	Retirement Vouchers	0,36
24RYLEG0248	EG - Ex gratia payments	Retirement Vouchers	0,20
24RYLEG0249	EG - Ex gratia payments	Retirement Vouchers	0,24
24RYLEG0250	EG - Ex gratia payments	Retirement Vouchers	0,21
24RYLEG0251	EG - Ex gratia payments	Retirement Vouchers	0,30
24RYLEG0252	EG - Ex gratia payments	Retirement Vouchers	0,21
24RYLEG0253	EG - Ex gratia payments	Retirement Vouchers	0,45
24RYLEG0254	EG - Ex gratia payments	Retirement Vouchers	0,38
24RYLEG0255	EG - Ex gratia payments	Retirement Vouchers	0,30
24RYLEG0256	EG - Ex gratia payments	Retirement Vouchers	0,36
24RYLEG0257	EG - Ex gratia payments	Retirement Vouchers	0,25
24RYLEG0258	EG - Ex gratia payments	Retirement Vouchers	0,27
24RYLEG0259	EG - Ex gratia payments	Retirement Vouchers	0,27
24RYLEG0260	EG - Ex gratia payments	Retirement Vouchers	0,36
24RYLEG0261	EG - Ex gratia payments	Retirement Vouchers	0,21
24RYLEG0262	EG - Ex gratia payments	Retirement Vouchers	0,26
24RYLEG0263	EG - Ex gratia payments	Retirement Vouchers	0,21
24RYLEG0264	EG - Ex gratia payments	Retirement Vouchers	0,34
24RYLEG0265	EG - Ex gratia payments	Retirement Vouchers	0,28
24RYLEG0266	EG - Ex gratia payments	Retirement Vouchers	0,23
24RYLEG0267	EG - Ex gratia payments	Retirement Vouchers	0,22
24RYLEG0268	EG - Ex gratia payments	Retirement Vouchers	0,29
24RYLEG0269	EG - Ex gratia payments	Retirement Vouchers	0,27
24RYLEG0270	EG - Ex gratia payments	Retirement Vouchers	0,39
24RYLEM0001	EM - Employment litigation	Settlement Agreements	22,27
24RYLEM0002	EM - Employment litigation	Settlement Agreements	61,45
24RYLEM0003	EM - Employment litigation	Settlement Agreements	25,50
24RYLEM0005	EM - Employment litigation	Settlement Agreements	30,00
24RYLEM0006	EM - Employment litigation	Settlement Agreements	7,50
24RYLEM0007	EM - Employment litigation	Settlement Agreements	9,03
24RYLEM0004	EM - Employment litigation	Settlement Agreements	443,02
24RYLLC0005	LC - Losses of cash	WRP Penalties	2,50
24RYLMN0178	Ombudsman	Damages	1,50
24RYLMN0187	Ombudsman	Damages	1,00
24RYLMN0198	Ombudsman	Damages	0,50
24RYLMN0206	Ombudsman	Damages	0,25
Total 01/01/2024 - 31/03/2024			**630,20**

Agenda Item
4.3

Audit & Risk Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James - Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

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

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

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 01.04.24 to 31.05.24

1.2 Purchase to Pay (PSPP)

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

1.3 Scheme of Delegation and Financial Control Procedures

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

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

2. Specific Matters for Consideration

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.04.24 to 31.05.24.

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 01.04.24 to 31.05.24

Table A – Single Tender Actions 01.04.24 to 31.05.24

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
CTM-STA-1731	Rev	Estates	Maintenance of life critical fire alarm systems across CTMUHB.	Morris Churchfield - Morris Line Engineering Limited	£90,620	(b)	TBC
CTM-STA-1732	Rev	ICT	FORUM Support & Maintenance	CARL ZEISS LTD	£17,249	(c)	02.05.24

CTM-STA-1734	Rev	Estates	Service and Maintenance of Steam Boilers at POW.	Byworth Boilers	£52,200	(c)	28.05.24
CTM-STA-1735	Cap	Estates	Relocation of existing Canon CT Scanner	Canon Medical Systems Ltd	£18,352	(b)	23.05.24
CTM-STA-1736	Cap	Estates	Relocation of existing Siemens Flurorscopy equipment	Siemens Healthcare	£75,336	(b)	29.05.24

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

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

None for this period

Table B - Single Tender Actions- Retrospective –

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
1722	Rev	Primary Care	The service provision requires appropriately trained security officers who are able to deal with any inappropriate, threatening and violent behaviour displayed by patients using this facility	Specialist Security Company Ltd	£34,560	(c)	22.04.24

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

None for this period

f) Summary of contracts awarded over £500,000

Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. Below is a retrospective summary of contracts awarded between 01.04.24 to 31.05.24

None for this period

g) 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 01.04-24 to 31.05.24:

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

h) Retrospective orders and non-receipting areas

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

Supplier	Areas	Value of retro orders	Comments
Blue Arrow	544063_LLW DOM TOP B	**£193,538.01**	Agency Staffing
	559148_Houskeeping YCC		
	555150 PCH ESTATES		
Boc Ltd	555100 PCH PHARMACY	**£37,992.42**	Industrial Gases and Equipment
	533044_DENTAL BRIDGEND CLINIC		
	533041_DENTAL SURGERY YNYSHIR		
Manpower UK LTD	555115 PCH DOMESTIC	**£37,376.37**	Agency Staffing
	555109 PCH CATERING		
	555150 PCH ESTATES		

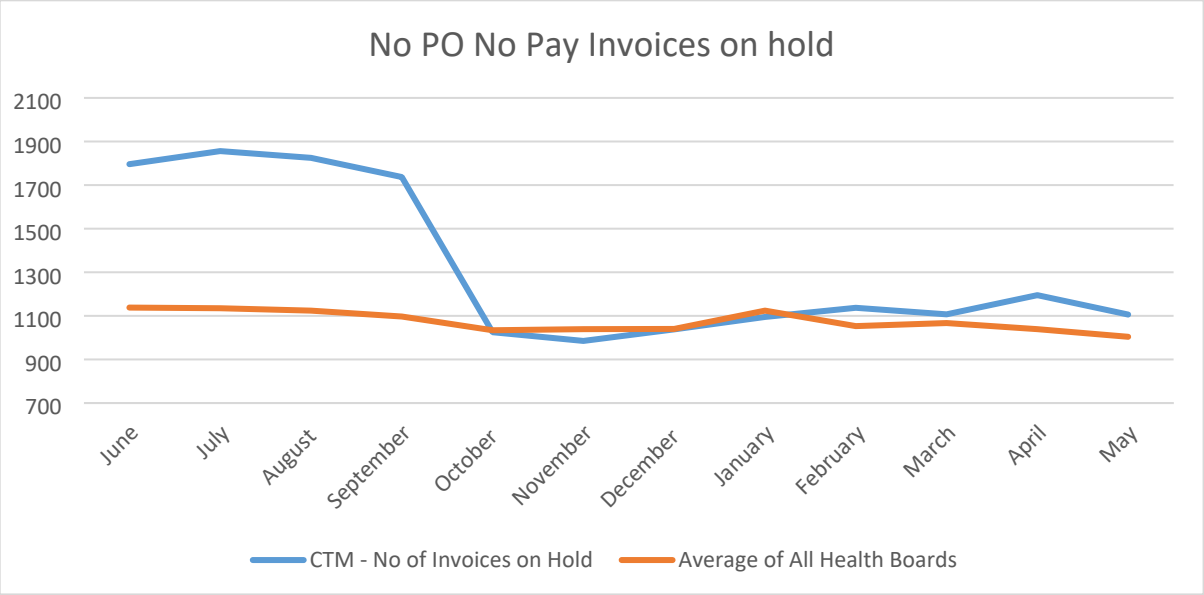
i) Consultancy Contracts

Below is a table detailing consultancy contracts that have been awarded between 01.04.24 to 31.05.24

Reference	Title	Supplier	Value	Date Awarded
T936/RFA1223	Cost Advisor Consultancy Services	Mott Macdonald Ltd	£20,242	18.04.24

j) No PO No Pay Summary

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



2.2 Purchase to Pay (P2P)

The PSPP figures are reported for period 1 of 2024/25, non-NHS invoices at 93.9% month 1 is below the target of 95% of invoices paid by number, however it is anticipated that this will improve for the remainder of the year and the target will be met by year end. The percentage for invoice paid by value is 92.7%, again it is projected that this will improve for the remainder of the year.

	0 - 30 Days		Total		%	
	Number	**Value**	**Number**	**Value**	**Number**	**Value**
Apr-24	22,259	35,686,635	23,700	38,481,025	93.9	92.7
YTD	**22,259**	**35,686,635**	**23,700**	**38,481,025**	**93.9**	**92.7**

The NHS invoice position continues to be challenging and shows that 85.4% (number) and 98.5% (value) of invoices were paid within 30 days to month 1 2024-25.

An All-Wales P2P governance group has been re-established with its first meeting taking place in May 2024. The Head of Corporate Finance will work closely with local procurement and accounts payable colleagues to work on improving the payment rate of NHS invoices, as well as establishing robust governance controls throughout the P2P process.

It is important for directorates to raise POs for both NHS and non-NHS goods & services in a timely and efficient manner.

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

Scheme of Delegation

A request has been made from the Executive Director with lead responsibility for CHC placements / packages for a change to the Scheme of Delegation. The requested change is detailed at Appendix 1, but is requesting delegation of authorisation of individual placements / packages with a value of up to £150,000 to the following:

- Ana Llewellyn, Nurse Director for placements / packages following recommendations from the Mental health and Learning Disabilities CHC Panel

- Lucie Williams, Nurse Director for placements / packages following recommendations from the Primary Care Community CHC Panel

Financial Control Procedures

There are a number of FCPs that have now passed their review date, however due to significant staff shortages on the financial accounts team due to long-term sickness and vacancies, the reviews have not been able to be carried out. There is a plan to review all outstanding FCPs over the summer with FCPs brought to Audit & Risk Committee for review and update by the end of the calendar year.

3. Key Risks / Matters for Escalation

3.1 Hospital Sterilisation and Decontamination Unit (HSDU) purchase Health Edge

- A capital business case was previously submitted by the PCH HSDU and was not approved. This decision was communicated to the individual who submitted the case.

- Subsequently eight separate revenue requisitions were raised, each for a sum under £5k (excluding VAT), for the system previously requested via the Capital Business Case. The total cost, including VAT, was £36,703, inclusive of VAT, with £15,283 relating to a hardware purchase which was later assessed as capital in nature. The capital element required retrospective approval by Executive Capital Management Group (ECMG). No procurement advice was sought and therefore no tendering process was undertaken.

- This appears to represent a deliberate sub-dividing of contracts to fall below a specific procurement threshold and is strictly prohibited (SFIs 11.11.3). Any attempt to avoid these limits may expose the Board to risk of legal challenge.

- It also appears to be a deliberate sub-dividing of purchases to fall below the capital threshold and thus circumvent capital approval processes. This action, during month 12, could have resulted in a breach of the UHB's statutory capital resource limit.

- This matter has been escalated to the Planned Care Group Director to determine the appropriate action with his team.

- Additional targeted training will be provided by Procurement to the relevant managers/budget holders.

3.2 **Payment of agreed 2023-24 NHS Wales invoices**

As part of the year-end closedown process all invoices between NHS Wales organisations are required to be agreed as part of an Agreement of Balance process.

Although NHS invoices are included as an exemption on the All-Wales No PO No Pay policy (i.e. they can be paid without PO) in Cwm Taf Morgannwg UHB, to ensure appropriate governance and control we request that requisitions are raised and approved for NHS invoices in the same way that they are for non-NHS invoices.

As previously reported to Audit & Risk Committee, there is a continuing issue with late payment of NHS Wales invoices, with payment within 30 days being far below that of NHS invoices and below the target of 95%. Despite the agreement of invoices being

made as part of the agreement of balances process, there was still an issue found with invoices not having POs raised and therefore not being processed in a timely and efficient manner.

By mid-May the health board were being chased for payment of a significant number of unpaid invoices relating to 2023-24 which while agreed at the year-end agreement of balances process, had not been paid by accounts payable due to having no PO. The month 1 monitoring return to Welsh Government also highlighted that CTMUHB has a high number of outstanding invoices over 10 weeks old that required payment.

Given this and the fact that these invoices had been agreed at year end and therefore have been fully accrued (accounted for) into the 2023-24 financial year, the Director of Finance agreed that these invoices can be paid without PO on this occasion.

This does not go against policy as NHS Wales invoices are on the No PO No Pay exception list, however it does go against CTMUHBs usual and expected P2P process. The number of invoices without PO at mid-May requiring payment was not insignificant at c.200 invoices, highlighting the issue the team is facing of directorates not raising POs in a timely and efficient manner.

The team is now working with accounts payable colleagues to process these payments as quickly as possible in order for them to be cleared in time for the month 2 monitoring return.

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 /	Not Applicable
	If more than one applies please list below:

Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*		
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:	
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	

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

5. Recommendation

5.1 The Audit & Risk Committee is asked to:

NOTE the position on procurement matters for the period 01.04.24 to 31.05.25;

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

NOTE the key escalation points raised in relation to non-compliance of procurement processes and payment of NHS invoices without PO.

ENDORSE FOR APPROVAL TO BOARD the update to the Scheme of Delegation detailed in Appendix 1.

6. Next Steps

6.1 If endorsed for approval take the updated Scheme of Delegation to the next Board for approval.

6.2 Carry out the actions in relation to training and communication in relation to the P2P process.

Request for changes to the Additional delegations linked to the SFIs

Please return completed form to Owen James - Owen.James2@wales.nhs.uk

SoD Ref.	SoD Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing		Cwm Taf Morgannwg proposed		Reason for the change	Requested by:	Requested timeframe for implementation
				Limits	Authority delegated to:	Limits	Authority delegated to:			
9. A4	17	Individual Continuing Health Care Placement / Packages	Authorisation of individual placements/packages following recommendation from the CHC panel	**i. Annual value up to £50,000** **ii. Annual value between £50,000 and £150,000** **iii. Annual Value over £150,000** **iv. Agreement of Changes to annual standard rates**	**i. Chair of CHC Panel** **ii. **Relevant Executive Director** **iii. Chief Executive and Director of Finance** **iv. Director of Nursing & Director of Finance**	**i. Annual value up to £50,000** **ii. Annual value up to £150,000** **iii. Annual Value over £150,000** **iv. Agreement of Changes to annual standard rates**	**i. Chair of CHC Panel** **ii. Relevant Executive Director / Nurse Director for** **iii. Chief Executive and Director of Finance** **iv. Director of Nursing & Director of Finance**		Executive Nurse Director / Deputy Chief Executive Officer	Immediate

Agenda Item
4.4

Audit & Risk Committee

Post Payment Verification End of Year Report 1st April 2023 – 31st March 2024

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Amanda Legge – All Wales Post Payment Verification Manager
Cyflwynydd yr Adroddiad / Report Presenter	Amanda Legge – All Wales Post Payment Verification Manager
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

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

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

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

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

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

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

2. Specific Matters for Consideration

2.1 The past year in 2023-2024, PPV began recovering from the backlog of work that we had, due to a new payment system within PCS and the inability for practices to submit NHS numbers to evidence their claims. This system was developed and enhanced which allowed us to return to Business as usual in April 2023, and has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

2.2 The following key points should be noted:

General Medical Services (GMS): Due to the backlog of PPV work across Wales, we created the visit plan for 2023-2024 to try to complete as many visits as possible that we could in the year with the aim of condensing our normal 3-year rolling plan into 2 years. We managed to complete all 172

routine visits across Wales with 13 for CTMHB. Regarding the revisits that were due in 2023-2024, and because we wanted to complete all routine visits along with Ad-hoc requests, we only managed to carry out a small number across Wales including 3 for yourselves.

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

General Ophthalmic Services (GOS): The visit plan for GOS 2023-2024 was not finalised after explaining to our HB's that these visits were subject to change due to a new way of verifying claims. PPV began remote access options having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful.

Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records and we did manage to complete 7 visits for CTMHB. Future visits will now be included in the 2024-2025 visit plan and is still changeable, and although we are hoping to increase the number of remote visits, we will also incorporate physical visits to carry us through this transition period of electronic patient records, which is being encouraged by Welsh Government.

General Pharmacy Services (GPS):
In 2023/2024 NWSSP/PPV introduced a new service check after a successful pilot, which was the Quality and Safety Scheme and completed all visits planned. We are also beginning the Collaborative Working Scheme verification this upcoming financial year 2024-2025. We can verify both these services remotely.

We are also investigating other avenues for PPV in GPS and beginning another pilot early this year.

Additional Services: After technical issues with our dispensing Data checks, and a lot of developing, we can now progress with our quarterly provision of these reports Nationally across Wales.

From the pilot we carried out and informing practices of the regulations surrounding dispensing eligibility, we have the data which shows the future success of this service.

Clinical Waste Self Assessments were piloted for GMS and have been Live this last year to ensure compliance with legislation. We are planning to conduct a pilot with the Self Assessments for Pharmacies in the next few months in 2024-2025.

Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes,

recommendations, and any risks. We are also investigating other avenues of savings from the provision of Clinical Waste services and now produce a 'non-collection' 6 monthly report to all our HB's.

There are bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. PPV are planning to commence a National GPS Working Group to align with the above which has proved successful.

PPV training events and roadshows to Practice Managers have been delivered locally and we now record these in advance, based on our trend data analysis. In addition to facilitating one-on-one training requirements, particularly for new practice managers, we created a video recorded guide for both GOS and GMS.

3. Key Risks / Matters for Escalation

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

4. Assessment

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

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

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

5. Recommendation

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

6. Next Steps

6.1 Produce Mid-Year Report

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
5.1

Audit & Risk Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
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	April / May 2024	RISKS REVIEWED
Operational Management Board / Offline via Email	April 20204	ENDORSED NEW RISKS FOR ELG
Executive Leadership Group (ELG)	13th May 2024	MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee	16th May 2024	ASSIGNED RISKS REVIEWED
Population Health & Partnerships Committee	20th May 2024	ASSIGNED RISKS REVIEWED
Digital & Data Committee	21st May 2024	ASSIGNED RISKS REVIEWED
Mental Health Act Monitoring Committee	5th June 2024	ASSIGNED RISKS REVIEWED
Health, Safety & Fire Sub Committee	19th June 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 3rd May 2024. Where review dates have passed and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

Training

2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.

2.5 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 **627** members of staff trained to date since training commenced in 2021.

2.6 Focussed sessions to discuss risk have 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:

- 40 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023).
    - 78% (31/40) provided a score of 5/5 in terms of content of the session
    - 20% (8/40) provided a score of 4/5 in terms of content of the session
    - 3% (1/40) provided a score of 3/5 in terms of content of the session

- 100% of the 40 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.

- 98% of the 40 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

- Some of the recent comments received through evaluation have been included below:
  From the session on the 2nd May 2024.
    - *"Clear guidance on what risks are how to score and actions."*
    - *"Clear explanations with good examples"*
    - *"All new info (to me), well presented. Thank you"*
    - *"Great insight clearly explained and would advise my team to attend".*
    - *Really good session. Friendly and informative."*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Children and Family Care Group

- Datix Risk ID 5755 - Princess of Wales Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 20.

Medical Directorate and Digital & Data Directorate

- Datix ID 5761 - Cross Health Board Data Sharing - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 16.

Finance Directorate

- Datix Risk ID 5764 - Failure to achieve the planned break-even position in 2024/25 - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 16.

- Datix Risk ID 5765 - Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 2 - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 16.

3.2 CHANGES TO RISKS

Medical Directorate Function

- Datix Risk ID 5640 - Potential Junior Doctors Industrial Action. Risk score reduced from a 20 to a 12 in May 2024. The rationale for change is that negotiations with UK Government is currently underway. This means that there is unlikely to be a strike until July/August at the earliest, and this is if there is no agreement made between Government and the BMA. Risk also reduced due to experience from the last 2 strikes and the ability to manage the impact on the Health Board. Risk will need to be reviewed if there are discussions/confirmation around another strike in the summer, based on pressures and staffing levels at the time.

Unscheduled Care (USC) – Care Group

- Datix Risk ID 1133 - Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). Risk score reduced from a 20 to a 12 in May 2024. USC Senior Management Team risk reviewed, nurse establishment invest to save paper under development unitising the RCN BEST tool (same tool used to review the Prince Charles Hospital nursing workforce 2021). In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff.

- Datix Risk ID 4732 - Lack of orthogeriatrician as NICE guidance and KPI1 NHFD. The USC SMT reviewed. Awaiting alignment of budgets, post phase 2 OCP. This forms part of the investment cycle for the financial period 24/25 and therefore risk has been de-escalated to a risk score of 12.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Diagnostics, Therapies, Pharmacy and Sciences Care Group

- Datix Risk ID 5602 - Door security in pharmacy Department at Ysbyty Cwm Rhondda (YCR) Hospital. Risk target score met so risk has been closed. The detail is captured in the report being received in the closed session of the Audit & Risk Committee.

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

Consequence						
	5			3337 3993 4080	4664 5276 5755	
	4				4337 4906 4809 3131 4671 4908 5404 5579 5658 5417 5765 4152 3133 4417 5374 5254 4907 5646 2713 5669 5761 5764	4491 4071 4103 3826 5590 5640 4632 5462
	3					4650 2808 5040 4672 4691
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 Emerging risks

- The Diagnostics, Therapies, Pharmacy and Sciences Care Group have indicated that the following risks, which have a current risk score of 15 and above, will be considered at the next Operational Management Board for consideration in terms of escalation to the Organisational Risk Register:
  - Datix Risk ID 5730 – No Health Board MRI Pacemaker Service
  - Datix Risk ID 5726 – Public Health Funding for Microbiology.

- The Patient, Care and Safety Team have indicated that they are currently reviewing the following risk to consider escalation to the Organisational Risk Register:
  - Investigation of post-April 2022 patient safety incidents of nosocomial COVID-19.

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	5755	Chief Operating Officer	Children and Families Care Group	Service Director - Children and Family Care Group	Improving Care	Environment /Estate/ Infrastructure	Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit	**If** the Air handling unit or the electrical system backups fail for the labour ward and neonatal unit template in POW. **Then** we do not have assurance that our backup systems will maintain critical equipment including ventilators, anaesthetic machines, pumps etc. and key life preserving equipment during clinical procedures. **Resulting in** harm to patients and potential for life changing consequences for mothers and babies.	All equipment is being assessed for battery backup. Emergency scenario planning will be arranged with Strategy team as a priority.	Capital resource has been approved and allocated to support the infrastructure work from Welsh Government during this financial year. Plans are being drafted for the temporary decant of services for the period of estates work.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	C3xL2	New risk escalated to the organisational risk register in May 2024	18.04.2024	18.04.2024	24.05.2024
3	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	**IF:** CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. **THEN** patients will not receive the necessary imaging **RESULTING IN** delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Update April 2024 - Swansea Bay University Health Board who supply CTMUHB's radioisotopes have instigated a brief firebreak in order to scale up their production. This would have had an impact on breast cancer surgery, however, the team have been able to use an alternative technique for this period, which has been used previously in Neath Port Talbot Hospital when part of the service was based there.	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	15.04.2024	20.05.2024
4	5276	Director of Digital	Central Support Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update May 2024 - CTMUHB have appointed internally into the 2 x fixed term band 7 clinical systems support roles for Pathology - once these posts have been backfilled these posts will be able to fully support LIMS implementation. The 1 x 8a fixed term clinical systems manager for Pathology has just gone out to advert, hoping to recruit externally - this post will provide project oversight and co-ordination. These posts will bring CTM in line with other Health Board's in terms of dedicated pathology IT support, however, Health Boards across Wales are looking for extra support in addition to this. Pathology continues to hold monthly LIMS deployment meetings with Digital Health Care Wales (DHCW) to facilitate progress.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	3.5.2024	31.05.2024
5	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 April 2024 - to align with the review of the Strategic Risk on the Board Assurance Framework, Planned Care and Unscheduled Care Group Service Directors have been asked to review this risk with a view to splitting it out to accurately reflect the performance and risk trajectories in each of these areas so they can be more clearly articulated. In terms of the management of flow CTMUHB is looking to transform the flow function across CTM to scope a flow hub 7 day week model of working (Currently in the early stages). Within Planned Care 6-4-2 embedded across the acute sites to support the maximum utilisation of theatres and outpatients, this is reflected in the current performance and reduction in waiting times in line with Welsh Government targets. The Navigation Hub is hugely successful and is constantly refining its ability to manage activity away from the Emergency Department. No change to risk score due to the review shortly to be undertaken.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	01.05.2024	30.06.2024
6	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 May 2024 - Risk unchanged. Sustained reduction in 104 day backlog. Improved percentage of patients informed that they do not have cancer <28 days. Reduction in USC and BSW endoscopy waiting times and now achieving 4 week standard for screening colonoscopy.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	26.04.2024	3.6.2024
7	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update April 2024 Previous high risk areas of the injection/macular clinic and the diabetic retinopathy service are now in a much better position with significant delays mostly eliminated. They remain vulnerable and work is ongoing to try and make them more robust and sustainable. CTMUH B did not have a substantive glaucoma consultant from 2017 to 2023. The glaucoma service is top of the list of services to fix but in the process of fixing it, we are going to come across many, many cases of avoidable vision loss. Aside from the human cost of avoidable blindness, there is a large financial and reputational risk to the HB. The glaucoma service is currently at score of 25 on risk matrix - catastrophic consequences (blindness in high volume of patients) (5) x almost certain to occur (5). This needs to be the highest priority area in ophthalmology for the HB. Cataracts and eye casualty are ongoing problem areas but are less urgent clinically than the risks outlined below. Major risks in ophthalmology at present 1) Glaucoma – glaucoma causes irreversible vision loss due to damage to the optic nerve. a. high volumes of long waiting patients. Many not seen for several years. Increasing Sis with severe harm as long-waiters finally being seen b. Large numbers of stage 4 glaucoma patients awaiting surgery, some for > 1 year. This is the highest risk glaucoma population. Patients are generally listed for surgery when medical treatment does not work – these patients are at high risk of vision loss with such long delays. Mitigating factors – we have 2 substantive glaucoma consultants, 1 locum consultant. Community glaucoma scheme and WGOS4 will allow some low risk patients to be monitored in the community Immediate actions: meeting next week to formulate plan for stage 4 patients Need decision on funding for diagnostic hub to increase capacity in glaucoma service 2) Medical retina a. Long delay for new appt. Few dedicated medical retina appointments. 3) Inappropriate discharge by outsourcing company in April 2019. a. ~3000 patients discharged after notes review by outsource company in April 2019. b. Was noted that many of these patients had sight-threatening disease and should not have been discharged. Some patients with ocular cancer received a discharge letter. c. Sample of 350 records reviewed in 2021: ~50% were appropriate discharge. 22% not appropriate. 23% uncertain. d. Initial plan was to review all notes of all discharged patients to ascertain if discharge was safe – this work still outstanding	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01.04.2014	26.04.2024	3.6.2024

	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
8	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 April 2024 - USC Care Group continue with new governance arrangements to give a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • Operational Performance Group and Stroke Programme board now fully established to focus on the performance and actions for improvement. • Consultant recruitment still remains challenged, no applicants when the job has been advertised. • On the 18th December the Brainomix AI Software (reporting for CTs and CT angiograms to minimise delays in referral for thrombectomy) was implemented and a report on its early stages was presented at February's Programme Board. It reported that whilst the access to view CT scans was much improved that the current stage of development of the AI was not sufficiently reliable for the reporting of scans. • The South Central Regional Stroke Programme continues in developing options towards a regional solution for stroke services. • Consultant vacancy - discussions are underway to explore opportunities for a Regional approach with Cardiff and Vale to support the Service. • In order to improve the performance of our Stroke service across both PCH and POW a proposal has been developed that would increase the CNS cover up to 12/7, due to limited number of strokes coming within the night. Operation proposal in progress, if approved and implemented this should contribute to improving the % of patients admitted to a stroke ward within 4 hours and the number of eligible patients thrombolysed door to needle time of >45mins. • A proposal has been made to expand the remit of the Stroke Data co-ordinator role at PCH to incorporate POW to achieve consistency of process and data collection and robustness across both sites. In addition to this it is inclusive of the operation proposal. • The Early Support Discharge Service has been extended to Bridgend to improve equity across the Health Board. • There are challenges to meet demand at the front door at both sites and achieve effective discharge pathways, this is impacting flow across the system, which is an issue in relation to the ring-fencing of Stroke beds, CT scans and conveyancing of self-presenting patients at RGH to PCH. This is not however a CTM only issue as reflected in the National Review of the impact of Flow on Stroke services. An improvement plan is in place to address the national recommendations. Risk rating to remain the same, 20. Next review date 30/06/24.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	03.05.2024	30.06.2024
9	5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	**If** there is insufficient capacity within the adult weight management service to meet the demand **Then** patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. **Resulting in** missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update April 2024 - Demand & Capacity continues to be reviewed each quarter. Q4, March 2024 showed a waiting List of 1500 patients, an increase from 1300 at Q3. Group education evaluation is positive, showing it is a suitable service model for 75% of patients requiring a level 3 service. This has increased service capacity by 50% compared to original service specification, however referral rates continue to exceed service capacity. Prescribing capacity for high-cost medications and implications for demand exceeding current funding has been agreed in collaboration with Medicines Management. Next rv 20.5.24	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	29.04.2024	20.05.2024
10	4664	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	Detail captured in closed session due to business sensitivities.										
11	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 April 2024 - The USC Senior Management Team (SMT) reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an Standard Operating Procedure (SOP) relating to fit2sit. The USC SMT continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Following the successful bid for Welsh Government funding for Royal Glamorgan Hospital nurse call bell and emergency call system within Ambulatory Emergency Care Unit (AECU), Prince Charles Hospital Ambulatory plans are in place to complete this work however there is a slight delay with this at present. This will improve patient experience within these departments. Work has commenced to create an action plan, linked to the quality statement for care in the emergency departments. Part of this work, will result in the development of an overcrowding score which should help reduce the risk of harm with overcrowding in the emergency department. This remains an ongoing risk for all 3 sites and is reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With sustained high level of escalation, risk rating to remain at 20. C4, likely hood 5. New review date 30/06/2024.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	3.5.2024	30.06.2024
12	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. As of March 2024, the update from DHCW is that they working on delivering the open architecture to support sharing documents and diagnostic results.	Quality & Safety Committee Digital & Data Committee	16	C4xL4	8 C4xL2	New risk escalated to the organisational risk register in May 2024	26.04.2024	26.04.2024	31.05.2024
13	5764	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to achieve the planned break-even position in 2024/25.	IF: The Health Board is not able to plan and deliver expenditure run rates that align with the available funding for 2024/25. THEN : The Health Board will not be able to deliver the planned break-even financial position for 2024/25. RESULTING IN : • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • Failure to deliver the financial plan for 24/25. • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 24/25. • Potential cash shortfalls in the latter months of 24/25	Financial Accountability letters issued from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	• Context: The Health Board has submitted a balanced financial plan for 24/25 but this plan includes significant risks, including the delivery of £26.3m of efficiency savings. The savings plans at the 26 March 24 total £23.0m with a RAG rating of £10.0m Green, £12.1m Amber and £0.9m Red. The following actions are to support savings plan identification, development and delivery: • Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Develop the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.	Planning, Performance & Finance Committee	16	C4xL4	12 C4xL3	New risk escalated to the organisational risk register in May 2024	30.04.2024	30.04.2024	31.05.2024
14	5765	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 2	IF: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding for 2024/25. THEN: The Health Board may not be able to deliver a break-even financial position for 2025/26. RESULTING IN : • The Health Board not being able to increase investments in services and/or reduce savings targets from current levels. • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • WG not supporting the Health Board's plan for 25/26 • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 25/26. • Potential cash shortfalls in 25/26.	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25.	Planning, Performance & Finance Committee	16	C4xL4	12 C4xL3	New risk escalated to the organisational risk register in May 2024	30.04.2024	30.04.2024	31.05.2024
15	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	**If...** Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. **Then...** the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. **Resulting in..** 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped form 48% to 80%. Children can only wait 8 wks form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update April 2024 - The Care Group have explored the mitigating action required to manage and reduce this risk and identified that the main mitigation will be the allocation of the adhoc additional lists by secondary care, however, these additional sessions are not yet confirmed. Until these sessions are confirmed this risk remains high. The Care Group are working through a plan around demand and capacity with the Planned Care – Care Group for additional theatre sessions but as indicated this has not yet confirmed. Once additional sessions are secured the risk will be reduced and be mitigated through to the backlog being resolved.	Quality & Safety Committee	16	C4xL4	9 C3xL3	↔	20.04.2023	18.04.2024	31.05.2024

	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
16	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care	**If** there is no dietetic service to POW critical care... **Then** this will impact on the safe and effective provision of nutrition and hydration to critically ill patients... **Resulting in** poorer nutrition provision and increased rated of malnutrition, which in turn lead to increased risk of infection, dependency on mechanical ventilation, poorer patient outcomes, increased length of stay and longer rehabilitation and recovery times following critical care. In addition to increased health utilisation costs, inequity of service provision across CTM critical care units, and non compliance with national standards and guidance as highlighted in critical care peer review.	At present there is no dietetic provision to POW critical care unit due to lack of specialist critical care dietitian on the POW site and lack of funding. Therefore the nutritional needs of critical care patients on the POW site are managed by the critical care Multi Disciplinary Team.	Update April 2024 - SBAR completed, meeting held on 10.4.24 between Head of Dietetics, Clinical Director for AHPs, Clinical Director for Critical Care and Clinical Service Group Manager . Next steps are to explore funding for proposed workforce via planned care board and Operational Management board. Next rv date 23.5.24.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	↔	19.12.2023	29.04.2024	23.05.2024
17	5669	Director of Digital	Central Support Function - Digital and Data	Assistant Director for Digital Delivery	Improving Care	Service / Business interruption	Increased cost of Citrix Subscription	**IF** the proposed increase in costs for providing thin client (Citrix) desktops to staff is not affordable or fully funded **THEN** Some or all of the staff that use Citrix will no longer be able to do so **RESULTING IN** Staff being unable to access local and national systems Citrix is used by staff to access Virtual Desktops from IGEL thin client devices - 4000 across. These devices only work with Citrix. Staff who access systems using Windows Laptops and PC's will be affected less severely, although many do use Citrix for certain functions. Aside from the CTM Local use and costs for Citrix - National applications that are delivered via Citrix are also in scope of the cost increase, and DHCW have indicated that any costs associated with this are likely to be passed on directly to the organisation.	Renewal costs will increase. Work underway with NHS Wales and Citrix to arrive at the best value licensing on an all Wales basis. CTM Renewal is March 2024, although an interim offer has been made which will take the renewal to December 2024 - allowing all NHS Wales organisations to align their renewals and for negotiations around licensing levels and quantities to be fully understood.	Update April 2024 Progress continues to mitigate the risk. A CTMUHB Task and finish group is now in place and meeting regularly. Significant investment has been made to buy PC to replace iGels, however resource to rollout the devices is constrained and an options paper is being drafted. Conversations with DHCW continue to co-ordinate a national response. Alternative technologies to Citrix have been identified, a small number of licenses have been procured to enable proof of concept testing.	Digital & Data Committee	16	C4xL4	2 (C1xL2)	↔	12.01.2024	25.04.2024	31.05.2024
18	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. Update March 2024 - Phase 1 of RCRP commenced 26/02/2024. Head of Nursing for MHLD Care Group is tactical lead. Awareness sessions attended by over 250 staff. Health Board wide planning meeting continues to meet. Daily troubleshooting Multi-agency meetings with South Wales Police continue. Update April 2024 - progress remains as captured in March 2024 and the next review date of this risk is scheduled for the end of May. No change to mitigation and risk score at this time.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	06.03.2024	31.05.2024
19	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	**IF** there is consistent backlog of Radiology reports **THEN** there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes **RESULTING IN** deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Update April 2024 - Review monitoring of additional funding. Vacancies.	Quality & Safety Committee Planning Performance & Finance Committee	16	C4xL4	4 C4xL1	↔	08.02.2017	15.04.2024	20.05.2024
20	5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	Update April 2024 - - Risk descriptor changed on this risk review. Business case finalised, and presented to Creating Health Steering Group 18.04.24. Proposal endorsed and the agreed next steps are to identify sources of funding. Next rv 25.7.24.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	29.04.2024	25.07.2024
21	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 May 2024 - Overtime work continues on redress backlog. New invest to save bid is to be updated with estimate of any potential change to thresholds from £25k to £50k (as per proposed Putting Things Right consultation). The demand versus capacity report has provided a snapshot of current position and has prompted a review of all case files. A review and reallocation of all redress cases will take place in May 2024. Redress is an area of high risk and will need some funding if the threshold changes from £25k to £50k as proposed in the Putting Things Right changes.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	22.04.2024	01.06.2024
22	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 May 2024 - New reports are required for the Care Groups. Inquests continue to be graded to identify high risk inquests (Red, Amber and Green). In April 2024, a data reconciliation took place with HM Coroner's Office, which allowed just over 50 cases to be closed and any outstanding information was highlighted. Communication channels remain open between CTMUHB and HM Coroner's Office. The demand versus capacity report has provided a snapshot of current position and has prompted a review of all case files. A review and reallocation of all Inquest cases will take place in June and July 2024. Care Group Governance meetings continue to be managed in a locality format therefore Legal Services team do not have capacity to attend all meetings. A new report is being devised by the BI team to support Care Groups.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	22.04.2024	01.06.2024
23	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences 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 April 2024 - Backlogs have improved with the use of medi-link. A bank APT has left however so we are short 1 APT, we are using a locum APT 1 day per week to support the Forensic service whilst UHW is undergoing re-furbishment.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	08.04.2024	08.05.2024

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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 Sciences 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 April 2024 - Mortuary staff resource is currently unstable due to some bank staff leaving making it difficult to efficiently move bodies. We are currently at 67% occupancy however this is including Nutwells contingency storage. Could potentially be de-escalated from the organisational risk register, however approval and further information will be required from the service manager prior to any de-escalation.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	08.04.2024	08.05.2024
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 May 2024 - Overtime continues to reduce the backlog of redress cases. Redress remains a risk area, particularly if the threshold increases from £25k to £50k following the PTR consultation. The demand versus capacity report has provided a snapshot of current position and has prompted a review of all case files. A review and reallocation of all redress cases will take place in May 2024.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	22.04.2024	01.06.2024
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.	Update April 2024 - Sustainability post approved and soon to go live for recruitment. Further mitigation action is to undertake work to assess the environmental impact of projects and programmes that are not classed as "sustainability" projects/programmes. Currently score remains unchanged.	Population Health & Partnerships Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	19.04.2024	31.07.2024
27	3133	Executive Director of Nursing / Deputy Chief Executive	Patient Care and Safety	Head of Clinical Education	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 March 2024 - New module of training and education related to medical gases has been introduced in collaboration with Learning & Development and All Wales ESR Team to improve compliance and flexibility for all relevant staff to undertake training. Risk score to remain unchanged until training embedded. Update May 2024 - Learning and Development function have supported the sourcing and roll out of an e-learning module for medical gas testing. The risk has remained at this score subject to assessment of the impact and uptake of the e-learning module.	Quality & Safety Committee. People & Culture Committee.	16	C4 x L4	8 (C4xL2)	↔	01.05.2018	07.05.2024	31.05.2024
28	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	Update April 2024 - -MRI van operational 22.4.24 Non Obstetric Ultrasound, decreased waiting list. 3865 CT increased demand 3021 Van to be cited at PCH (to cover building work) - explore costs to extended with and without staff. Out of hours staffing an issue across all sites.	Quality & Safety Committee	16	C4 x L4	4	↔	01.06.2020	15.04.2024	20.05.2024
29	4337	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Digital Systems	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	**If:** The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers **Then:** The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	**Key Controls** 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems, the ABHB Clinical Workstation or Local Authority system Numerous delays in NHS Wales progressing open architectural approach which results in CTM UHB being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Update April 2024 - Progress is being made with consolidation/merger of the clinical systems to provide single departmental solutions across CTM to allow for better patient experience and help service redesign. The Welsh Patient Administration System (WPAS) merger is still on track for May 2025 this will deliver a single Patient Administration System (PAS) solution across CTM which is then the platform to look at how CTM delivers services. There is on going work with Digital Health Care Wales (DHCW) to ascertain the impact of the WPAS merger on the National suite of systems and how the changes will impact data and data flows.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	25.04.2024	31.05.2024
30	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	A training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. **If** the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. **If** there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. **If** the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery **then** advice to clinical areas is greatly reduced. **Resulting in** non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Update April 2024 - Additional Training Resource Required - Discussions are still underway with Mental Health and draft Business case developed and discussed - this position has not changed since last update. Timeframe for action 30.06.2024. Module D PMVA Training Provision / Programme Delivery - 5/3/24 Discussed concerns regarding the training programme trainers making themselves unavailable to deliver , withdrawing , courses being cancelled at the Mental Health and Safety meeting. Deputy HoN in MH Team requested to provide an updated proposal paper. Timeframe for action 6-8.2024.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	02.01.2024	31.3.2024

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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
31	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 April 2024 - LFER status is regularly monitored in: Q&S Business 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. One penalty received in respect of one outstanding deferred LFER. Regular review and liaison with the Heads of Quality & Safety. Linking with the WRP Safety Learning advisor for any problematic LFERs. Proactive management of LFERs is proving beneficial. Proactive management and monitoring will continue. Updated May 2024 - LFERs continue to be monitored in: Q&S Team Business meeting, and Weekly Executive Patient Safety Meeting and Quality & Safety Committee.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	22.04.2024	01.06.2024
32	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 March 2024: Update from Health & Safety Co-ordinator and Head of Business Support. Night shift / Out of Hours observations was completed for Princess of Wales and the report uploaded to document section. Meeting held with Head of Business Support for the Chief Operating Officers team on 4 March 2024 to plan acute site assessments looking at arrangements in all ward areas for access. The first assessment will happen on Monday 11 March at the Royal Glamorgan Hospital, to be followed by the other DGH sites and also Community Hospitals. A template has been developed as a starting point for discussion – and will look at current and preferred arrangements, demographics of ward, CCTV, staffing and any other implications. It is anticipated that after the first day's assessment, the process will develop as the themes come more sharply into focus. Update May 2024 - No change to risk score or mitigation. Further review scheduled for 30.05.2024.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	17.04.2024	30.05.2024
33	4671	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	Detail captured in closed session due to business sensitivities.										
34	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	Update March 2024 - led by the Change Hub Programme Team, in collaboration with the Care Group leads and Chief Operating Officer, the Medical Workforce Productivity Programme (MWPP) has now been reformed to focus its efforts on workforce performance across the health board. There are now two accountability groups that meet monthly (Performance and Escalation Group & Workforce Framework Group) - these feed in to the MWPP, Value and Efficiency, and then Transformation Board. No change to risk score. Update April 2024 - risk mitigation remains as reported in March 2024. No Change to risk score.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	04.03.2024	31.05.2024
35	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	3.5 wte AHP/Nurses successfully appointed, starting June/July 2024 Demand and capacity modelling completed. Merging of Community and ND waiting lists to enhance capacity has taken place. Capacity available should meet demand following 3.5 wte commencing in post. However, this does not account for the average 20% increase in referrals accepted each year. This also doesn't address the backlog of patients already on W/L. (SBAR developed and presented at OMB seeking 2.0 wte B7 AHP for 2 years to clear backlog. SBAR also submitted for PCR monies) NDIP funding for 24/25 awaiting final agreement (funds to include WLI clinics, additional overtime for A4C staff, medicine costs and ADOS training).	Update May 2024 -Consideration required for further investment in service to address backlog of longest waiters. Funding for 2024-2025 from WG still on hold - funding from this will help address backlog but not provide the required capacity.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	08.05.2024	08.07.2024
36	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 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. Update May 2024 - status of the Fire Enforcement Notice remains as outlined in January 2024. Business Case is in development for Welsh Government Funding and is due to be submitted by October 2024.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	03.05.2024	30.06.2024

	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
37	4672	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record.	**IF:** The Health Board is not able to record information accurately and reliably, with complete and up to date information **Then:** the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete **Resulting in:** Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	**Operational controls:** Coding key performance indicators covering productivity, demand and backlog robustly monitored Digitised Patient Notes programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT onotology server, WCP & E-forms etc. **Tactical controls:** Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme . **Gaps in controls** Scanning time of outpatient activity to digitise the record is at 51 days cf maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT/ structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update April 2024 - Day forward scanning has been maintained to be within the agreed 48 hour turn around due to a focus by internal scanning bureau. Moratorium on destroying records has been lifted, reviewing resource ask to allow for a restart of destruction inline with Standard Operating Procedure (SOP). Digital dictation programme being refreshed as part of the wider Digital transformation business case. Optimise launch using HB developed e-forms well received by clinicians and operational team to be refreshed as part of the wider Digital transformation business case.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	30.04.2024	31.05.2024
38	5040	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies	**IF:** The Health Board can not integrate new applications into its digital architecture in a timely fashion **Then:** there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered **Resulting in:** delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrddin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity {much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC} and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	Update May 2024 - Board Development Session requested a strategic outline proposal is presented to the July 2024 Board on the potential delivery of a modular Electronic Patient Record (EPR). During May 2024, the Health Board will support the national review of an EPR requirement.	Digital & Data Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	03.05.2024	31.05.2024
39	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update March 2024 - There is still no confirmation of national replacement system as yet. The Health Board and Care Group are exploring alternative interim digital systems and there are 2 events in March to look at the suitability of the PARSI and RIO systems. The mitigation and risk score remains unchanged. Update April 2024 - as at March 2024. During the review of risks it was identified that there were 7 WCCIS related risks registered for the MHLD Care Group, the other 6 have been closed to leave this as the main cross covering entry. The other risks were (4613, 4786, 4804, 4813, 4991, 4996).	Quality & Safety Committee	15	C5xL3	6	↔	07.11.2018	21.03.2024	31.07.2024
40	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update March 2024 - Still Awaiting a feasibility review on Mental Health inpatient space that will support the mitigation for this risk. Care Group Director engaging with the Capital Team on progressing this at present. No change to risk score at this stage. Update May 2024 - risk mitigation remains as reported in March 2024. No change to risk score. Next review date set for the 01.07.2024.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	29.02.2024	01.07.2024

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
5640	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 21st-23rd February 2024 and as expected monthly going forward **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 and 25th-29th March. 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. Update March 2024 - Medical Directorate undertaken a review of this risk and no changes made to mitigation or risk score on this review.	Planning, Performance & Finance Committee Quality & Safety Committee People & Culture Committee	12 Decreased from a risk score of 20 in May 2024	9 C3xL3	Risk Score reduced to a 12 in May 2024. Negotiations with UK Government is currently underway. This means that there is unlikely to be a strike until July/August at the earliest, and this is if there is no agreement made between Government and the BMA. Risk also reduced due to experience from the last 2 strikes and the ability to manage the impact on the Health Board. Risk will need to be reviewed if there are discussions/confirmation around another strike in the summer, based on pressures and staffing levels at the time. Risk will be monitored by the Medical Directorate function.
1133 Linked to risk 3826	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department (ED) 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 April 2024 - USC Senior Management Team risk reviewed, nurse establishment invest to save paper under development unitising the RCN BEST tool (same tool used to review the Prince Charles Hospital nursing workforce 2021). In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff. Risk rating reduced C4 & L3, risk score 12. Target score 9. Review date 30/06/2024.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	12 Decreased from a risk score of 20 in May 2024	9 C3xL3	In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff. Risk rating reduced C4 & L3, risk score 12. Risk will be monitored by the USC Care Group.
4732	Chief Operating Officer	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	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. Update March 2024 - Previous update remains, Orthogeriatrician service model is being reviewed in CTM as part of the trauma and orthopaedic reconfiguration of service. SMT reviewed and has requested that this risk is transferred to planned care Directors for management. Update April 2024 - USC SMT reviewed, Awaiting alignment of budgets, post phase 2 OCP. This forms part of the investment cycle for the financial period 24/25 and therefore risk has been de-escalated to a risk score of 12.	Quality & Safety Committee	12 Decreased from a risk score of 15 in May 2024	4 (C2xL2)	Update April 2024 - USC SMT reviewed, Awaiting alignment of budgets, post phase 2 OCP. This forms part of the investment cycle for the financial period 24/25 and therefore risk has been de-escalated to a risk score of 12. Risk will be monitored by the USC Care Group.

	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	5602	Chief Operating Officer	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Door security in pharmacy Department at Ysbyty Cwm Rhondda (YCR) Hospital.	Detail captured in report received in closed sesssion due to business sensitivities.					

Agenda Item
5.2

Audit & Risk Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
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

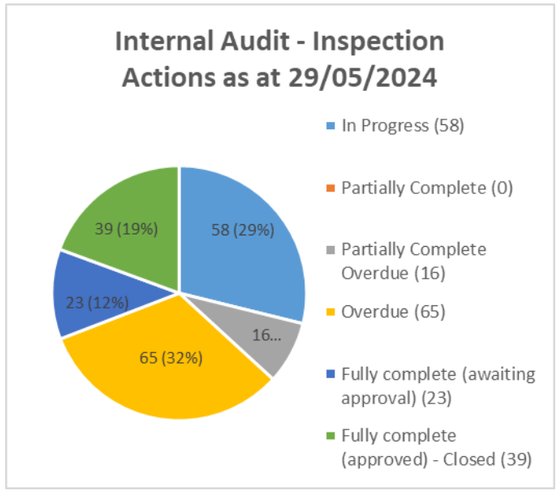
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	10th June 2024	Reviewed and Management Sign Off Received

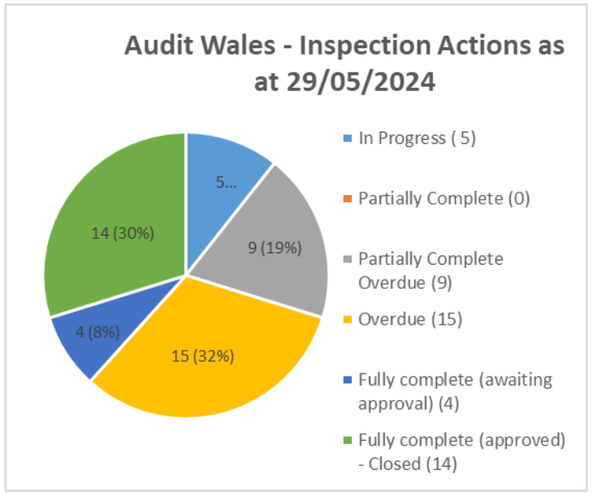
Acronyms / Glossary of Terms	
AMaT	Audit Management and Tracking
HIW	Healthcare Inspectorate Wales

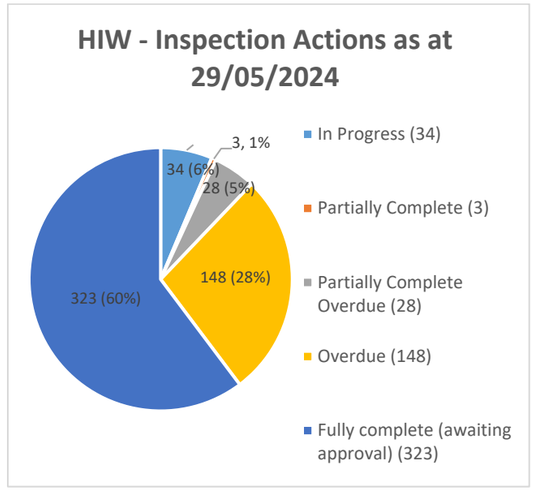
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

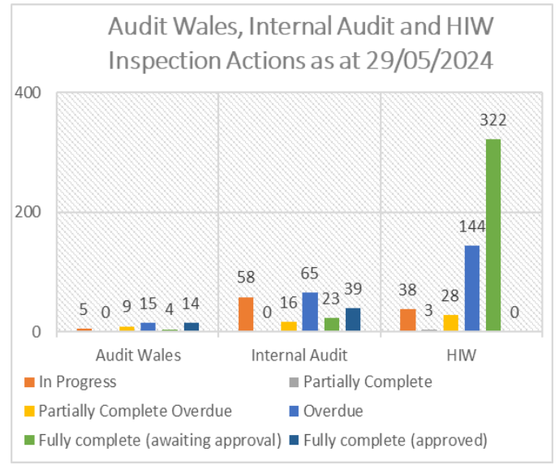
Tracker Dashboard

Status: Inspection Actions:









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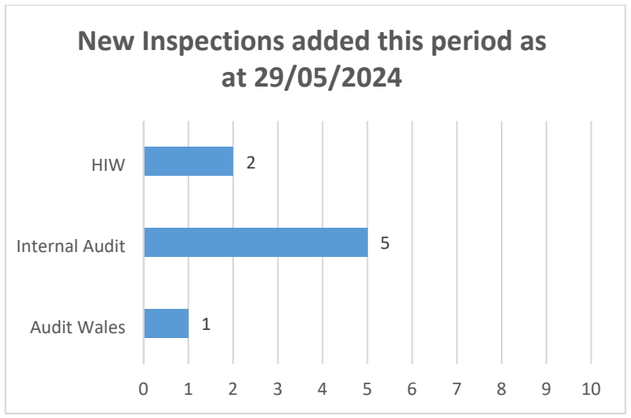

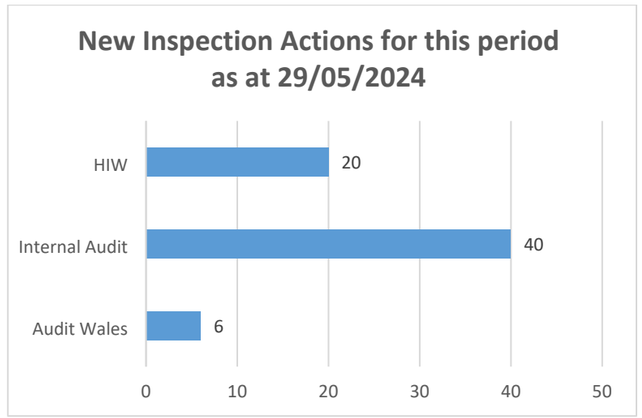

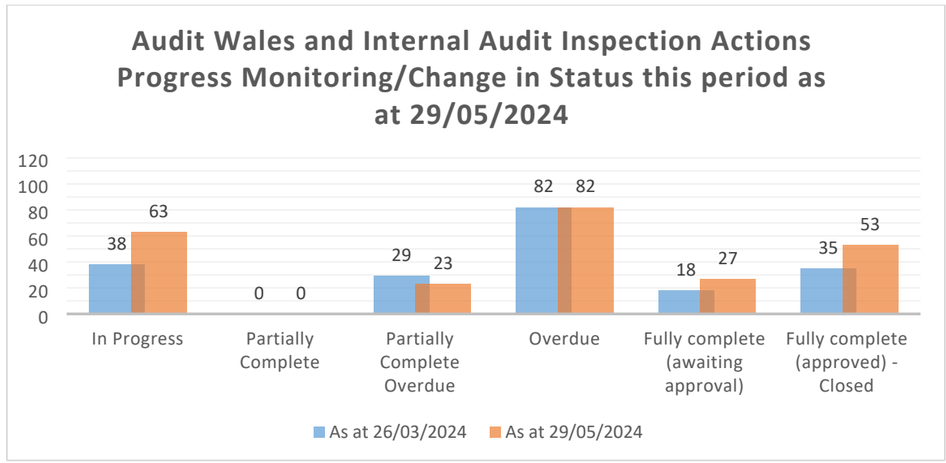

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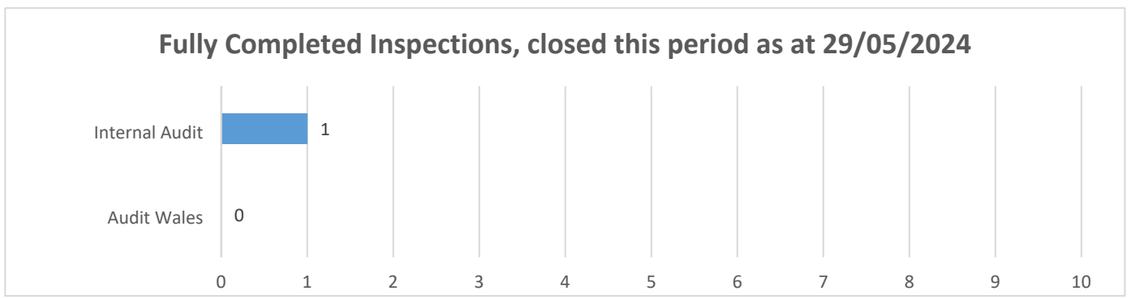

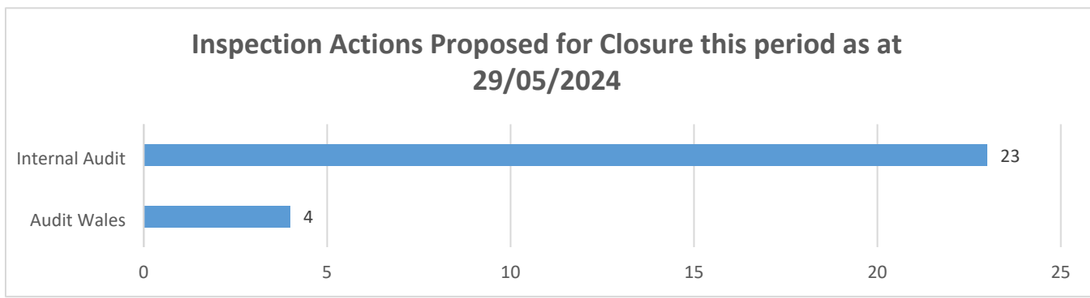

1. Situation /Background

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 Audit Management and Tracking (AMaT) inspection module. Included in **APPENDIX 2** is a table of development requests made by CTMUHB that we are engaging with the software developers in order to improve the system for our assurance priorities. The Quality Assurance and Compliance Team will shortly be engaging in a meeting with the developers of AMaT to further highlight our need for more adept assurance and governance capabilities of the software alongside allowing independent maintenance of audits by Care Groups.

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

1.3 This report captures Health Inspectorate Wales (HIW) Improvement plans and Immediate Assurances inspections in terms of the dashboard infographic, however, as a cleansing of data exercise is underway in terms of progress against actions the full tracker has not been included. The Head of Quality Assurance and Compliance is working with Care Group Nurse Directors to review ahead of submission to the Quality & Safety Committee in July 2024 and the August meeting of this Committee thereafter.

2. Specific Matters for Consideration

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

2.2 **Report format**

The Committee are reminded that the report being presented is a transitioning process and will continue to evolve. There have been some changes and advances made in the dashboard capabilities allowing a more in-depth review of the progress. We recognise that progress of the process may appear slow however please be assured that the work is continuing with us and software developers to build the system. The team are also working with other Health Boards in Wales to seek support for system developments that will enhance the level of assurance data being gathered and encourage shared learning. The team have also been liaising with NHS Trusts in England which has allowed a better understanding of how other areas use the system to track and Manage their audits and external inspections whilst maintain high levels of assurance.

The report at **Appendix 1**, remains a hybrid approach 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 as evidenced in **Appendix 2**.

The Quality Assurance and Compliance team are continuing to work with leads on the robustness of the progress updates for the tracker.

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 including **40 NEW** Inspections Actions:

- Internal Audit/2024/169 (Medical Director / Diagnostics, Therapies, Pharmacies and Specialties)
  Management of Controlled Drugs Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)
- Internal Audit/2024/170 (COO / Planned Care)
  Gastro-Intestinal Pathways – Demand Management Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02).
- Internal Audit/2024/171 (Executive Director of Strategy and Transformation / Strategy, Planning and Transformation)
  Decarbonisation Internal Audit Report April 2024 (Review reference: CTMUHB-2324-13)
- Internal Audit/2024/173 (Director of Finance / Capital & Estates)
  PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report April 2024 (Review reference: CTM-SSU-2324-06)
- Internal Audit/2024/172 (Director of Digital / Digital & Data)
  Follow-up: Digital Operating Model Final Internal Audit Report April 2024 (Review reference: CTM-2324-24

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

- "Internal Audit/2023/148 - IT Infrastructure Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)
  R4.1"
- "Internal Audit/2024/171 - Decarbonisation Internal Audit Report April 2024 (Review reference: CTMUHB-2324-13)
  R2"
- "Internal Audit/2024/171 - Decarbonisation Internal Audit Report April 2024 (Review reference: CTMUHB-2324-13)
  R3"
- "Internal Audit/2023/147 - Follow-up: Facilities Systems Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)
  Facilities Systems Follow Up Review
  R4.0"

- "Internal Audit/2023/147 - Follow-up: Facilities Systems Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)
  Facilities Systems Follow Up Review
  R5.0"
- "Internal Audit/2023/147 - Follow-up: Facilities Systems Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)
  Facilities Systems Follow Up Review
  R2.4"
- "Internal Audit/2023/147 - Follow-up: Facilities Systems Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)
  Facilities Systems Follow Up Review
  R1.0"
- "Internal Audit/2023/147 - Follow-up: Facilities Systems Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)
  Facilities Systems Follow Up Review
  R2.2"
- "Internal Audit/2023/147 - Follow-up: Facilities Systems Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)
  Facilities Systems Follow Up Review
  R2.3"
- "Internal Audit/2022/66 - Financial Systems Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)
  R8.1"
- "Internal Audit/2022/66 - Financial Systems Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)
  R8.2"
- "Internal Audit/2023/107 - Decontamination Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)
  R2.0"
- "Internal Audit/2023/113 - National Incident Framework Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)
  R1.1"
- "Internal Audit/2023/152 - PCH Redevelopment Programme: Supervisor Role Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)
  R2.2"
- "Internal Audit/2024/173 - PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report April 2024 (Review reference: CTM-SSU-2324-06)
  R1"
- "Internal Audit/2024/173 - PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report April 2024 (Review reference: CTM-SSU-2324-06)

R2"
- "Internal Audit/2021/76 - Sunnyside Health & Wellbeing Centre Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)
R15"
- "Internal Audit/2021/76 - Sunnyside Health & Wellbeing Centre Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)
R01"
- "Internal Audit/2021/76 - Sunnyside Health & Wellbeing Centre Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)
R07"
- "Internal Audit/2021/76 - Sunnyside Health & Wellbeing Centre Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)
R17"
- "Internal Audit/2021/76 - Sunnyside Health & Wellbeing Centre Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)
R05"
- "Internal Audit/2021/76 - Sunnyside Health & Wellbeing Centre Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)
R04"
- "Internal Audit/2021/76 - Sunnyside Health & Wellbeing Centre Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)
R10"

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

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

- Audit Wales/2024/168 (Executive Director for People / People Services). Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)

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

- "Audit Wales/2023/150 - CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)
R1"

- "Audit Wales/2023/150 - CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)
  R3"
- "Audit Wales/2023/150 - CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)
  R5"

  Due to the confidential nature of the Audit of Accounts report the detail within the tracker is captured in the closed session.

- "Audit Wales/2023/18 - Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)
  R8"

2.2.3 **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 in June for monitoring and tracking.

2 New agreed Improvement Plans:

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

323 Inspection actions fully **complete** and awaiting **approval.**

3. Key Risks / Matters for Escalation

3.1 The audit tracker will continue to be updated with a targeted focus on actions where the implementation date has passed. Due to competing priorities and operational challenges a number of actions under the remit of the Chief Operating Officer (Operational Services Teams) have not been updated. Updates will continue to be sought as a matter of urgency in readiness for the next meeting.

3.2 Steps have been taken to seek updates from Management leads in relation to outstanding internal and external audit recommendations which are classed as high/medium/low priority. Leads had been previously contacted and registered for AMaT in order to provide updates independently through the AMaT system. It was identified, however that in allowing such access to the Care Group leads, meant that this reduced the level of assurance and the governance ability since changes were not automatically tracked within the system. This has now been identified as a high priority system development for AMaT to address. There has been a slightly improved, temporary process implemented whereby leads were asked to update their progress via a live SharePoint document with limited

access. Although this method does mean that manual manipulation and input of data is required by the team, it does, as a temporary measure provide a higher level of assurance and oversight.

3.3 Due to the change in the audit management and tracking process which is still a work in progress (please see table of software development requests **(Appendix 2),** there continues to be a requirement for extra manual inputting and management of the data in order to provide committee members with useable data. This continues to necessitate the requirement to adhere to a strict deadline for receipt of updates. Where updates are received after the deadline date these may be noted in the cover report however not included in the dashboard data.

3.4 Identification of themes and risks will continue to develop over the next 6-12 months. It is expected that with the new HIW management process that this will strengthen the evidence gathering to inform future areas of quality and safety improvements.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	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	Yes (Include further detail below)	
	There may be an adverse effect on the organisation if CTMUHB does not fully implement learning and improvements identified as part of Audit arrangements.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATION

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

Code	Title	Date of Inspection	Executive Lead	Inspection Lead(s)	Function	Recommendations	Actions	Assurance Rating
Audit Wales/2021/144	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	01/08/2021	Greg Dix, Executive Director of Nursing & Deputy CEO	• Deputy Executive Director of Nursing • Assistant Director Quality & Safety • Business Manager, Patient Care & Safety	Central Corporate Function - Patient Care & Safety	7	7	Not Applicable
Audit Wales/2021/7	Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 253SA2021-22)	01/08/2021	Hywel Daniel, Executive Director for People	• Head of Policy, Compliance and Agenda for Change • Assistant Director of Workforce and OD • Business Support Manager, People Services	Central Corporate Function - People	1	1	Not Applicable
Audit Wales/2022/12	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	01/08/2022	Linda Prosser, Executive Director of Strategy & Transformation	• Deputy Director of Strategy and Partnerships • Head of Regional Commissioning Unit • Executive Assistant - Strategy & Transformation	Central Corporate Function - Strategy & Transformation	5	5	Not Applicable
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	01/10/2023	Gareth Watts, Director of Corporate Governance & Board Secretary Linda Prosser, Executive Director of Strategy & Transformation Stuart Morris, Director of Digital	• Assistant Director of Governance & Risk (Governance actions) • Linda Prosser, Executive Director of Strategy & Transformation (Performance related actions) • Stuart Morris, Director of Digital (Digital and Performance related actions)	Central Corporate Function - Corporate Governance	6	6	Not Applicable
Audit Wales/2023/150	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	01/11/2023	Sally May, Executive Director of Finance	• Deputy Director of Finance • Head of Corporate Finance • Executive Assistant - Finance	Central Corporate Function - Finance	9	9	Not Applicable
Audit Wales/2023/18	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	01/02/2023	Gareth Watts, Director of Corporate Governance & Board Secretary Sally May, Executive Director of Finance Linda Prosser, Executive Director of Strategy & Transformation Stuart Morris, Director of Digital	• Assistant Director of Governance & Risk (Governance actions) •, Deputy Director of Finance (Finance actions) • Linda Prosser, Executive Director of Strategy & Transformation (Performance related actions) • Stuart Morris, Director of Digital (Digital and Performance related actions)	Central Corporate Function - Corporate Governance	8	8	Not Applicable
Audit Wales/2023/23	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	01/03/2023	Gethin Hughes, Chief Operating Officer	• Director of Operations - Planned Care • Director of Nursing, Planned Care • Medical Director Planned Care & Consultant Orthopaedic Surgeon • Personal Assistant, Planned Care	Care Group - Planned Care	3	3	Not Applicable
Audit Wales/2024/168	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	01.02.2024	Hywel Daniel, Executive Director for People	• Head of Workforce Planning • Head of Policy, Compliance and Agenda for Change • Assistant Director of Workforce and OD • Business Support Manager, People Services	Central Corporate Function - People	6	6	Not Applicable
Internal Audit/2020/120	Health & Safety Management_Final Internal Audit Report August 2020 (Review reference: CTMU-1920-16)	03/08/2020	Hywel Daniel, Executive Director for People	• Assistant Director of Health Safety and Fire • Department Administration Manager, Health, Safety and Fire • Head of Policy, Compliance and Agenda for Change • Assistant Director of Workforce and OD • Business Support Manager, People Services	Central Corporate Function - Health Safety & Fire	1	1	Reasonable
Internal Audit/2020/65	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	29/07/2020	Gethin Hughes, Chief Operating Officer	Emergency & Acute Medicine Directorate • Directorate Manager • Service Manager • Service Manager	Care Group - Unscheduled Care	2	2	Reasonable
Internal Audit/2020/74	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU 1920-45b)	24/01/2020	Gethin Hughes, Chief Operating Officer	• Divisional Director Of Facilities • Assistant Director OSS (Facilities • Head Of Clinical Engineering • Medical Electronics Engineering Manager	Corporate Central Function - Facilities	1	1	Reasonable
Internal Audit/2021/76	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	06/08/2021	Sally May, Executive Director of Finance	• Deputy COO Mental Health, Primary Care and Community Services •Service Director Primary Care and Community • Primary Care & Community Estates Development Manager, • Interim Clinical Service Group Manager, Primary and Community Care • Assistant Director of Planning - (Capital and Estates) • Capital Finance Manager	Corporate Function - Capital and Estates	15	15	Reasonable
Internal Audit/2022/161	Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36)	14/02/2022	Greg Dix, Executive Director of Nursing & Deputy CEO	• Lead Nurse for CHC and NHS Funded Care •,Nurse Director (Primary Care, Community & MHLD) • Business Manager, Patient Care & Safety	Corporate Function - Patient, Care and Safety	1	1	Reasonable
Internal Audit/2022/25	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	15/06/2022	Gethin Hughes, Chief Operating Officer	All Care Groups initially to establish lead • Service Director (DTPS, Children & Families) •Service Director (Primary Care and Community) • Service Director (Unscheduled Care) • Service Director (Mental Health and Learning Disabilities) • Service Director (Planned Care)	All Care Groups	8	8	Limited
Internal Audit/2022/40	Fire Safety Management_Final Internal Audit Report February 2022 (Review reference: CTM_2021_01)	07/02/2022	Hywel Daniel, Executive Director for People	• Assistant Director of Planning (Capital & Estates) • Assistant Director of Health, Safety & Fire • Senior Fire officer • Department Administration Manager, Health, Safety and Fire • Head of Policy, Compliance and Agenda for Change • Assistant director of Workforce and OD • Business Support Manager, People Services	Corporate Function - Health, Safety & Fire	2	2	Limited
Internal Audit/2022/43	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	29/07/2022	Linda Prosser, Executive Director of Strategy & Transformation	• Assistant Director of Planning (Capital & Estates) • Service Project Manager, Capital Planning • Senior Projects Manager, Capital Planning • Capital Finance Manager	Corporate Function - Capital and Estates	13	13	Limited
Internal Audit/2022/66	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	15/06/2022	Sally May, Executive Director of Finance	• Deputy Director of Finance • Head of Corporate Finance • Assistant Director of Finance - Financial Planning & Reporting • Executive Assistant - Finance	Corporate Function - Finance	4	4	Reasonable
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	24/10/2022	Gethin Hughes, Chief Operating Officer	• Service Director DTPS •Medical Director DTPS •Radiology Service Manager • Superintendent Radiographer, • Superintendent Radiographer	Care Group - Diagnostics, Therapies, Pharmacies & Specialities	5	5	Reasonable
Internal Audit/2022/89	Follow-up: Consultant Job Planning_Final Internal Audit Report May 2022 (Review reference: CTM 2122.16)	12/0/	Dom Hurford, Executive Medical Director Hywel Daniel, Executive Director for People	• Assistant Director, Strategic Workforce Planning • Senior HR Manager - Medical Workforce • Deputy Executive Medical Director • Head of Policy, Compliance and Agenda for Change • Assistant director of Workforce and OD •, Business Manager - Medical Director • Business Manager - People Services	Corporate Function - People	1	1	Reasonable
Internal Audit/2022/95	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	15/06/2022	Dom Hurford, Executive Medical Director Hywel Daniel, Executive Director for People	• Assistant Director, Strategic Workforce Planning • Senior HR Manager - Medical Workforce • Deputy Executive Medical Director • Head of Policy, Compliance and Agenda for Change • Assistant Director of Workforce and OD • Business Manager - Medical Director • Business Manager - People Services	Corporate Function - People	1	1	Reasonable
Internal Audit/2022/97	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	10/10/2022	Stuart Morris, Director of Digital	• Head of Clinical Administration Transformation •Medical Records Manager •, Clinical Records Modernisation Project Manager,	Corporate Function - Digital & Data	1	1	Reasonable
Internal Audit/2023/100	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	• Assistant Director Quality & Safety • Assistant Director of Concerns and Claims • Head of Legal Services • Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	3	3	Reasonable
Internal Audit/2023/107	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	• Deputy Executive Director of Nursing • Lead Infection Prevention & Control Nurse • Deputy Lead Infection Prevention Control Nurse & Decontamination Officer • Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	5	5	Reasonable
Internal Audit/2023/113	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	•,Assistant Director of Quality & Safety • Clinical Lead, Serious Incidents and Complex Concerns, • Head of Concerns & Business Intelligence •, Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	8	8	Reasonable
Internal Audit/2023/117	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	28/07/2023	Linda Prosser, Executive Director of Strategy & Transformation Stuart Morris, Director of Digital	• Linda Prosser, Executive Director of Strategy & Transformation • Stuart Morris, Director of Digital	Corporate Function - Performance	2	2	Reasonable
Internal Audit/2023/124	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	• Assistant Director Quality & Safety • Assistant Director of Concerns and Claims •,Head of Concerns & Business Intelligence • Business Manager - Patient Care & Safety	Corporate Function - Patient, Care and Safety	4	4	Reasonable
Internal Audit/2023/146	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	11/10/2023	Dom Hurford, Executive Medical Director	• Dom Hurford, Executive Medical Director • Director of Operations - Planned Care • Personal Assistant, Planned Care	Care Group - Planned Care	8	8	Limited
Internal Audit/2023/147	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	16/10/2023	Gethin Hughes, Chief Operating Officer	• Divisional Director Of Facilities • Assistant Director OSS (Facilities • Facilities Manager	Corporate Central Function - Facilities	7	7	Limited
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	09/10/2023	Stuart Morris, Director of Digital	• Assistant Director for Digital Delivery • Lead Infrastructure and Security Architect,	Corporate Function - Digital & Data	5	5	Reasonable
Internal Audit/2023/151	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	28/11/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	• Deputy Executive Director of Nursing • Head of Safeguarding • Deputy Head of Safeguarding • DoLS and Mental Capacity Act Team Leader • Business Manager - Patient Care & Safety	Corporate Central Function - Patient, Care and Safety	8	8	Reasonable
Internal Audit/2023/152	PCH Redevelopment Programme: Supervisor Role_Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)	07/12/2023	Sally May, Executive Director of Finance	• Assistant Director of Planning (Capital & Estates) • Responsible Officer PCH Construction Programme, • Programme Director PCH • Capital Finance Manager	Corporate Central Function - Capital and Estates	4	4	Substantial
Internal Audit/2023/37	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	06/06/2023	Linda Prosser, Executive Director of Strategy & Transformation	• Assistant Director of Transformation, Strategic and Operational Planning • Executive Assistant - Strategy & Transformation	Corporate Central Function - Commissioning	5	5	Limited
Internal Audit/2023/57	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	03/04/2023	Gethin Hughes, Chief Operating Officer	• Deputy Chief Operating Office - Acute Services • Director of Operations - Planned Care • Acute Services General Manager • RTT Manager, Information Systems • Medical Records Manager • WPAS Compliance, Training & System Manager • Personal Assistant, Planned Care	Care Group - Planned Care	4	4	Limited
Internal Audit/2023/73	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	08/08/2023	Gethin Hughes, Chief Operating Officer	• Service Director DTPS • Medical Director DTPS •, Radiology Service Manager	Care Group - Diagnostics, Therapies, Pharmacies & Specialities	4	4	Reasonable

Code	Title	Date of Inspection	Executive Lead	Inspection Lead(s)	Function	Recommendations	Actions	Assurance Rating
Internal Audit/2024/162	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	06.02.2024	Gethin Hughes, Chief Operating Officer	• Deputy COO - Acute Services • Service Director - Unscheduled Care • Nurse Director - Unscheduled Care	Care Group - Unscheduled Care	15	15	**Limited**
Internal Audit/2024/163	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	08.02.2024	Stuart Morris, Director of Digital	• Assistant Director of Digital Delivery • Head of End User Computing •.Lead Infrastructure and Security Architect	Central Corporate Function - Digital & Data	11	12	**Reasonable**
Internal Audit/2024/169	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	11/04/2024	Dom Hurford, Executive Medical Director	• Chief Pharmacist • Lead Nurse Advisor Medicines Management and Medication Safety • Principal Pharmacist - Quality and Safety & Medication Safety Officer	Care Group - Diagnostics, Therapies, Pharmacies & Specialities	17	18	**Reasonable**
Internal Audit/2024/170	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	12.04.2024	Gethin Hughes, Chief Operating Officer	• Director of Operations - Planned Care • CSG Manager Surgery/T&O, Theatres • Medical Records Manager • Personal Assistant, Planned Care	Care Group - Planned Care	7	7	**Limited**
Internal Audit/2024/171	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	09.04.2024	Linda Prosser Executive Director of Strategy & Transformation	• Deputy Director Strategy and Partnerships • Executive Assistant - Strategy & Transformation	Central Corporate Function - Strategy & Transformation	9	9	**Limited**
Internal Audit/2024/172	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	02.04.2024	Stuart Morris, Director of Digital	• Assistant Director of Digital Delivery	Central Corporate Function - Digital & Data	2	2	**Reasonable**
Internal Audit/2024/173	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06)	03.04.2024	Sally May, Executive Director of Finance	• Assistant Director of Planning (Capital & Estates) • Responsible Officer PCH Construction Programme	Corporate Central Function - Capital and Estates	4	4	**Reasonable**

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

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2021/144	01.08.2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	Audit Wales/HIW Quality Governance Follow Up Review R3.5 Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: a- Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety b- Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates c- Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety	Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.10.2021	Revised Due Date October 2024	High	Partially complete (Overdue)	**May 2024 Update - Complaints and Concerns compliance is remains at 88% (Jan-Mar 2024); real time data and learning continues to be shared with the Care Groups in a timely manner. LFERs compliance continues to improve. Patient Experience data is being reported to the QSC. Following completion of the OCP process internal Care Group Quality & Safety Governance frameworks is complete, which supports clarify of the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the Care Groups. The structure now clearly outlines the quality and safety responsibilities of both Medical and Nurse Directors. This is now embedded at directorate and service level leadership, with established governance reporting mechanisms. The corporate function has also been designed to ensure quality and safety support to individual care groups whilst ensuring corporate oversight and reporting to triangulate learning and data collection.** **OCP Phase 2 is now complete and the result is that quality and safety responsibilities have been fully embedded at an operational level across the Health Board, therefore action is complete.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
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 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 Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.12.2021		High	Partially complete (Overdue)	**May 2024 Update - All operational quality and governance patient safety groups have clear and defined Terms of Reference which relate to the specific Care Group. Administrative support is utilised to ensure that actions can be logged and monitored and minutes are completed and circulated in a timely manner. Bi monthly QPSE meetings take place within the care groups. These are chaired by the Nurse Director/ Medical Director within the care group. A governance agenda includes an overview of governance within the care group with a focus on NRI/ DOC incidents, LFER status, Risk status and any key learning from incidents. Heads of Nursing provide an overarching presentation for their sites which includes incidents and themes and trends, with an element around pressure and fall incidents as well as clinical effectiveness and mortality KPI's. Fortnightly governance meetings are held within the care groups where open/ overdue NRIS/ LRIs/ DOCs are discussed. LFERS & Risks are also highlighted here. These meetings are attended by lead nurses, senior nurses and service managers and medical representation when they are able to attend with clinical commitments. An example of TOR for children and families governance meeting is also attached.** **Overarching Health Board Pressure Ulcer and Falls Steering Groups are currently awaiting establishment, ToRs have been developed and are awaiting approval.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
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 R6.1 There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.	Health Board purchased CIVICA (captures population feedback using a patient insight software platform).	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.07.2021	Revised Due Date: Now December 2024 when Civica contract ends	High	Partially complete (Overdue)	**May 2024 Update - Unsuccessful recruitment of B2 apprentice role which continues to cause delays in collecting and entering Have Your Say onto the Civica system. Agreed with Civica and NWSSP to extend the contract for 1 year with the option of +1 if required. Work is ongoing to create a daily automated data flow from Civica to CTM warehouse team for all patient experience data. Once this link is established the team will be linking up with the performance team to start creating internal dashboards. SMS in Neonatal and Gynae has now gone live. Currently testing SMS in Phycology Paediatric, if successful further rollout within Paediatrics will progress.** March 2024 Update - v8 of system has been released. Scoping out SMS across CTM. Still awaiting B2 Apprentice job approval from workforce. Awaiting copy of CTM Civica contract from NWSSP to be reviewed by Finance and procurement internally before agreement can be made on renewal of contract to 2027 or not. Meeting with the NHS Executive Quality & Safety Manager for Performance and Assurance to be organised and discussed on the future of Civica within CTM.
Audit Wales/2021/144	01.08.2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	Audit Wales/HIW Quality Governance Follow Up Review R14.5 The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital.	Implementation of PREMS and CIVICA system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	01.09.2021	Revised Due Date June 2024	High	Partially complete (Overdue)	**May 2024 Update - People's Experience Forum has been established and the inaugural meeting was held on 03 April 2024. Awaiting CEDAR and WG to approve and release the new set of core and optional questions that all Welsh HB should adopt- these have not been definitively agreed yet. Discussion will take place at the EDON's on 24th May with regards to the new People's Experience FRAMEWORK. work continues to review and agree the scoring of each question to ascertain a benchmark on an all Wales basis enabling a clear, standardised, systematic approach. Discussions are required to map out the new set of questions against the old version.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2021/7	01.08.2021	Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	The Health Board should review its governance and procedures in place for the appointment of senior officers, and as part of the review ensure that it fully understands the extent of WG's delegated authority to the Health Board, and importantly, the decisions that WG has not delegated. The Health Board should ensure that minutes, particularly those of the Remuneration Committee, are clear. For example, minutes should make a clear distinction between when the Remuneration Committee has approved (or rejected) a business case; and when it has endorsed (or not endorsed) a business case that then needs the approval of the WG. In respect of retire and return cases, the Health Board should ensure that it has appropriate procedures in place for the consideration and approval/ rejection of business cases. The Health Board should record the process contemporaneously and provide accurate information to the payroll department.	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	People Executive Director for People	31.08.2021	Revised Due Date May 2024	High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. January 2024 Update - The Health Board was instructed by the NHS Wales Confederation to withdraw our draft Retire and Return Procedure which was being consulted upon internally during December 2023. They advised this matter had been raised with them by a Full-time Trade Union Officer as the new All Wales Pension Policy will set out the process and procedure in respect of this matter. The NHS Wales Confederation were not able to indicated when the All Wales Policy would be ready for Welsh Partnership Forum approval, noting they had previously advised it would be published to the Service by the autumn of 2023. Completion of this action is now dependent on the progress made by Welsh Partnership Forum and at this time no revised timescales have been advised.
Audit Wales/2022/12	01.08.2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R1 Strategic planning and applying the sustainable development principle Our work found opportunities for the TLPB to strengthen its planning arrangements and demonstrate how it is acting in accordance with the sustainable development principle (as set out in the Well-being of Future Generations (Wales) Act). The principle should be integral to the TLPB's thinking and genuinely shaping what it does by: 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	Agreed. Although the sustainable development principle is a fundamental consideration in all decision making, this will be made more explicit in reports to TLPB and RPB going forward. Transition to a new delivery plan has been completed and work will continue to integrate the long term plans of the four statutory bodies improve involvement of non-statutory partners.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	Revised Due Date 31 March 2024	High	Overdue	**May 2024 Update - Discussion paper outlining the opportunities and challenges with formal partnership working arrangements including examples and options open for binding joint working presented to Integrated Leadership Board. Paper explored both the maximum potential of a section 33 structure and the practicalities of a formal public sector joint venture agreed as the best options for further exploration as part of the enablers within the integrated pathways implementation programme.** March 2024 Update - Following an initial pilot in 2020/21 the Welsh Government have developed a self assessment exercise for Regional Partnership Boards. The purpose is to give RPBs a chance to reflect on how they operate, how effectively they carry out their statutory duties. The survey was issued to all RPB members for completion by 7th March 2024. A summary of the results will be provided by independent facilitators (CIW and HIW). Workshop planned for 18th April to feedback results and provide opportunity for discussion. The online assessment covered the following areas - Governance systems and arrangements, Workforce strategies (development and practice), outcome measurement and frameworks, resources and progress in developing integrated models of care.
Audit Wales/2022/12	01.08.2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R4 Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated.	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	Revised Due Date 31 March 2024	High	Overdue	**May 2024 Update - Regional Integration Fund plan agreed for 2024/25. A number of projects provided initial 6 months funding to align with any changes required limed to community pathway development. Funding likely to be extended until the end of the financial year. Funding within the wider programme identified to take forward a number of priorities under the children and young peoples board that historically has seen less RIF investment.** March 2024 Update - On the 5th February a letter was received from WG that stated that the tapering element of the Regional Integration Fund had been removed. This news was welcomed by partners however letter reinforced other elements of RIF including - Embedding the 6 models of care consistently and equitable across Wales, focus on benchmarking against other regions, and support 'once for Wales' approach.
Audit Wales/2022/12	01.08.2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R5 Regional Commissioning Unit Our work found that the lack of capacity within the RCU was leading to some delays in progressing actions. The work of the RCU is crucial to the continuing success of the TLPB. The TLPB needs to consider how it can build capacity and maximise resources to support the TLPB and minimise overreliance on a small team."	Agreed. Additional infrastructure has been agreed to support dementia work and NEST framework and capital. Additional capacity will also be identified from partner organisations to support the programme delivery.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.12.2022	Revised Due Date January 2024	High	Overdue	**May 2024 Update - Additional Capacity secured. Director for Integration post commenced November 2023, Capital Planning Officer October 2023 (plus 3x capital Project Manager roles being interviewed for May 2024), NEST Co-ordinator commenced in post March 2024.** March 2024 Update - NEST Co-ordinator now appointed to commence early April. 3 capital programme manager currently out to advert, Additional programme Management to support the Integration Director agreed, to be advertised in April.
Audit Wales/2022/12	01.08.2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R6 Use of Resources Improving the health and social care outcomes of the region will require efficient and effective use of combined resources. Our work found that there had been some limited examples of pooled budgets and other arrangements for sharing resources. The TLPB needs to explore more innovative ways of sharing and pooling core.	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	Revised Due Date 31 March 2024	High	Overdue	**May 2024 Update - RIF budgets agreed for 2024/25. Programmes will be realigned in year in line with community pathways modelling.** March 2024 Update - Through the regional Integrated Community Care Services Program the Director for Integration is supporting the region to jointly define and implement a target service and management model for our community services across the region. Regular meetings scheduled with Chief Executives to update on progress.
Audit Wales/2022/12	01.08.2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 2934A2022)	Transformational Leadership Programme Board – Baseline Governance Review R7 Regional workforce planning Like many parts of the public sector, the region is experiencing significant workforce challenges. The TLPB needs to consider how it can facilitate a regional and strategic approach to addressing these challenges and to help it deliver its priorities"	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	Revised Due Date 31 March 2024	High	Overdue	**May 2024 Update - Review of all RIF funded post has commenced to support urgent and emergency care pathways. As part of development work teams will be reviewed and aligned against the agreed pathways once agreed.** March 2024 Update - The priority for the Integrated Community Care Services program is the development of robust pathways. As part of this work exploration of organisational forms will be explored as to how they can best support integration. Section 33 agreements are being reviewed and memorandum of understanding being drafted.
Audit Wales/2023/149	01.10.2023	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	Structured Assessment 2023 R3 Enhancing transparency of committee business Draft committee meeting minutes are produced quickly and reviewed by the relevant chair; however, they are not made publicly available until the papers of the subsequent meeting are published. Furthermore, committee meetings are not livestreamed or recorded for public use. The Health Board, therefore, should consider putting appropriate arrangements in place to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. (Medium Priority).	The Corporate Governance Team will be reviewing how it can further enhance transparency around its Board Committee Business e.g. sharing a summary of planned business on the website ahead of publication of papers, publishing shared listening and learning videos (linked to R2) etc.	Corporate Governance Director of Corporate Governance/Board Secretary	01.03.2024	**Request to revise due date to 30 September 2024** Revised Due Date 31 May 2024	Medium	Overdue	**May 2024 Update - The Assistant Director of Governance & Risk is undertaking a review of the Committee structure with the new approach to be implemented following approval by the Board in September 2024. As the Committees will be changing it is proposed that this recommendation is addressed in terms of the new Committee Structure and the new effectiveness plans that that will be in place from 1st October.** March 2024 Update - A revised implementation date is requested as this recommendation will be built into the programme of work being undertaken in relation to the Effective Management of Board Business Proposal which will be completed circa July 2024. There is a specific focus in this work on the commitment to openness and transparency.
Audit Wales/2023/149	01.10.2023	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	Structured Assessment 2023 R6 Performance Management Framework The Health Board has appropriate arrangements in place to manage operational performance; however, it lacks a documented performance management framework. In order to enhance its arrangements further, the Health Board should prepare a written framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at service, management, committee, and Board levels (High Priority).	The Health Board has developed a working version of the Performance Framework, however it does require updating to reflect the new organisational structure and the latest Welsh Government performance framework. This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27 February 2024), for approval.	Performance Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	01.02.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested. February 2024 Update - This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27th February 2024), for approval.
Audit Wales/2023/150	01.11.2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	Updates captured in closed session of the Audit & Risk Committee on the 20th June 2024. Agenda Item 4.2.							
Audit Wales/2023/150	01.11.2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)								
Audit Wales/2023/150	01.11.2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)								
Audit Wales/2023/150	01.11.2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)								
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	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.	Corporate Governance Director of Corporate Governance/Board Secretary	30.10.2023	**Request to revise due date to 30 September 2024** Revised Due Date 31 July 2024	High	Partially complete (Overdue)	**May 2024 Update - Actions a, c and d are completed. Action B update is that as part of the Effective Management of Board Business review underway consideration will be given to the publication of papers received at the Advisory Groups and Sub Committees of the Board. Benchmarking has been done but it is difficult as not all Health Boards are operating the same Advisory Groups or Sub Committee meetings. The Health Board is also introducing two new Sub Committees which need to be taken into consideration. It is therefore proposed that recommendations in this regard are captured in the submission to Board in September for Approval.** March 2024 Update - Items a, c and d are complete. A revised implementation date is requested as the publication of Advisory and Sub Committee minutes is being captured in the Effective Management of Board Business Proposal which is due to conclude circa July 2024.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R3 Strengthening performance management arrangements The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being escalated to enhanced monitoring from routine arrangements under Welsh Government's Escalation and Intervention Arrangements. The Health Board, therefore, should ensure its performance management and reporting arrangements are appropriately focused on the key challenges it faces in both planned care and urgent and emergency care, especially where performance in those areas is comparatively worse than other Health Boards in Wales.	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable the Board to align measures to strategic priorities etc, the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.	Performance Executive Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	30.09.2023	Revised Due Date December 2023	High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R4 Establishing measurable outcomes for strategic priorities Whilst the Health Board has made positive progress in developing a long-term vision, strategic goals, and strategic priorities for the organisation, the new strategy (CTM 2030) lacks clear and measurable outcomes. The Health Board, therefore, should seek to articulate outcomes for each strategic priority, what success would look like, and how it will measure and report progress. In doing so, it should consider the relationship between the goals of the Population Health Strategy and the wider strategic goals and public health 'life course' approach set out in CTM 2030.	We agree that this work needs to progress. The ongoing work of the Strategy Groups and the CTM 2030 steering group is to set out clearly the measurable improvements to be delivered. Most of these relate to pre-existing measures set out in the Quadruple Aims. Each lead for a "strategy chapter" are responsible for identifying the measurable outcomes for their "chapter". In addition, work has already commenced to align the strategy group work to the goals and measures set out within the Population Health Management plan. We will continue to work to ensure that the thread between these aspects is more visible.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation (Performance Framework)	01.09.2023		High	Partially complete (Overdue)	**May 2024 Update - Workforce a key workstream within the urgent and emergency care pathway development programme.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R9 Maximising the benefits of digital technologies and solutions There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it indents to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	The themes identified in the existing Digital Strategy continue to be aligned to the NHS Wales Digital Strategy and are embedded and will continue to evolve with the CTM2030 strategy in relation to digital activity. The Health Board has performed an analysis and identified a minimum set of resources (staff and capital/revenue) required over the next 3 years. Aligned to this work, during 2022 the Health Board completed a functional map of services required from a Digital and Data perspective. The next stage in the process is to align staffing resources to the functions, which will be achieved by following organisational change process. For significant Digital and Data changes (i.e. projects/programmes) the Health Board has developed a process of creating business cases to support service transformation. These business cases indicate the resources (staffing & Infrastructure) required to implement service change and ensure ongoing provision of support services to sustain change. The Health Board is committed to adopting all National Digital developments, where appropriate, and has invested heavily in the deployment of these products across the Health Board. The current strategy is to continue to operate in this manner and ensure it maximises resources efficiently and effectively.	Digital Director of Digital (Performance Information)	31.12.2023		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided against this recommendation on this occasion. October 2023 Update - 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.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R5 We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring: a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	a) All plans and strategies will contain an executive summary setting out this information. As set out above, work is ongoing around outcome measures. b) Executive Directors are clear on their responsibilities for delivery so we will ensure this is more visible. c) Reports will be reviewed to ensure they provide the Board with sufficient information to assess the impact of implementation of key actions and deliverables on the Health Board's Performance.	All Executives	30.06.2023		High	Partially complete (Overdue)	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Added back onto the Tracker December 2023. No update has been received on this recommendation. October 2023 Update - a) Recommendation understood and is an ongoing action. The recommended action will be included in all appropriate documents moving forward. Action complete, b) Action complete, c) Recommendation understood and is an ongoing action. The ability to complete this action will be supported by the launch of the revised integrated performance management framework in September 2023. Action complete.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R7 Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions - NOT COMPLETED	a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance. b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is Chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas. c) A review of all the outdated Financial Control Procedures is underway.	Finance Executive Director of Finance	31.12.2023	Revised Due Date 31 December 2024	High	Partially complete (Overdue)	**May 2024 Update - c) Due to staff shortages on the team, there remains a number of FCP reviews outstanding. We anticipate these reviews to take place over the summer once vacant posts have been recruited to, for approval by the end of the calendar year.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Added back onto the Tracker December 2023. No update received on this recommendation.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	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 Director of Finance	31.07.2023		High	Fully complete (Awaiting approval)	**May 2024 Update - There is a process in place to discuss the financial positions of individual care Groups and Directorates via the monthly/bi-monthly finance meetings, this includes risks, opportunities and any mitigating actions where appropriate. The table in the Finance reports to the Board captures the material risks and opportunities affecting the Health Board's overall financial position and the year end forecast. This information in the Board report is consistent with the Risks and opportunities reported to WG via the monthly Monitoring Return submissions.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Added back onto the Tracker December 2023. No update received on this recommendation.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R10 Strengthening Board-level oversight of estates issues and risks Structured Assessment 2022 R10: There is currently insufficient Board-level oversight of the condition of the estate and other significant related risks. The Health Board, therefore, should: a) ensure there is regular reporting on estates-related performance indicators and risks to the Planning, Performance, and Finance Committee NOT COMPLETED; b) update the committee's Terms of Reference to reflect these responsibilities; and c) establish a clear process for ensuring appropriate cross referral of estate issues which may have a significant health and safety impact with the Quality and Safety Committee NOT COMPLETED	On publication of Welsh Government's annual Estates, Facilities Performance Management System data, the findings are reported to the Planning, Performance and Finance (PPF) Committee. The report includes the Health Board's performance measured against the national estates key performance indicators which are Physical Condition, Statutory and Safety compliance, fire safety, functional suitability and space utilisation. In addition the report includes the estates operational planned and reactive performance data for statutory and mandatory jobs and also captures helpdesk request data, the reported data is compared against previous years so that trends can be analysed. The report also includes the organisations energy performance and Carbon Dioxide (CO2) emissions which is measured and reported against the Welsh Government performance targets. At all of the Health Board's Health, Safety and Fire Sub Committees there is a standard agenda item for an Estates Safety and Compliance report and a fire safety report. These reports cover the critical infrastructure systems such as high and low voltage electricity, medical gases, ventilation and water. The Estates and Capital Directorate has its own risk register which is reported quarterly to the Estates / Capital Governance Board, the risks identified with a score above 15 are subsequently reported to Corporate Governance for inclusion on the Health Board's Organisational Risk register. The Health Board is also considering its approach to developing an Estates Strategy within the Health Board and how this will align with other key strategic documents and plans. The Planning, Performance & Finance Committee Terms of Reference will be reviewed to reflect the responsibility to receive Board level oversight of estates issues. The Health Board has a defined Committee Referral process which will be used if there are matters considered at either the PPF Committee or HS&F Sub Committee that require consideration at the Quality & Safety Committee. The HS&F Committee will also ensure any estates issues will be notified to the Q&S Committee through the Committee Highlight Report.	Finance Executive Director of Finance	31.10.2023	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)	High	Partially complete (Overdue)	**May 2024 Update - Key performance indicators and backlog maintenance costs were reported to PPFC in February 2024, to be reported to Board July 2024.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Added back onto the Tracker December 2023. No update received on this occasion.
Audit Wales/2023/23	01.03.2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R3 The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	The Health Board will undertake the following in order to maintain oversight and scrutiny and ensure action plans are in place: • Ensure that prehab services are improved by setting up a Prehabilitation Service to ensure patients are medically optimised for surgery. Both digital and face to face options to be considered. • The GIRFT implementation will be included in the reconfiguration programme and updated through the Improving Care Board • Increase the capture of PREMs and PROMS data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMS or PREMS. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures –timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement • Updated GIRFT action plan to be created with new CD and monitored through the reconfiguration programme. • Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved.	Planned Care Chief Operating Officer	01.05.2023		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues in this area as part of the Planned Care Programme and other projects. In particular, the Prehabilitation Service has just been launched and monitoring of the GIRFT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.
Audit Wales/2023/23	01.03.2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	The Health Board will undertake the following in order to ensure the recommendations are achieved: • The fragility of a small CMATS team was recognised within physiotherapy. Since the merger with Bridgend the UHB has invested training and development into the band 7 clinical specialist team in order to increase the number of staff working at the advanced practice level, to meet the demand across CTM. • In PCH, CMATS is undertaken via digital referrals (started April 22). Referrals are received centrally and then pooled out within sub specialties, Nurse led, Consultant led and AHPs • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Planned Care Chief Operating Officer	01.01.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided against this recommendation on this occasion.

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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 RS There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	The Health Board will undertake the following in order to ensure the recommendations are achieved: • Within POWH, PREMS and PROMs data is currently being captured electronically for all arthroplasty patients and utilising the MyMobility applications AI system, patients with anticipated poorer outcomes are having enhanced Therapies input digitally. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Within POWH, all Arthroplasty patients are enrolled on the MyMobility application to provide prehab for all patients awaiting surgery to try and minimise the harm caused by delays and ensure patients are medically optimised. There is at present no system for PROMS or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Single Clinical Director Leadership required to establish performance structure and review of current services. • Weekly performance reviews that monitor waiting list volumes and actions being taken to address and recover the position • Action plan development with singe CD for performance and governance structure across CTMUHB.	Planned Care Chief Operating Officer	01.04.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update has not been provided against this recommendation on this occasion.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To address the absence of clear workforce plans, the Health Board should prepare sustainable and balanced short-, medium-, and long-term workforce plans with measurable goals and clear timelines aligned to the CTM2030 Strategy. As part of this, the Health Board should ensure that its intent to reconfigure services focusing more on prevention, population health, and digitally enabled health services is appropriately built into long term service workforce design and transformation plans.	Work has begun on the development of the CTM SWP, approach underpinned by the KPMG action plan, next steps are: - • Using workforce data and wider information to develop high level workforce plans by staff group to enable the development of short, medium and long-term goals, with action plans, aligned to CTM 2030, in partnership with key stakeholders. Build into the plans:- • Agreed priorities aligned to the Acute Clinical Services Plan • To agree SWP actions for Llantrisant Health Park • Identify opportunities from regional working and other programmes e.g. Accelerated Cluster Working, Six Goals, HEIW workforce Plans	People Executive Director for People	01-Mar-25		High	In progress	**May 2024 Update - The new Retention and Workforce Planning Lead commenced in post in April 2024. The Heads of People are cascading and embedding the CTM Strategic Workforce Planning approach to align to Care Group Service Plans. The next step is to develop data and information packs for Care Groups to help enable Care Groups to create their local Workforce Plans.**
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board should assess and agree its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually.	• Annual budget setting with Care Groups in place with alignment to Heads of People. • Establishment Control options appraisal underway to consider and agree preferred option to progress.	People Executive Director for People	01.05.2024		High	Overdue	**May 2024 Update The People Directorate is working with Finance to review processes and develop an option paper for implementation of establishment reporting to enable full establishment control.** Due Date - May 2024 for decision on options appraisal, with revised assessment of timeline for implementation.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board should review its operational workforce planning capacity and capability and then ensure it is sufficient to support their operational workforce planning requirements within the new Care Group model.	• Develop SWP skills within People Directorate to promote into the organisation. • Working with Care Groups and Heads of People, assess current SWP capacity and capability. • Explore opportunities to embed SWP methodology in CTM Leadership Development programmes. • Develop workforce planning materials and toolkits to support workforce planning delivery.	People Executive Director for People	01.09.2024		High	In progress	**May 2024 Update The team is working with Heads of People to undertake a baseline assessment of SWP capabilities. Working with L&D colleagues around opportunities to include SWP in the new leadership programmes.**
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To help determine the extent that the action it is taking to mitigate workforce risks is having an impact, the Health Board should set trajectories and timescales to meet their target risk ratings and more clearly assess the impact of the actions that it is taking.	• Develop a workforce baseline assessment based on risk linked to the UHB risk register to identify key workforce priority areas. • Agree actions, targets and trajectories for improvement with outcome measures. • Agree reporting arrangements and monitor progress (including escalations and improvements) through quarterly reviews of the risk register and at Inspiring People Board to assess any impact of the SWP actions on managing risks.	People Executive Director for People	01.10.2024		High	In progress	**May 2024 Update - Development of a baseline assessment of our workforce challenges based on risk, using the Risk Register as a guide to identify potential current and future opportunities.**
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board needs to reinforce arrangements to both oversee progress and then assess the impact of the recommendations set out in the recent strategic workforce planning review via its People and Culture Committee.	• Assessment of progress and impact of recommendations to be on the agenda for PCC June 2024. • Regular progress updates to the relevant Board Committee.	People Executive Director for People	01.06.2024		High	In progress	**May 2024 Update - Provide update to PCC in June 2024 and update to Board in July 2024.** Due Date - June 2024, with further updates to future PCCs.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To inform the development of its medium-term plans for workforce redesign and service transformation, the Health Board should use its workforce benchmarking to adopt best workforce practice and workforce models, ensuring similar system conditions, demographics, and population characteristics.	• Development of a horizon scan to support strategic workforce planning and to inform potential changes and/or impact to people/population/services which include: – Census analysis – Population Needs Assessments – Evidenced based practice – Use the benchmarking data and information e.g. HEIW People analytics tools and dashboards/NHS England and wider sources – Case studies and lessons learned – Changes to Policies/Standards, education and training – New roles, advanced and extended practice – Labour market changes and generational changes	People Executive Director for People	01.10.2024		Medium	In progress	**May 2024 Update - Initial scoping of relevant evidence and research is underway.**

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2020/120	03.08.2020	Health & Safety Management_Final Internal Audit Report August 2020 (Review reference: CTMU-1920-16)	Health & Safety Management 06 The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Health, Safety & Fire Executive Director for People	01.01.2021	Revised Due Date June 2024	Low	Partially complete (Overdue)	**May 2024 Update - The Health and Safety Team are now using MS Forms to undertaken their audit work and are currently undertaking a COSHH Audit using this system. Reports will be provided to the Health Safety and Fire Sub Committee once completed (September 2024).** March 2024 Update - The 2 trial audits using the new software are planned for April and June 2024 and a further evaluation of the software will then be undertaken.
Internal Audit/2020/65	29/07/2020	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	Directorate Review Acute Medicine & A&E 13 An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Unscheduled Care Chief Operating Officer	01.04.2021	Revised Due Date July 2024	High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers February 2024 Update - Position remains the same. December 2023 Update - position remains the same as a consequence of staffing resource. It is hoped that the resolution of the OCP process will mitigate this situation. Too early to make a commitment - so update will be available for the meeting in February 2024.
Internal Audit/2020/65	29/07/2020	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMU-1920-23)	Directorate Review Acute Medicine & A&E 04 1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for reviewing and updating the policy."	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Unscheduled Care Chief Operating Officer	01.12.2020	Revised Due Date April 2024	Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - Position remains the same. This will be picked up with the newly appointed Directorate managers February 2024 Update - Position remains the same. December 2023 Update - situation remains the same as a consequence of lack of resource in staff. Anticipated that the OCP process will resolve this - but too early to make any commitment in this area. Update will be available in January 2024.
Internal Audit/2020/74	24/01/2020	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU 1920-45b)	Medical Equipment and Devices Follow Up 03 While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. 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 Chief Operating Officer	01.04.2020	Revised Due Date January 2024	Medium	Partially complete (Overdue)	**May 2024 Update - Switchover to new server environment pending a final data backup and quality assurance software application checks for complete switch over. Await some outstanding quotes for some infrastructure cabling to install hardware purchased as could not be completed last financial year - small amount of capital fund request made for this. Additional server request made to ICT as required for new ficed readers purchased. IOT Wi-Fi @ POW still to be resolved. Data migration and Xtrack 2 app to be completed by July 2024. WG 21-05-2024.** March 2024 Update - data migration of existing data to Xtrack 2 performed and undergoing live testing and bug checking on existing server prior to switching to new server environment. Capital funding approved via WG digital funding for increased infrastructure and coverage in Feb 2024. Equipment received and to be installed ASAP. Wi-Fi limitations still an issue at POW for aspects surrounding any IOT Wi-Fi requirements, such as handheld scanners for cylinder tracking aspect. This will remain an issue until POW ICT desegregation is completed.
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 Executive Director of Finance	01.09.2021	Revised Due Date June 2024	Medium	Fully complete (Awaiting approval)	**May 2024 Update - PEP not formally agreed however below requirements all covered by the established project Board and established sub committees effective cost management;** **• contractual relationships, values and payment arrangements;** **• committee reporting of project risks;** **• scheduled outputs from sub-groups for scrutiny; and** **• stakeholder engagement.** March 2024 Update - As per previous update start date for the health centre has been agreed as 3rd June 2024. Linc's Employer's Agent and Contract Administrator (Expedite) can now prepare a PEP, which will be available before start on site June 2024
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 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 Executive Director of Finance	01.03.2022	Revised Due Date July 2024	Medium	Fully complete (Awaiting approval)	**May 2024 Update - Complete. Expedite, the Employer's agent and Contract Administrator provide monthly reports detailing the required information regarding provisional sums.** March 2024 Update - No further update. Expedite, the Employer's agent and Contract Administrator will provide monthly reports detailing the required information regarding provisional sums and contingencies however this cannot be evidenced until after a month after the start on site in June.
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 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 Executive Director of Finance	01.01.2022	Revised Due Date August 2024	Medium	Fully complete (Awaiting approval)	**May 2024 Update - Complete - Monthly update reports received.** March 2024 Update - No further update . Expedite, the Employer's agent and Contract Administrator will provide the required monthly reports however this cannot be evidenced until a month after the start on site in June.
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 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 Executive Director of Finance	01.09.2021	Revised Due Date February 2024	Medium	Fully complete (Awaiting approval)	**May 2024 Update - Documentation received from Linc.** March 2024 Update - documents requested but still not received. Followed up 18th March. January 2024 Update - These documents have been requested now that the contract has been signed and a pre-start meeting has taken place.
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 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 Executive Director of Finance	01.12.2023	No original agreed Due by Date / Revised Due Date July 2024	Medium	Fully complete (Awaiting approval)	**May 2024 Update - Any contract variations are tracked and reported by Expedite, the Employer's Agent and Contract Administrator, and require explicitly confirmation from the HB. Variations have now been received which can evidence this process.** March 2024 Update - No further 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.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 12 A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	Capital and Estates Executive Director of Finance	01.11.2021	Revised Due Date July 2024	Medium	Overdue	**May 2024 Update - no further update. A costed risk register is maintained by Expedite, the Employer's Agent and Contractor Administrator, and will be reviewed at monthly progress meetings but evidence of this cannot be provided until further into the programme.** March 2024 Update - no further update. A costed risk register is maintained by Expedite, the Employer's Agent and Contractor Administrator, and will be reviewed at monthly progress meetings but evidence of this cannot be provided until further into the programme.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 13 Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Capital and Estates Executive Director of Finance	01.09.2021	Revised Due Date July 2024	Medium	Overdue	**May 2024 Update - No further update. This will be actively monitored and managed as an integral part of the above action once project starts on site.** March 2024 Update - no further update. This will be actively monitored and managed as an integral part of the above action once project starts on site.
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 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 Executive Director of Finance	01.01.2021	Revised Due Date February 2024	Medium	Fully complete (Awaiting approval)	**May 2024 Update - Complete. Copy of signed contract between Linc and Wynne construction obtained.** March 2024 Update - documents requested but still not received. Followed up 18th March.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 18 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Capital and Estates Executive Director of Finance	01.01.2022	Revised Due Date June 2024	Medium	Overdue	**May 2024 Update - discussions ongoing with GPs however progress being made and agreement expected soon.** March 2024 Update - discussions ongoing with GPs.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 19 Management should confirm an agreed service model with measurable outcomes for front line and support services.	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Capital and Estates Executive Director of Finance	01.03.2022	Revised Due Date June 2024	Medium	Overdue	**May 2024 Update - no further update. Recommendation will not be complete until service model is agreed.** March 2024 Update - no further update. Recommendation will not be complete until service model is agreed. January 2024 Update - Recommendation will not be complete until service model is agreed. December 2023 Update - This will be led by the Primary and Community Care Group and the relevant steering group. At Project Board on the 23rd November ToR for the subgroups were shared with members for review with updates to be provided before the next meeting for review and sign off. This included as a key responsibility for the relevant group but as recommendation will not be complete until service model is agreed the revised implementation date has been moved to 6 months into the project.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 20 Objectives at the business case should be measurable.	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	Revised Due Date February 2024	Medium	Overdue	**May 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward.** March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 21 Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	Revised Due Date February 2024	Medium	Overdue	**May 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward.** March 2024 Update - no further update. Benefits will be periodically reviewed as part of the Project Board agenda moving forward.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	Sunnyside Health & Wellbeing Centre 09 Performance of relevant parties should be monitored appropriately	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable although there will be a delay with the appointment of a new contractor.	Capital and Estates Executive Director of Finance	01.09.2021	Revised Due Date February 2024	Low	Overdue	**May 2024 Update - no further update. Ongoing. Performance of the main contractor will be managed and monitored via the HB's appointed Clerk of Works (DRAC), the Employer's Agent and contract Administrator (Expedite) and via regularly progress meetings and reports. These in turn will be reported up to Project Board and its sub-groups.** March 2024 Update - no further update. Ongoing. Performance of the main contractor will be managed and monitored via the HB's appointed Clerk of Works (DRAC), the Employer's Agent and contract Administrator (Expedite) and via regularly progress meetings and reports. These in turn will be reported up to Project Board and its sub-groups.
Internal Audit/2021/76	06/08/2021	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	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 Executive Director of Finance	01.11.2021	Revised Due Date January 2024	Low	Fully complete (Awaiting approval)	**May 2024 Update - Complete. The HB is fully involved in any changes proposed and none will be made without formal HB sign off. This has been evidenced with the changes required for decarbonisations.** March 2024 Update - The HB is fully involved in any changes proposed and none will be made without formal HB sign off. This will be evidenced when the changes required for decarbonisations follow the agreed process.
Internal Audit/2022/161	14/02/2022	Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-2122-36)	CHC and FNC 1.3 The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board.	The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed. As part of an internal review of CHC we have identified the need for a policy to outline the principles of CHC commissioning and the financial control procedure can be incorporated.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.05.2022	Revised Due Date April 2024	Medium	Overdue	**May 2024 Update - This work will now be reviewed and amended as an action in the forthcoming CHC Board.** March 2024 Update - As part of an internal review of CHC we have identified the need for a policy to outline the principles of CHC commissioning and the financial control procedure can be incorporated.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.1 Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	All Care Groups Chief Operating Officer	01.08.2022	Revised Due Date April 2024	High	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - this work has been the focus of joint working, is now nearing completion and a report will be available at the next meeting.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.3 On receipt of the outcome reports, management within the CSGs should ensure that they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data or making the errors. Appropriate action should be taken including the provision of additional training on the WPAS.	ILGs will ensure that they undertake this action.	All Care Groups Chief Operating Officer	01.08.2022	Revised Due Date April 2024	High	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 1.5 Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022	All Care Groups Chief Operating Officer	01.09.2022	Revised Due Date April 2024	High	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.1 Management should ensure that the correct data detailed within the closed pathway reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	All Care Groups Chief Operating Officer	01.08.2022	Revised Due Date April 2024	High	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.2 Management should ensure that closed pathway reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that the patients are put onto an open pathway. In addition, closed pathways reports should be sent on a regular basis to staff within Bridgend ILG, or checks should be made to ensure managers are accessing this data for themselves.	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	All Care Groups Chief Operating Officer	01.08.2022	Revised Due Date April 2024	High	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.3 On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS.	ILGs will ensure that they undertake this action	All Care Groups Chief Operating Officer	01.08.2022	Revised Due Date April 2024	High	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 2.4 The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	All Care Groups Chief Operating Officer	01.09.2022	Revised Due Date April 2024	High	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2022/25	15/06/2022	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)	Patient Pathway Appointment Management Process Follow Up 3.1 Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members	This will be addressed by the ILG with colleagues from Performance	All Care Groups Chief Operating Officer	01.09.2022	Revised Due Date April 2024	Medium	Overdue	**May 2024 Update - Internal Audit has undertaken a review of this Audit and the draft Report is with the COO for comment. The Report includes new recommendations in some areas while others are regarded as completed. It is anticipated that the Report will be signed off in the near future.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2022/40	07/02/2022	Fire Safety Management_Final Internal Audit Report February 2022 (Review reference: CTM_2021_01)	Fire Safety Management 2.1 Local procedures will be reviewed and updated within specified review periods - and associated uniform approval arrangements applied.	Agreed. A review is in progress to align and standardise procedures.	Health, Safety & Fire Executive Director for People	01.03.2022	Revised Due Date June 2024	Medium	Partially complete (Overdue)	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - 90% of site specific procedures for sites are complete and the Team are on course to complete the remainder by June 2024.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 3.1 The Health Board should ensure timely completion of contacts.	Agreed – though in this case, due to the bespoke nature of the contract – a single phase business case, this did not align with the national framework contract stages - requiring additional edit prior to issue. Covid also impacted timely return.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date January 2025	Medium	Overdue	**May 2024 Update - as per March below, is likely to be in January 2025.** March 2024 Update - As per Dec 2023, this is scheduled to be in January 2025. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.1 The Health Board should assess the methodology of awarding direct contracts at design and construction projects.	Agreed – we will ensure this at future awards. However, in the early stages of this project, we did not want to contractually commit to the full scheme at the outset, until the position had been appraised.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date March 2024	Medium	Overdue	**May 2024 Update - to confirm the design team appointment was subject to a competitive process. Construction tenders will also be subject to competitive process.** March 2024 Update - Tender has been completed & returned for the design team, preferred bidder informed w/c 18 March. Discussions started with NHS England re: SBS framework, likely to be a mini competition rather than a direct award.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.2 The Health Board should confirm how value for money will be assured at the letting of the construction stage award for a Cost Adviser.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Medium	Overdue	**May 2024 Update - as per March below.** March 2024 Update - As per Dec 2023, this is likely to be in January 2025. February 2024 - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 4.3 The Health Board should ensure appropriate contractual arrangements are in place for the Cost Adviser.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Medium	Overdue	**May 2024 Update as per March below.** March 2024 Update - As per December 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Action to be addressed once there is an approved business case in place - based on current timeline this is scheduled to be January 2025.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 8.1 Management should ensure appropriate reporting, forecasting and management of project costs, for each project phase, to a project group, accountable for delivery, including overall project reporting of: • contacted sums; • cash flow budgeted to date; • expenditure to date; • forecast out-turn; and	Agreed. However, profiled costs are provided from the Supply Chain Partner. There is formal cost monitoring in terms of performance against funding to ECMG and monthly reviews of capital costs. Further reporting of the formats suggested will follow as appropriate upon review pending scale of the revised proposal.	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date February 2024	Medium	Overdue	**May 2024 Update - A new design team has been appointed, a PO is being issued for their costs and other costs (specialist consultants, surveys etc) are being compiled with an update so far to ECMG on 23 May. Costs will be reported regularly to Project Board and ECMG once they commence being invoiced.** March 2024 Update - Progress has been reported to Project Board and costs will start being incurred from April now that a new design team has been appointed.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 9.1 Pending the outcome of the options appraisal, in the circumstance that Theatres reprovision remains within preferred option, the Project Board should re-assess procurement options to ensure value for money.	Agreed. This will be undertaken at the future procurement.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date November 2024	Medium	Overdue	**May 2024 Update - as per March below.** March 2024 Update - Procurement for modular supplier is under discussion, procurement of a building contractor for works will be by competitive tender to inform the BJC costs, if and when the BJC is approved we can enter into a works contract.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.1 A costed risk register should be regularly maintained and reported, as applicable to the current project phase.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Medium	Overdue	**May 2024 Update - as per March, a new risk register to reflect the new design solution is being compiled, it will be reported to Project Board and be part of the BJC.** March 2024 Update - As it is a different way forward for the scheme the risks will be costed as part of the BJC process in Summer 2024.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.2 Management should actively monitor and report the value of residual risk v remaining contingency.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2025	Medium	Overdue	**May 2024 Update - as reported at March.** March 2024 Update - As above will be within BJC process and once contract has commenced.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.3 Risks should be individually assigned to those best placed to control them, with time parameters for action.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date December 2023	Medium	Overdue	**May 2024 Update - this will be part of the BJC.** March 2024 Update - As per Dec 2023, this is likely to be in January 2025. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Key has been agreeing preferred way forward and pulling together a timeline for the project to present to the fire service , now this has been agreed the risk register will be fully reviewed and updated to address the recommendation.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 10.4 An exception report should be published of targeted risk mitigations not achieved.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date December 2023	Medium	Overdue	**May 2024 Update - as per March below.** March 2024 Update - Exception reporting will form part of regular risk monitoring.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 2.1 The Health Board should confirm that resource requirements are appropriately assessed utilising a detailed resource schedule at the business case stage.	Agreed. The project has been adequately resourced with two internal officers to date. Formal application for resources would be made at a formal business case, and we will look to make appropriate application at that time.	Capital and Estates Executive Director of Strategy & Transformation	01.01.2023	Revised Due Date October 2024	Low	Overdue	**May 2024 Update - internal resource costs will be submitted as part of the BJC cost form, have been adequate to date but now entering a busier phase.** March 2024 Update - As per December 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - Preferred option now agreed by the project board and programme updated. Business case is due for submission to WG October 2024. Adequate resources will be factored into the fees requested.
Internal Audit/2022/43	29/07/2022	Princess of Wales Theatres: Fire Safety Works_Final Internal Audit Report July 2022 (Review reference: CTMUHB-2122-01)	POW Theatres Fire Safety Works 7.1 The Health Board should obtain advice from NWSSP: Specialist Estates Services in relation to a performance bond for construction works.	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	Revised Due Date January 2024	Low	Overdue	**May 2024 Update - as the new design team have been appointed this will form part of the discussions with NWSSP-SES on design & tender process in the summer.** March 2024 Update - As per Dec 2023. February 2024 Update - An update has not been provided against this recommendation on this occasion. December 2023 Update - This will be discussed with NWSSP in advance of tendering for the works and modular hire.
Internal Audit/2022/66	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 Executive Director of Finance	01.07.2022	Revised Due Date March 2024	High	Fully complete (Awaiting approval)	**May 2024 Update - An All-Wales P2P governance group has been re-established and is commencing in May 2024. Actions coming from the group will be implemented by the local P2P and finance teams. An updated No PO No Pay Policy and exception list has been developed and is due for roll-out.** March 2024 Update - This will be an ongoing action with collaborative working between procurement and finance. Discussions are currently being has on the governance arrangements for the All Wales P2P group which will agree updates to P2P policies. CTM are actively involved in these discussions and will ensure appropriate roll out of training following any update to No PO No Pay policies.
Internal Audit/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	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 Executive Director of Finance	01.03.2023	Revised Due Date November 2023 pending AW P2P group	Medium	Fully complete (Awaiting approval)	**May 2024 Update - Retrospective Orders are reviewed and reported as part of the Audit & Risk Committee SoD & Procurement report, with high offending areas being targeted for review.** March 2024 Update - This will be an ongoing action with collaborative working between procurement and finance. Discussions are currently being has on the governance arrangements for the All Wales P2P group which will agree updates to P2P policies. CTM are actively involved in these discussions and will ensure appropriate roll out of training following any update to No PO No Pay policies.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2022/66	15/06/2022	Financial Systems_Final Internal Audit Report June 2022 (Review reference: CTMUHB-2122-04)	Financial Systems 8.4 Documentation to support all orders should be retained made available if required	Documentation will be made available via SharePoint.	Finance Executive Director of Finance	01.03.2023	Revised Due Date November 2023	Medium	Partially complete (Overdue)	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - No further update since February 2024. February 2024 Update - Documentation and information will be available through the development of the CTM SharePoint page which will be linked to the NWSSP SharePoint page with all relevant 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.
Internal Audit/2022/67	24/10/2022	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	Radiology Service Review 12.1 A detailed workforce plan should be developed by the CSG in conjunction with their Workforce Business Partner that incorporates both the current workforce situation, plus longer-term plans in relation to areas such as known retirements.	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	30.11.2022	Revised Due Date December 2023	High	Partially complete (Overdue)	**May 2024 Update - Departmental Core Mandatory training compliance is 73.35%. All M&D staff have been contacted regarding compliance. Ongoing inhouse training.** March 2024 Update - All 3 groups have met in relation to short/medium/long term workforce plans. Meeting needed with Sally Bolt and Sam Britton to consolidate work and strategy going forward.
Internal Audit/2022/89	12.05.2022	Follow-up: Consultant Job Planning_Final Internal Audit Report May 2022 (Review reference: CTM 2122.16)	Consultant Job Planning Follow Up 5.1 Residual work in relation to the principals of the ADH rate card and its subsequent approval should be completed.	A paper discussing the principles on which a rate card will be developed has been submitted to Director of People. Agreement of these principles will then result in the engagement of interested parties to develop the rate card.	People Executive Director for People	01.12.2022	Revised Due Date Spring 2024	Medium	Partially complete (Overdue)	**May 2024 Update - Consultant Rate Card Paper is ready and is going to ELG. Upon approval, the AMD for Workforce will launch the rate card in a similar way to the launch of the non-consultant rate card.** March 2024 Update - The implementation of the consultant rate-card has been postponed due to the doctors' industrial action. We are reviewing further actions and seeking clarity around the feasibility and affordability of the proposed rate card. * Update received after deadline and not included in ARC excel spreadsheet 18/04/2024 *
Internal Audit/2022/95	15/06/2022	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	Medical & Dental Rostering Follow Up Review 3.1 The draft Medics Rostering Policy should be further reviewed to remove any legacy references to the Nursing Rostering Policy. Feedback should then sought from the appropriate groups and approval obtained from the appropriate committee ahead of making the policy available to all relevant staff.	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	People Executive Medical Director Executive Director for People	01.11.2022	Revised Due Date April 2024	Medium	Partially complete (Overdue)	**May 2024 Update - The policy is currently being updated and will submitted back to the LNC for approval.** March 2024 Update - The Policy has been submitted to LNC and has received comments have been received; the policy is currently being updated and will submitted back to the LNC for approval. * Update received after deadline and not included in ARC excel spreadsheet 18/04/2024 *
Internal Audit/2022/97	10/10/2022	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	Medical Records Management 1.1 The responsibilities of the Health Records departments across the Health Board should be standardised. Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation.	Accept There are challenges to standardising the operational procedures of the Health Records teams due to the variances between the digital systems used within the Princess of Wales and the rest of the Health Board. It should also be noted that some of the Health Records personnel within the Health Board are not under the direct responsibility and accountability of the Director of Digital. The Health Board has devised a programme of work to standardise the PAS in use across the Health Board. This programme is planned until the Autumn of 2024. Process will be aligned as practically possible prior to the completion of the programme.	Digital & Data Director of Digital	01.07.2024		Medium	In progress	**May 2024 Update - The standardisation work of the PAS will allow to support this, there are a number of health records and patient contact functions that sit outside of core health records including Mental Health, Therapies and some Community records. These are all managed within their own directorates, but we as core record managers share openly our processes and procedures. This includes the recent updates to the retention and destruction of records in line with national guidelines. I also chair the HB health records group which meets quarterly and include records managers from across the HB, this is due to meet again in June to review pressures, share good practice and process.** March 2024 Update - Monthly meetings now established. SOPs in place and shared with Care Groups in relation to the management of patients that have care delivered across the organisation. WPAS project governance structure revised and now has medical records and operational representatives at every level to ensure a consistent approach to the management of patients for the duration of the project.
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.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	Revised Due Date April 2024	Medium	Partially complete (Overdue)	**May 2024 Update - a preliminary claims audit tool has been developed by the Business Intelligence (BI) team. A meeting has been arranged with BI and Legal team to review the audit tool and develop a similar tool for Redress.** March 2024 Update - Inquest audit tool completed, with weekly reports produced by the Business Intelligence team. The development of Claims and Redress dashboards have been delayed due to system issues and the need to prioritise more urgent matters.
Internal Audit/2023/100	31/05/2023	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	Welsh Risk Pool 2.2 Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	Revised Due Date April 2024	Medium	Partially complete (Overdue)	**May 2024 Update - a preliminary claims audit tool has been developed by the Business Intelligence (BI) team. A meeting has been arranged with BI and Legal team to review the audit tool and develop a similar tool for Redress.** March 2024 Update - Inquest audit tool completed, with weekly reports produced by the Business Intelligence team. The development of Claims and Redress dashboards have been delayed due to system issues and the need to prioritise more urgent matters.
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 1.0 The decontamination policy should be reviewed and updated to reflect the most up to date guidance and practices. The revision should ensure that the updated policy reflects the current decontamination monitoring arrangements, the roles and Responsibilities of Decontamination Officer and the role and purpose of the Local Decontamination Groups. The policy should also reflect the impact of the Health Board's new operating model. Once revised and approved, the policy should be made available to relevant staff.	1a Update the Decontamination of Reusable Medical and Surgical Devices Policy (IPC 27). 1b Present the updated policy to the appropriate oversight committee for ratification. 1c Implementation of the updated policy to include appropriate team briefing and advisory support.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.11.2023	Revised Due Date 1a October 2023 Out for Comment / 1b December 2023 to Decontamination Committee/ IPCC March 2024 / 1c March 2024	Medium	Partially complete (Overdue)	**May 2024 Update - The Decontamination Policy has been reviewed in Decontamination and IPC Committee. The policy will be ratified in the next Q&S Committee meeting.** March 2024 update - Part (1a) completed. The Decontamination Policy will presented to IPC committee on the 16th April 2024 (1b). The briefing and advisory support will be issued following approval of the policy as above (1c).
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	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 Executive Director of Nursing/Deputy Chief Executive	01.09.2024		Medium	Fully complete (Awaiting approval)	**May 2024 Update - action completed.** March 2024 update - Part (2a) completed. Audit program ongoing (2b). Service users have been asked to transfer current SOP's to the new SOP template. This is monitored via the local decontamination meetings (2c).
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 3.0 Arrangements be put in place to ensure that there is a dedicated Microbiologist (Decontamination) in place for Princess of Wales site as soon as practically possible.	3a Escalation to the Deputy Medical Director and escalated to the last IP&C Committee meeting (11/07/23). 3b Multi-stakeholder meeting to discuss the current arrangements with active service level agreements, Public Health Wales and CTM to inform the programme of work required to reach an appropriate substantive outcome. 3c Outcome report and appropriate plan from stakeholder engagement to be presented to IPC Committee meeting.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	Revised Due Date 3a July 2023 / 3b October 2023 / 3c March 2024	Medium	Overdue	**May 2024 Update - a Consultant has been asked to review the current Service Level Agreement (SLA) for laboratory services and microbiology cover in CTM. The review will take place this year.** March 2024 update - Strategic review of IPC service ongoing. Led by Richard Hughes, Deputy Executive Director of Nursing.
Internal Audit/2023/107	08/08/2023	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	Decontamination 5.0 A schedule/programme of independent decontamination audits be implemented to evaluate and assess the decontamination facilities/arrangements across the Health Board. The outcome of these audits be summarised into a report for presentation to the Decontamination Committee so that appropriate actions can be taken.	5a Decontamination audit tools are currently being developed. Three audit tools will be taken to the next Decontamination Committee meeting for approval. Decontamination audit programme to commence. 5b Audit program to review decontamination facilities/arrangements across the Health Board to inform all appropriate future governance.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2024		Medium	In progress	**May 2024 Update - Audit program ongoing. An additional audit tool has been developed for USS probe decontamination. This will be circulated for comment and added to the next Decontamination Committee meeting agenda (04/06/24).** March 2024 update - Part (5a) completed. Audit program ongoing (part 5b).
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident Framework 2.1 The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend incident management training and RCA training. As part of the process of identifying staff training needs, consideration should be given to if refresher training on Datix is required.	A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements. Following approval of the Strategy, a training need analysis will be undertaken and a training Programme established.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.11.2023	**Revised Due Date October 2024** from Revised Due Date February 2024	Medium	Partially complete (Overdue)	**May 2024 Update - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme.** March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024.
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident Framework 2.2 In the meantime, it should be ensured that at least one member of the investigation team on cases is RCA trained.	Ensure that a member of the Investigation Team has received the appropriate RCA Training. Remind Care Group Leads of the requirement to include one appropriately RCA trained member in the Investigation Team. Undertake checks during the Quality Assurance Process to confirm the requirement has been fulfilled. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.09.2023	**Revised Due Date October 2024** from Revised Due Date February 2024	Medium	Partially complete (Overdue)	**May 2024 Update - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme.** March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024.
Internal Audit/2023/113	08/08/2023	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	National Incident 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 Director of Nursing/Deputy Chief Executive	01.10.2023	Revised Due Date May 2024	Medium	Fully complete (Awaiting approval)	**May 2024 Update - All 'out of date' guidance documents, have been removed from the intranet and replaced with relevant current policies and procedures. Incident Management SharePoint pages have been created and will continue to be developed as an interactive support tool.** March 2024 Update - Work continues to be undertaken to update the SharePoint Pages. This will be an iterative process, however the approved documents have been uploaded to the SharePoint Pages.
Internal Audit/2023/117	28/07/2023	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	Performance Reporting Integrated Performance Report 2.1 The Standard Operating Procedure for preparing the performance report should be enhanced to fully set out the process for preparing the report. It should include more comprehensive information on how it is determined, which performance measures are to be reported on, how data should be checked for accuracy and completeness and a detailed monthly timetable for production that allows sufficient time for Executive review.	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	Performance Executive Director of Strategy & Transformation, Director of Digital	01.01.2024	Revised Due Date - end of Qtr1 2024/25 (30/06/2024)	High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - Work continues and is in progress as per January 2024 update. On track for end of June 2024 due date. January 2024 Update - Performance Report continues to iterate - likely to continue into 2024/2025.
Internal Audit/2023/117	28/07/2023	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	Performance Reporting Integrated Performance Report 1.1 The draft performance management framework should be reviewed to ensure: • There is alignment to the most up to date Welsh Government Performance Framework, ensuring all metrics and measures outlined are accurate and there is link the IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Performance Executive Director of Strategy & Transformation, Director of Digital	01.01.2023	Revised Due Date - Revised Due Date end of Quarter 3 2024-2025 (31.12.2024)	Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - A session is being planned with the Executive Team in April to develop the next stage of the framework. 6 month extension requested. January 2024 Update - Performance Report continues to iterate - likely to continue into 2024/2025. Framework will be developed in parallel.
Internal Audit/2023/124	31/05/2023	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	Concerns Follow Up Review 3.1 3.1a Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes. 3.1b A training programme should be put in place to deliver the identified concerns training requirement.	3.1a Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training 3.1b Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board 3.1c Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	Revised Due Date October 2024 from Revised Due Date May 2024	Medium	Partially complete (Overdue)	**May 2024 Update - A meeting was held on the 01.05.24 to review draft documentation and agree a way forward. Links have been established with Organisational Development colleagues to ensure a collaborative approach alongside Restorative, Just and Learning training programme.** March 2024 Update - Finalisation of the Training Strategy has been impacted by Datix Cymru system critical issues which required prioritisation. The strategy will be circulated for Consultation during April 2024.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 1.1 Key staff, especially those listed as the target audience at the start of the INNU policy, should be made aware of the revised policy and its contents. Where necessary, training should be carried out to ensure staff understand the policy and the application of it.	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Planned Care Chief Operating Officer	01.09.2023		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 1.2 A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Planned Care Chief Operating Officer	01.01.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 2.0 For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy or within WHSSC guidance has been met. Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	Individual patient funding request panel to be re-established to receive INNU. Intervention requests necessary. Application and outcome to be documented and WPAS to be updated.	Planned Care Chief Operating Officer	01.01.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 5.1 The monitoring mechanisms set out in the INNU policy should be implemented as soon as possible. Appropriate reports should be produced monthly to monitor INNUs at an operational level which are distributed to all relevant stakeholders. These should include totals by month and by specialty/clinician so that trends and anomalies can be easily spotted and investigated. Sample checks back to patient records should be carried out to confirm all criteria had been met. The use of a checklist as recommended in Matter Arising 2 would aid this process. An appropriate mechanism should be in place for addressing any matters identified, so that corrective action can be promptly taken.	With the establishment of the recording and monitoring mechanism. Monthly reports will be produced with trends and anomalies highlighted. Any matters that require addressing will be via the Care Group with the service performance meeting structures.	Planned Care Chief Operating Officer	01.03.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 1.3 The policy, and an associated SOP, should provide greater clarity on whether the IPFR process can be used for those interventions that are listed as 'Do Not Do' and the relevant process to follow.	Application of the above actions	Planned Care Chief Operating Officer	01.01.2024		Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 4.0 A mechanism should be put in place that will allow the Health Board to monitor if activity has taken place against interventions that are classed as DNDs where no clinical code currently exists and the level of activity against the INNU interventions where no clinical code is recorded.	Data work stream established to look at the recording of INNU's across CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented.	Planned Care Chief Operating Officer	01.03.2024		Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 5.2 Consideration should be given to the need to periodically report compliance / non-compliance at a relevant level within the Health Board.	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	Planned Care Chief Operating Officer	01.03.2024		Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 3.0 The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing.	Review and update of waiting list 'holding names' to be undertaken	Planned Care Chief Operating Officer	01.03.2024		Low	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - An update against this recommendation has not been provided on this occasion. December 2023 Update - An update has not been provided against this recommendation on this occasion.
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 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 Chief Operating Officer	01.02.2024		High	Fully complete (Awaiting approval)	**May 2024 Update - This is included within the Facilities Performance and Governance audits which are completed monthly. This action can now be closed.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate Report provided by the DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.
Internal Audit/2023/147	16/10/2023	Follow-up: Facilities Systems_Final Internal Audit Report October 2023 (Review reference: CTM-2022.23-42)	Facilities Systems Follow Up Review 6.0 Management should review and clarify purchasing and budgetary arrangements and responsibilities for Central Facilities Hub and ensure that they align to the Health Board's revised Operational Structure.	The Facilities Hub and non-hub no longer exist. Systems are now in place to track and monitor, however further review is required to reduce activity and achieve budget. The services se arears are significantly overspent. Further control measures need to be determined, implemented and monitored.	Facilities Chief Operating Officer	01.10.2023	Revised Due Date February 2024	High	Overdue	**May 2024 Update - Purchasing and budgetary arrangements have been put in place for the revised Facilities Directorate and these align to the UHB Operational Structure. Systems are in place to track and monitor activity for Compliance to procurement process and for budgetary control.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.
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 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 Chief Operating Officer	01.02.2024		Medium	Fully complete (Awaiting approval)	**May 2024 Update - Additional P2P training has been provided and compliance is now at 95%. As with the Qlik training, this is also included on the Facilities Performance and Governance audit Training Matrix and monitored monthly. This action can now be closed.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.
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 2.2 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 [illegible]	Facilities Chief Operating Officer	01.02.2024		Medium	Fully complete (Awaiting approval)	**May 2024 Update - This is included within the Facilities Performance and Governance audits which are completed monthly. This action can now be closed.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.
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 2.3 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 Chief Operating Officer	01.02.2024		Medium	Fully complete (Awaiting approval)	**May 2024 Update - This is included within the Facilities Performance and Governance audits which are completed monthly. This action can now be closed.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.
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 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 Chief Operating Officer	01.10.2023		Medium	Fully complete (Awaiting approval)	**May 2024 Update - Invoices on Hold statements are received from Procurement services by all Facilities teams. Monitoring action taken against any IOH is included within the Facilities Performance and Governance audits. This action can now be closed.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update.
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 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 Chief Operating Officer	07.10.2023		Low	Fully complete (Awaiting approval)	**May 2024 Update - Additional training has been provided and the training compliance rate is 88% The requirement for Qlik training is included in the Facilities Performance and Governance audit Training Matrix and monitored monthly. This action can now be closed.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - Separate report to be made by DoF. An action tracker has been developed within Facilities to address the required Management Actions raised in the internal audit. The action tracker has been submitted for consideration as a separate agenda item and contains a full update. Update received after deadline and not included in ARC Excel Report 22nd February 2024.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 2.1 Older, out of support devices should be removed from use.	Continue to prioritise and review aged assets with a view to replacement, balanced with limited funding sources. Manage and maintain the related risk within the Departmental risk register.	Digital & Data Director of Digital	30.06.2024		Medium	In progress	**May 2024 Update - Rollout has begun of the endpoint devices procured through the Cyber bid and end of year slippage funding. Progress is being made with our server estate, and we have removed a further 20 servers running Windows 2003/2008. We are actively working with Clinical Systems and suppliers to work through the remaining legacy servers. As a mitigation we are using Trend software to apply security patches to the legacy servers. Progress is also being made with our legacy network equipment. We have replaced 213 older Cisco 3750 switches. We have also recently purchased 900 new wireless access points through funding for the ePMA project to improve wireless resilience. This will enable us to replace the majority of our legacy access points. Additional funding is still required to be able to replace core network switches and edge switches. We have allocated some funding in the 24/25 Digital discretionary capital allocation to help redress the issue. However relying on discretionary capital and end of year slippage monies rather than a fully funded rolling replacement programme makes it challenging to manage our legacy estate.** March 2024 Update - We have received further money further end of year slippage money from WG. This included £1m to improve wireless resilience, replacing older access points. £700k to replace iGels devices, and £1m to improve infrastructure across CTM, with a focus on Bridgend.
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 3.1 Documentation should be produced that sets out the processes for: - Managing and configuring Solarwinds; and - Handling of alerts.	The individual has now left. Management of the SolarWinds platform is now shared across the infrastructure team, although there is no lead and documentation produced is of limited value. Develop the skills and documentation within the team to maximise the use and value of the system for monitoring purposes. Recruit Additional staff in line with the Infrastructure Review resource plan."	Digital & Data Director of Digital	30.06.2024		Medium	In progress	**May 2024 Update - limited progress has been made here due to our ongoing operational workload and staff shortages in our networking team. We are about to start a recruitment campaign to add much need capacity to the team.** March 2024 Update - No further progress. Cyber staff aligned to networking and (as anticipated Solarwinds) is currently assigned to urgent firewall and routing reviews in relation to protecting the CTM perimeter and in particular the links in and out of SBU to The Princess of Wales site. Plans for Solarwinds training and ownership will require further review and potentially realignment or resourcing.
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	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 Director of Digital	31.12.2023		Medium	Fully complete (Awaiting approval)	**May 2024 Update - the patching policy is now in place - this audit item can be closed.** March 2024 Update - Patching policy has been written and is now an accepted document within the department.
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 1.1a Work to complete the register / CMDB should be progressed. Asset information for the Bridgend area should be included and kept up to date.	The Asset manager has been extended to March 2024. They will continue to gather and maintain records of these assets. Service Management tooling and the related CMDB are not in place and a system for this requires investment. A case will be developed to support with the specification, costs and resources required for this.	Digital & Data Director of Digital	31.03.2024	Revised Due Date - end of Qtr 2 2024/2025	Low	Overdue	**May 2024 Update - We are trialing a passive discovery tool that will be used to monitor the network, identify devices and develop a CMDB.** March 2024 Update - No further update this month. February 2024 Update - An assessment has been produced assessing ITSM Tooling - we will factor this into IMTP planning for the next FY. The current Asset/Configuration manager has now moved to another post, leaving us short on resource. Recommend a revised implementation date July 2024.
Internal Audit/2023/148	09/10/2023	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 6.1 The network topology and make up should be recorded outside of the monitoring tools.	Plans in place to review and document individual sites. Staffing levels will determine the time it will take to complete the work. Priority will be given to the critical sites, as this also supports the review work required for NIS-D assessment.	Digital & Data Director of Digital	31.03.2024	Revised Due Date - end of Qtr1 2024/2025	Low	Overdue	**May 2024 Update - Good progress is being made, draft version of network topology has been created, which will be verified and continually developed.** March 2024 Update - No further update this month. February 2024 Update - Staffing levels and other more urgent work is impacting delivery of this action. Discussions are in place to alleviate the resourcing issue. Recommend a revised implementation date of June 2024.
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 1.1 A standard operating procedure (SOP) should be developed for reference by current and future DoLS staff to ensure a consistent approach is in place for all applications. The SOP could include the process for reviewing applications ahead of logging on the spreadsheet, completion of the spreadsheet, processes for chasing outstanding information, quality checks and the authorisation process.	The DoLS team will develop a Standard Operating Procedure (SOP) for the following processes: • Identification of a Deprivation of Liberty and how to make a referral (ward Based) • Receiving, prioritising and recording applications. • Completion of Welsh Government datasheet and referral maintenance. The Role of the Best Interest Assessor, s12 Doctor, DoLS Administrator, DoLS Team Leader, Signatories, Relevant Persons Representative. • The ward responsibilities following authorisation. This SOP will complement the Health Board and Safeguarding Board DoLS policy.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.04.2024		Medium	Overdue	**May 2024 Update - The consultation period exceeded expected time frame as it required relevant amendments, resulting in the SOP being unable to be approved at April's Safeguarding executive Group. The SOP is out for final consultation of two weeks and will be presented to the Safeguarding Executive Group in July for approval.** March 2024 Update - The Standard Operating Procedure is currently out for consultation and due to be presented to April Executive Group for approval.
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 3.3 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 Director of Nursing/Deputy Chief Executive	01.01.2024	Revised Due Date April 2024	Medium	Partially complete (Overdue)	**May 2024 Update - Quality assurance meeting has been held by Deputy Head of Safeguarding on the 10th of April 2024. Terms of reference have been agreed. Meetings are scheduled quarterly. Membership includes primary care, mental health, advocacy, DoLS team Leader and a member of the DoLS team. Quarterly reports will be presented to the Safeguarding Executive Group by Deputy Head of Safeguarding.** March 2024 Update - The TOR for the quality assurance group are complete, with a meeting scheduled for April. The agenda will include overview of the audit recommendations, future planned audits, MDT approach to quality assuring each step of the DoLS process. Colleagues from Care Groups and advocacy have been invited. Monthly reports are provided to the Head of Safeguarding detailing any quality and performance issues.
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 4.3 Consideration should be given to capturing time in relation to casework stages to assist in identifying, quantifying and confirming areas where delays commonly occur.	The Health Board will undertake a retrospective review for the number of DoLS applications for the previous 4 years, when the MCA Amendment Act (2019) was passed. This data set will then be examined with a view to identifying possible trends in order to condition a respective trend for the forthcoming year. This will in turn decide on the ability to predict future flow and numbers for DoLS activity in CTMUHB.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.02.2024	Revised Due Date April 2024	Medium	Partially complete (Overdue)	**May 2024 Update - A report detailing analysis of four year data and future predicted DoLS activity was presented to the Safeguarding Executive Group in April 2024. Based on current resource and activity, the team would need to double to maintain a reduced backlog. This is currently being managed by outsourcing assessments to an external agency.** March 2024 Update - This report is complete and will be presented to Safeguarding Executive Group in April 2024.
Internal Audit/2023/151	28/11/2023	Deprivation of Liberty Safeguards (DoLS)_Final Internal Audit Report November 2023 (Review reference: CTMUHB-2324-07)	Deprivation of Liberty Safeguards 4.2 Consideration should be given to capturing time in relation to casework stages to assist in identifying, quantifying and confirming areas where delays commonly occur.	• Current performance management spreadsheets will be reviewed and amended to reflect the complete DoLS process from referral to authorisation. • The development of a quality assurance and monitoring group headed by the Deputy Head of Safeguarding will identify and deliver a process for escalating operational deficits which impact on time.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.01.2024	Revised Due Date February 2024	Low	Partially complete (Overdue)	**May 2024 Update - As above, the quality assurance meeting has been held for April and quarterly meetings planned. Updates will be provided in a report at the safeguarding executive group. Sequential numbers are now utilised within the database.** March 2024 Update - 6 of the 8 recommendations have been completed. Draft version of the SOP has been completed and is awaiting approval. First Quality Improvement Group planned for April 24 where the TOR will be discussed, preparatory work remains ongoing.
Internal Audit/2023/152	07/12/2023	PCH Redevelopment Programme: Supervisor Role_Final Internal Audit Report December 2023 (Review reference: CTM-SSU-2324-07)	PCH Redevelopment Supervisor Role 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	Capital and Estates Executive Director of Finance	01.01.2024		Medium	Fully complete (Awaiting approval)	**May 2024/June 2024 Update - Supervisor's report now identifies those defects that have a priority.** March 2024 Update - there is no additional update to that provided as at February 2024. Reports are developed and presented on a monthly basis. This will be reviewed at the QI group moving forward. Quarterly scorecards have been adapted to ensure appropriate escalation through the Safeguarding Executive Group.
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.	Commissioning Executive Director of Strategy & Transformation	01-Sep-23	jun-24	High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - A service agreement template has been approved for use for 2024-25 agreements. Due to changes to procurement requirements in 2024, staff will require further training to undertake agreements with providers. Training is being organised for Wales NHS teams and spaces for CTMUHB teams have been requested. The process for ceasing arrangements has been reviewed based on NHS service agreement changes and will be supplemented by a process for initiating new agreements. Meetings with each care group occur bi-monthly and provide a mechanism to support setting up, monitoring and ceasing agreements.
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 5.0 Adequate data should be obtained in line with SLA requirements to allow effective performance, quality and financial monitoring of the SLA to take place. The supporting data should be provided in sufficient time before SLA reviews are scheduled to occur so that it can be properly considered at the review. Evidence and supporting data should be retained of the SLA review process.	Please refer to action four above, which confirms that information requirements and review frequency will be determined with Care Groups. The capacity of the Strategy and Transformation team's commissioning function has been a limiting factor in the robust development of processes. A Commissioning Support Officer vacancy is being considered by the organisation's scrutiny panel. This post will lead on organisation of the administration of the register of agreements and the meetings with Care Groups. A Head of Commissioning job description has been developed and has been sent for Agenda for Change banding. This post will be recruited to on a fixed-term basis while the Head of Planning post is vacant due to secondment. Should this role provide successful, every effort will be made to structure the team to retain this function, however this will be dependent upon the team budget.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	Revised Due Date June 2024	High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - The regular care group commissioning meetings provide a structure to ensure appropriate review of agreements. A final adjustment to the register of agreements is inclusion of monitoring leads for both planning/ commissioning and care groups.
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 3.0 When SLAs are agreed the documentation should be completed to include the details of the lead contact for the Health Board. SLAs should be signed on behalf of the Health Board as the commissioning body and by the provider before the start of the period to which it applies to confirm agreement with its terms and conditions.	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	Revised Due Date June 2024	Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - Guidance will be finalised when the HB teams complete training on new procurement requirements, however the commissioning meetings with care groups provide a structure to ensure there is support for appropriate sign off and storage of agreements.
Internal Audit/2023/37	06/06/2023	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	SLA Arrangements 4.0 SLAs should be reviewed in line with timeframes set out within them and the spreadsheet register kept up to date with renewal dates.	The meetings to be initiated with Care Groups as described in the actions above and the updating of the register of agreements will include the required performance information for each agreement and frequency of reporting, with the officers responsible for review to be identified.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	Revised Due Date January 2024	Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - Monitoring and review of agreements is a constituent part of the regular commissioning meetings with care groups.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 1.1 As we continue to move away from a pandemic environment, the Health Board should review its approach to the provision of reasonable appointment offers and the subsequent management of waiting lists, in light of any additional WG guidance issued during the course of the pandemic. The Waiting List Management Standard Operating Procedure should be reviewed, updated and appropriately approved. Previous versions of the Waiting List Management Standard Operating Procedure should be removed from the Health Board's intranet site and only the current version published.	Standard Operating Procedures to be reviewed and updated with approval at OMB and Executive Leadership Group. Once approved, the SOP will be published and issued to all booking teams. Previous versions of the SOP will be removed from the intranet and kept in a historical record.	Planned Care Chief Operating Officer	30.04.2023	Revised Due Date April 2024	Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report.
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 2.3 Consideration should be given to the current approach of having some bookings managed centrally and some managed within specialities, to ensure that the chosen approach does not place the Health Board at greater risk of having inconsistent approaches, errors in application of the RTT rules and over-reliance on key individuals. (We acknowledged that instigating data validation checks will need to take place first to allow relevant information to be available on non-conformance.)	A review of the structures in Bridgend will take place. A plan for an organisational restructure with a standardised approach will be developed.	Planned Care Chief Operating Officer	30.06.2023	Revised Due Date April 2024	Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report.
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 3.1 The Health Board should perform a training needs assessment of staff responsible for booking appointments and arrange for refresher training on the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	A training needs assessment and compliance sign off will take place post implementation of the agreed SOP. Refresher training to be organised where required for staff identified.	Planned Care Chief Operating Officer	01.08.2023	Revised Due Date April 2024	Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report.
Internal Audit/2023/57	03/04/2023	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)	Reasonable Offer Process 5.1 A review of the approach to data validation to ensure compliance with the Waiting List Management SOP and RTT rules should be undertaken. A pro-active, consistent and independent approach should be adopted regardless of whether the booking has been made by a central booking team or the speciality themselves. The Waiting List Management SOP should be updated to reflect the validation process. Ongoing data validation work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams / specialities. Where there are persistent errors in specialities consideration should be given as to whether it is appropriate for that service to retain managing its own bookings, or if the process should revert to one of the central booking teams.	5.1.1 - Identification of WPAS reports to allow for identification of compliance. 5.1.2 - Development of process to escalate where processes are not being followed consistently, sharing training documents/ SOP to support improvements"	Planned Care Chief Operating Officer	01.08.2023	Revised Due Date April 2024	High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 Update - as a consequence of staffing issues connected with OCP 2 there is no further action to report.
Internal Audit/2023/73	08/08/2023	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	Radiology Workforce Follow Up Review 4.1 Management at RGH should continue to liaise with the Learning and Development team to ensure the suggested amendments to learning profiles are implemented on ESR. It should be determined if similar exercises to refine learning requirements are required for staff at the PCH and POW sites.	Two members of staff have been assigned responsibility to review all Radiology staff core competencies as a focussed piece of work. They will liaise with learning and development.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	01.09.2023	Revised Due Date February 2024	Medium	Overdue	**May 2024 Update - Meeting to review competencies on 18/04/24. Appeals process underway 16/05/24.** March 2024 Update - work still underway. Learning and Development team have responded to state that they are short staffed but have signposted information on next steps to appeal against competencies which are felt unnecessary.
Internal Audit/2023/73	08/08/2023	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	Radiology Workforce Follow Up Review 4.2 The CSG should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role. It should be ensured that all staff are provided with the opportunity to undertake their mandatory training.	Module of the month is promoted through the Staff Newsletter, reports regularly circulated to Superintendents.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	01.12.2023	Revised Due Date December 2023	Medium	Overdue	**May 2024 Update - Departmental Core Mandatory training compliance is 73.35%. All M&D staff have been contacted regarding compliance. Ongoing inhouse training.** March 2024 Update - Current Overall Core Mandatory Training compliance 69.65%. Moving and Handling and Resus are lowest compliance due to lack of training available or staffs inability to attend due to clinical needs. The department has since trained the trainers to roll out both modules in house and are training 6 staff per month to improve compliance.
Internal Audit/2023/73	08/08/2023	Follow-up: Radiology Workforce_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2324-22)	Radiology Workforce Follow Up Review 5.0 Work should continue to resolve the issues raised with the five Consultant job plans within PoW.	Current compliance POW: • 7 signed off • 1 awaiting 1st sign off • 1 expired but booked – date arranged for 20/09	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	30.09.2023	Revised Due Date December 2023	Low	Overdue	**May 2024 Update - 21 with an up to date JP, 6 booked or need further amendments, 3 not booked. 70% compliant.** March 2024 Update - 17 with an up to date JP, 11 booked, 2 not booked.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	1.1a A standardised approach to the application of the 4-hour performance clinical exception guidance should be established by the Health Board. 1.lbA comprehensive SOP should be created for use across all sites setting out a standardised approach to the application of the WG guidance on calculating the 4-hour performance target and the use of breach exemptions. The SOP should include details on capturing and recording data in relation to the 4-hour performance target, especially definitions for recording of times, when breach exception codes can be used, the responsibility for inputting data and the validation process. Managers across all sites need to be involved in the process of creating SOP.	Develop standardised approach to application of 4 hour clinical exception to include a pan CTM SOP for application of WG guidance.	Unscheduled Care Chief Operating Officer	01.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	1.2 A review of the breach reason codes should be carried out to establish a consistent set of codes to be used across all sites. This will allow the Health Board the ability to consistently monitor reasons for patients spending longer than 4 hours in ED and help inform decision making.	Develop a standardised set of codes to be used across all sites.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	2.1Staff should be reminded of the importance of consistently and fully completing CAS cards with all required information. Management should gain an understanding from staff why the summary table as seen on the front of PoW CAS cards is not being completed and determine if it's used could be beneficial for all sites.	Communicate through safety briefings the importance of fully completing CAS Cards and review implementation of summary table across all sites.	Unscheduled Care Chief Operating Officer	01.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	2.2 The CAS cards at each site should be reviewed with a view to creating a standardised CAS card that explicitly sets out the key information that should be recorded.	Develop standardised CAS card for all sites in conjunction with Clinical Director and Lead Nurse.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	3.1 Acknowledging that two versions of WPAS are in use by the Health Board, were possible a consistent approach to WPAS training should be in place for staff across the sites to ensure data capture is consistent. Once a SOP has been agreed, standard training on the application of the breach exemption and breach reason codes should be provided to relevant staff, along with an overview of the rationale for capturing information.	Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	4.1The importance of clearly and consistently capturing key date and time information on the CAS cards should be reiterated to staff and additional training provided where necessary. The importance of accurately transferring data from the CAS cards to WPAS should be reiterated to staff and additional training provided where necessary.	Ensure standardised approach to training across all ED', monitor through Directorate Performance Meetings.	Unplanned Care Chief Operating Officer	01.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	4.2The criteria for determining the treatment complete time should be reviewed with a view to having a consistent definition in place across all sites. Similarly, the approach to applying breach exemption codes, specifically relating the time in the patient's journey when they are applied, should be reviewed to ensure consistency. The agreed approaches should be captured in a SOP.	• Undertake review of treatment complete time and implement consistent definition on all sites. • Ensure breach exemption codes applied consistently, develop SOP and monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.1A record should be maintained of the adjustments made including who originally input the data and the error that was rectified. The data should be used to identify staff training requirements.	Implement a standardised approach to capturing any changes to records, monitor through Directorate Performance reviews	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.2Further work should be undertaken to ensure that those cases adjusted as part of the retrospective validation process are being correctly captured and reported. Consideration should be given to maintaining a record of the WPAS entries that have been adjusted in order to allow spot checks to be performed to confirm the adjustment was correctly captured on the system.	Undertake regular "snapshot" audits to ensure validation is correctly captured and monitor through Directorate Performance reviews.	Unscheduled Care Chief Operating Officer	01.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.3A review of the validation approaches currently in place across the sites should be carried out. It should be clear what the objective of validation work is, and a standard approach applied across site to ensure consistency in reporting.	Review validation approaches across all ED's and implement a standardised approach to reporting.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.4A data cleansing exercise should be carried out on the POW outstanding cases spreadsheet. Given the age of some of the entries, it should be determined if validation is worthwhile.	Undertake review of outstanding cases at POW and determine if validation is required	Unscheduled Care Chief Operating Officer	01.06.2024		Low	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.1 Weekly senior management team meetings at POW should be reinstated as a forum for discussing ED performance matters including performance against the 4-hour target.	Re-instate weekly SM meetings at POW.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.2 Agendas and action logs of all key groups and committees should be retained to support the discussions and decisions made during the meeting and to ensure actions are captured and followed up at subsequent meetings.	Ensure agenda and action logs are retained.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.3 Consideration should be given to incorporating site specific data as part of the slide deck taken to the USC Care Group performance meetings to allow more enhanced monitoring and discussion of issues per site.	Site specific slide deck in place, ensure used to underpin discussions.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	6.4Consideration should be given to undertaking more detailed reporting that provides analysis of the data currently presented, such as the proportion of non-breaches that are as a result of clinical exemptions, and the proportion of 'did not wait'. Analysis of the breach reason codes, should be undertaken with the aim of better understanding the causes of patients exceeding the 4-hour target.	Develop a more detailed report to include analysis of breach codes.	Unscheduled Care Chief Operating Officer	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.** March 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	1.1Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated.	Ensure the Service Catalogue is updated to reflect all of the critical systems in place and complete the additional fields including identifying if the system is locally managed or run by a supplier, and also identify where the system is hosted.	Digital & Data Director of Digital	01.07.2024		Medium	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	1.1Management should ensure that the service catalogue is complete with all required information, and that it is regularly reviewed and updated.	Further refine and review the Service Catalogue and extend it to include dependencies of local, national and cloud infrastructure. E.g. The majority of systems are accessed via CTM Managed end user devices so the review should ensure that these common components (such as Citrix, Wireless, LAN and WAN) are reviewed for their resilience and recover ability.	Digital & Data Director of Digital	01.07.2024		Medium	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	2.1Management should ensure that knowledge management is progressed through the creation and development of ITIL aligned processes and procedures.	Creation of a Digital Service Management Function. Create a Digital Service Management function as part of current structural review of Digital Delivery. Appoint into the vacant Head of IT Service Management role. Then assess current maturity of ITIL aligned processes and procedures and prioritise development.	Digital & Data Director of Digital	01.10.2024		Medium	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	3.1 Management should establish a defined relationship management framework to align expectations, improve communication and manage risk, and develop relationship metrics to assess their quality, value and impact.	Once a Digital Service Management function has been created (Action 2.1) develop a framework and approach to internal service relationship. This action is predicated on the development of our service catalogue (Action 1.1) as well as an approach to business relationship management (BRM) that will need to span the Digital Delivery, Digital Systems and Digital Intelligence, Compliance & Design.	Digital & Data Director of Digital	01.01.2025		Medium	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.1Management should implement and maintain a single, central register of suppliers and contracts to allow visibility and control over contract data, costs, documentation, action plans and supplier performance data.	Once a Digital Service Management function has been created (Action 2.1) develop a single, central register of suppliers and contracts. This will need co- ordination with our internal Business Admin team, Finance and Procurement.	Digital & Data Director of Digital	01.10.2024		Medium	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.2Management should ensure that an appropriate framework for effective supplier and contract management is developed which allows for clear, planned, and regular activity e.g., measuring and policing supplier performance and active management of contract key dates and milestones.	Creationof a tiered frameworkcategorising high, medium andlow value/importancesuppliers and contracts, and the appropriate level of governance and level of management given to each category.	Digital & Data Director of Digital	01.10.2024		High	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	4.3 Management should ensure that efficient contract control measures are developed and employed with appropriate oversight, to ensure that suppliers maintain performance and invoices are issued correctly.	This action is closely tied to action 4.2 and the appropriate controls will need to be placed with supplier and contract management framework.	Digital & Data Director of Digital	01.10.2024		High	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.1 Management should ensure that the pre-defined call functionality is expanded to all applicable services, to have a consistent approach to logging calls and more accurate metrics.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25.	Digital & Data Director of Digital	01.04.2025		Low	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.2 Management should ensure that where available, the pre-defined call functionality is used to allow for the accurate recording of details, such as call type and priority.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025		Low	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.3Management should ensure that requests such as staff termination forms are accurately logged.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025		Low	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	5.4 Management should ensure that the classifications data held within ServicePoint is reviewed and cleansed of duplications and are configured for all applicable services.	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025		Low	In progress	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024.

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Internal Audit/2024/163 Internal Audit/2024/169	08.02.2024 11/04/2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18) Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.1Management should ensure that a defined problem management process and procedure is finalised, published, and adopted. 1.1a Management should ensure there is a standardised approach to Controlled Drugs incident reporting. As such, the draft guidance should be reviewed and finalised as soon as possible, and made available to all relevant staff.	Once a Digital Service Management function has been created (Action 2.1) complete process and procedures for Problem Management. CD Incident Reporting Standard Operating Procedure to be approved by Operational Management Board.	Digital & Data Director of Digital Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.01.2025 01.04.2024		Medium Medium	In progress Overdue	**May 2024 Update - There are delays to start of recruitment of a Head of IT Service Management, it is hoped recruitment will start in July 2024.** March 2024 Update - Activity is underway to shape an updated Head of IT Service Management to go out for recruitment in April 2024. **May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	1.1b If the existing SOP at YCR is needed following the implementation of all Health Board guidance, it should be reviewed to ensure that it is consistent with the Health Board wide guidance.	Review of YCR SOP to see if still needed.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	1.2 Management should review the controlled drugs documents on the Health Board's intranet to ensure that only the correct procedures are available.	Review of searches for common controlled drugs search terms: CDs, Controlled Drug, Controlled Drugs, Gabapentin, opioid, opiate to be reviewed and flagged to IT for removal.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.08.2024		Low	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1a A review of authorised signatory lists should take place to ensure they are up to date.	A review of authorised signatory lists will take place to ensure they are up to date.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.09.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1b Management should remind ward and theatre manager that it is their responsibility to inform pharmacy of any amendments that need to be made to authorised signatory lists.	Nursing management to remind ward and theatre manager that it is their responsibility to inform pharmacy of any amendments that need to be made to authorised signatory lists.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1c A process should be established for reviewing authorised signatory lists on a periodic basis, for example forming part of the quarterly audit checks that pharmacy undertake at each ward or theatre.	A process will be established for reviewing authorised signatory lists on a periodic basis, for example forming part of the quarterly audit checks that pharmacy undertake at each ward or theatre.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.1d Pharmacy staff should be reminded of the importance of referring the authorised signatory lists to ensure order have been place by authorised staff.	Pharmacy staff will be reminded of the importance of referring the authorised signatory lists to ensure order have been place by authorised staff.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024		High	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.2 Management should remind ward and theatre staff of the SOP requirements around: • Retaining copies of order books and controlled drugs registers for the required period of 2 years. • The importance clearly signing controlled drugs orders and registers and printing names where required. • Completing all required fields within the order book and the controlled drugs register. Consideration could be given to requiring staff to sign to confirm they have read the SOPs and understood them, as was the practice at on theatre visited.	Nursing management should remind ward and theatre staff of the SOP requirements around: • Retaining copies of order books and controlled drugs registers for the required period of 2 years. • The importance clearly signing controlled drugs orders and registers and printing names where required. • Completing all required fields within the order book and the controlled drugs register. Consideration will be given to requiring staff to sign to confirm they have read the SOPs and understood them, as was the practice at on theatre visited.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024		Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	2.3 Consideration should be given to amending the SOP to: • Require staff to print their name in addition to signing when taking receipt of controlled drugs from pharmacy and when entering the drugs in the controlled drugs register. • Being more explicit in the name used to describe the drug being ordered i.e. manufacturer name or drug name.	During the next review of the procedure, consideration will be given to amending wording to: • Require staff to print their name in addition to signing when taking receipt of controlled drugs from pharmacy and when entering the drugs in the controlled drugs register. • Being more explicit in the name used to describe the drug being ordered i.e. manufacturer name or drug name.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	31.10.2024		Low	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	3.1 Management should ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.	Communication to ensure staff are reminded that the CD cabinet keys are to be kept separate and unattached to other keys.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024		Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	4.1a Discussions should be held with wards and theatres managers to understand why the weekly checklists are not being completed and if necessary amendments should be made to the current checklist.	Discussions will be held with wards and theatres managers to understand why the weekly checklists are not being completed.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	4.1a Discussions should be held with wards and theatres managers to understand why the weekly checklists are not being completed and if necessary amendments should be made to the current checklist.	If necessary amendments will be made to the checklist during the review of the CD procedure.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	31.10.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	4.1b Ward and theatre managers should be reminded that the weekly checklists cover a wider remit than just a count of controlled drugs held, and of the requirement to complete and retain them in line with the SOP.	Ward and theatre managers will be reminded that the weekly checklists cover a wider remit than just a count of controlled drugs held, and of the requirement to complete and retain them in line with the SOP.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024		Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	5.1 Management should ensure Pharmacy audit checks are performed quarterly in line with the SOP.	Management will ensure Pharmacy audit checks are performed quarterly in line with the SOP.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024		Low	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.1 The importance of fully completing the quarterly CDLIN highlight / occurrence reports, including the details of the ward or theatre, should be emphasised.	When the request for the occurrence reports are sent out before the CD LIN, the importance of fully completing the reports, including the details of the ward or theatre, will be emphasised.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.04.2024		Low	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.2 To aid the ability to proactively monitor CD related incidents for patterns and trends that could allow targeted training, the Medicines Management team should liaise with the Datix team to establish if there is a way for meaningful data that is quality checked to be extracted from the system. If this is deemed to not be feasible, then consideration should be given to collating the information captured in the quarterly CDLIN highlight reports to allow analysis to take place.	To aid the ability to proactively monitor CD related incidents for patterns and trend that could allow targeted training, the Medicines Management team will liaise with the Datix team to establish if there is a way for meaningful data that is quality checked to be extracted from the system. If this is deemed to not be feasible, then consideration will be given to collating the information captured in the quarterly CDLIN highlight reports to allow analysis to take place.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	6.3 Consideration should be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.	Consideration will be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.05.2024		Low	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/169	11/04/2024	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	7.1 A central electronic record should be retained of those staff that have undertaken Controlled Drugs training and refresher training. Consideration should be given to using ESR for this purpose.	A central electronic record is retained for staff trained since 2020, however consideration will be given to using ESR for this purpose.	Diagnostics, Therapies, Pharmacies and Specialities Medical Director	01.09.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	1.1a A policy that outlines the Health Board's approach and responsibilities for GI pathways including demand management should be put in place. 1.1b A review of the draft 'Single CTM Colorectal USC Pathway GP Referral Triage' SOP should be carried out, with a view to creating a single SOP that describes the step-by-step process that should be followed to ensure consistency in service delivery across all sites. It should be ensured that the SOP clearly sets out the excepted process to be followed for areas such as GP and internal referrals, the triage and triage process and timeframes for undertaking the various stages in the process. The draft SOP should be agreed at an appropriate level within the Health Board. Where there are variations in service delivery, such as the Nurse Led Rapid Access One Stop Colorectal Clinic based at PCH, then a	A CTM Standardised LGI SOP to be developed, reviewed and agreed.	Planned Care Chief Operating Officer	30.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	1.2 Specific guidance should be developed and made available in relation to: • GPs outlining the processes relating to general or non-USC GI referrals. • Internal hospital departments in respect of processes to be undertaken for internal GI referrals.	Following completion of the LGI SOP - this will include flow/process charts and referral criteria to support internal and external referral process.	Planned Care Chief Operating Officer	30.06.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	2. Work should continue to explore the feasibility of integrating the WPRS and WCP/WPAS at PCH and RGH sites and negate the need for the current process of printing referrals from one system for scanning into another system. Management should remind staff that referral and triage documentation for cases should be complete, and records saved within WCP/WPAS.	1. Need confirmation for go live date for LGI/Surgery. 2. Set up meeting with Records and Digital Team	Planned Care Chief Operating Officer	30.04.2024		Medium	Overdue	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	3.1 Processes should be implemented to ensure that referrals are efficiently and effectively triaged by clinicians within the shortest reasonable timescale after receipt, to minimise delay risks that could lead to patient harm. This should include the process to be followed where there is the known absence of a clinician. Where there appears to be service areas where triage is not being carried out as timely as others, then a review should be undertaken to understand the cause of this and identify ways of improving service delivery.	1. Complete and roll out new CTM LGI SOP. 2. Produce referral and vetting process in line with SOP.	Planned Care Chief Operating Officer	30.09.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	3.2 Management should review of the paper-based triage process used in a number of service areas to establish if the electronic processes used elsewhere can be rolled out. The use of fully electronic files will negate the need for printing and rescanning of records, meaning files can be traced and accessed, with an electronic record of decision making retained. Where paper triage forms continue to be used, forms should be revised to require the triage clinicians printed name in addition to their signature. Clinicians should be reminded of the importance of signing triage forms once complete to provide a complete record of the decision-making process.	1. Understand go live date for E-Refs for LGI/Surgery. 2. link in with Records/Digital team.	Planned Care Chief Operating Officer	30.09.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	4. Periodic 'peer review' quality assurance exercises should be undertaken by clinicians to ensure consistency in approach to patient referral triage and triage. The review should consider patients that were added to pathways and patients where their case was considered to be an 'inappropriate referral'.	1. To become part of the GI Directorate agenda - date of first meeting to be confirmed. 2. Replicate endoscopy peer review in line with JAG guidelines.	Planned Care Chief Operating Officer	30.06.2024		High	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	5. There should be a consistent approach to reviewing and monitoring referral and demand activity across the Gastroenterology and Colorectal GI services. This could be supported further by the use of the Medical Records reports that outline delayed and unvetted referrals.	1. Imbed new CTM leadership structure. 2. Continue to work with our informatics teams to build purpose dashboards that support D&C and monitoring of productivity and efficiencies.	Planned Care Chief Operating Officer	31.12.2024		Medium	In progress	**May 2024 Update - An update against this recommendation has not been provided on this occasion.**

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Inspection / Executive Lead	Date Due	Revised Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	1.1 The terms of reference for the Environmental Sustainability Group should be reviewed in line with the frequency set out in them to ensure they remain current in relation to membership details and reporting arrangements. The review should ensure that there are named representatives for each of the Executive leads with decarbonisation responsibilities.	This recommendation is accepted and the terms of reference for the Environmental Sustainability Group will be updated to reflect this.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.07.2024	Revised Due Date 31/07/2024	Medium	In progress	May 2024 Update - The terms of reference have been re-drafted and will be discussed at the next ESG meeting in July.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	1.2 The minutes of the ESG should capture the department / workstream that members are representing to ensure there is clear representation.	This recommendation is accepted and changes will be made to how the minutes record representation.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.07.2024	Revised Due Date 31/07/2024	Medium	In progress	May 2024 Update - This recommendation will be enacted from the July ESG meeting.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	2. Data in relation to the uptake of the 'Achieving Net Zero in Wales' ESR training module should be obtained reviewed to determine if additional work needs to be carried out to raise awareness of the availability of training module.	This recommendation is accepted. Work will be done with the People Team to understand the uptake of the ESR training module.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.12.2024	Revised Due Date 31/12/2024	Low	Fully complete (Awaiting approval)	May 2024 Update - This recommendation has been completed. Uptake of the module is low so action will be taken to raise the profile of the module and the benefits of completing it with staff.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	3. Management should review the resource dedicated to decarbonisation to identify if it can meet the Health Board's requirements.	Additional resources have now been identified from within the Deputy Director of Strategy and Partnerships team with the establishment of a Sustainability Manager post which is currently being recruited to.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.07.2024	Revised Due Date 31/07/2024	High	Fully complete (Awaiting approval)	May 2024 Update - The sustainability manager role has been recruited to and the successful candidate will commence on the 25th June 2024.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	4.1 To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed and approved in line with organisational governance. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not.	Action will be undertaken to cost appropriate elements of the plan as resources and available information allows. However budgetary constraints are such that it is unlikely that all elements will be affordable and as for 4.2 we will stay in close dialogue with Welsh Government regarding priorities.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	Revised Due date 31/03/2025	High	In progress	May 2024 Update - Following discussion at the Audit and Risk Committee, this recommendation and management response was revised and updated.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	4.2 For those initiatives that can be quantified, a long-term model for the funding required to support the decarbonisation programme should be developed.	This recommendation needs to be undertaken in partnership with Welsh Government (through Directors of Planning/Directors of Finance channels) as the UHB works within its revenue and capital resource limits. For example, a key component of the UHB's capital planning is maximising access to funds available from Estates Funding Advisory Board for decarbonisation (which provided £0.9m in 23/24). There is a developing consensus that the decarbonisation goals for NHS Wales and those portions of it assigned to the individual health boards cannot be achieved simply by funding decarbonisation projects and initiatives; the carbon savings required are too great. What is needed is for decarbonisation to be considered for each action and activity undertaken by the health boards in their daily operations, as opposed to decarbonisation actions being thought of in isolation. Whilst the Health Board's IMTP references decarbonisation as a key priority in the 'Green 2030' section of the document, there is an opportunity to make greater emphasis on it throughout. For example, when discussing the major transformation schemes.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2026	Revised Due Date 31/03/2026	High	In progress	May 2024 Update - Following discussion at the Audit and Risk Committee, this recommendation and management response was revised and updated.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	5. Carbon impact assessments should form part of the decisions made and actions taken by the Health Board, especially in larger scale transformational projects.	This recommendation is accepted by the Health Board. Work on this recommendation will commence following the recruitment of the Sustainability Manager as this will create additional capacity needed to better understand how this can be enacted systematically across the health board. Environmental Sustainability Group meetings The terms of reference for the ESG state that they are responsible for monitoring progress in implementing the Health Board's DAP. We acknowledge that it would not be practical to review each initiative during these meetings. However, from our review of minutes for the group, it was not clear how the ESG is actively managing and overseeing the progress of implementation of the 30 initiatives it is responsible for that make up the DAP. The DAP is structured around the six Welsh Government workstreams. Highlight reports from three of the six workstreams should be presented at alternate ESG meetings. Whilst we could see regular updates from a number of departments, such as facilities, pharmacy and ICT, these did not clearly align to the workstreams. As such, we were unable to confirm if there was appropriate reporting on the workstreams. Board and Committee reporting Reporting progress against implementation of the DAP does not appear to be taking place bi-annually, as set out in the ESG terms of reference. Our fieldwork identified one instance of the DAP / monitoring return being submitted to the Population Health and Partnership Committee since returns began in quarter two of 2022/23. The report that we saw used the Welsh Government monitoring return format, so did not include narrative for the reader to gain an overarching view of the position of the Health Board against its targets. Whilst the cover report referred to 'varying degrees of success' and the risks to achievement of the target, there did not appear to be reporting against the Health Board's overall carbon reduction target of 16% by 2025.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	Revised Due Date 31/03/2025	Medium	In progress	May 2024 Update - No update this month.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	6.1 Reporting arrangements for the Environmental Sustainability Group should be reviewed to ensure that it receives the necessary information to have oversight of the DAP implementation, including clear reporting from each workstream, to allow meaningful updates on progress to be reported to the Board and its committees.	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.09.2024	Revised Due Date 30/09/2024	High	In progress	May 2024 Update - This recommendation will be discussed at the July ESG meeting.
Internal Audit/2024/171	09.04.2024	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	6.2 The reporting format should be supplemented to include a narrative report that allows readers to gain a clear understanding of the current position of the Health Board in achieving the initiates in place for each workstream and the overall position against the Welsh Government targets. Reporting on progress in implementation of the DAP to the Population Health and Partnership Committee should take place at regular intervals, as set out in the ESG terms of reference.	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.09.2024	Revised Due Date 30/09/2024	High	In progress	May 2024 Update - this recommendation will be discussed at the July ESG meeting.
Internal Audit/2024/172	02.04.2024	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	1.1 Once the organisational governance structures are finalised a steering / ownership structure for digital should be defined.	Accept. The implementation of ePrescribing and the development of a Patient Contact Transformation Programme provides the Health Board with a new way and ownership of delivery for digital and data programmes. It is anticipated (ahead of final confirmation), that both programmes will report into the Improving Care Board and then into Executive Management Board. Discussions are also ongoing with the Chair regarding a greater emphasis at our public board on the	Digital & Data Director of Digital	31.12.2024		Medium	In progress	May 2024 Update - The plans for governance structures are still being discussed, Digital will look to report to an Operational Delivery Committee, as well as a Strategic Committee. We will also look to carry out an annual Board development session dedicated to Digital themes.
Internal Audit/2024/172	02.04.2024	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	2.1 The requirement for digital literacy for all staff should be defined and for the Health Board, with the provision of training for staff if required.	Accept With the development of the Digital Transformation function within the digital and data function, roles are being created to support digital literacy, including an assessment of capability. This will be done in collaboration with Digital Communities Wales	Digital & Data Director of Digital	01.10.2024		Medium	In progress	May 2024 Update - Digital undertook a Board development session in March, which walked the Board through a range of Digital considerations such as Digital Literacy. The Board have asked for a follow up session in July to include an outline case for the next stage in the Digital Journey at CTM.
Internal Audit/2024/173	03.04.2024	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06)	1. Improved monitoring protocols should be embedded within the valuation scrutiny process for individual hours worked on-site.	Agreed. Enhanced monitoring measures have been adopted since the time of fieldwork, as noted above.	Capital and Estates Executive Director of Finance	01.07.2024		Medium	Fully complete (Awaiting approval)	May / June 2024 Update - Hours verified for staff by time management system.
Internal Audit/2024/173	03.04.2024	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06)	2. On a periodic basis, management should review the administration of compensation events against contractual requirements.	Agreed. Amendment will be introduced to reporting to monitor compensation event administration.	Capital and Estates Executive Director of Finance	01.07.2024		Medium	Fully complete (Awaiting approval)	May/June 2024 Update - Change Control spreadsheet incorporates relevant administration dates, issued monthly with PM report.
Internal Audit/2024/173	03.04.2024	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06)	3. Management should ensure compliance with payment timescales e.g. communicate with NWSSP Accounts Payable to confirm contractual obligations and ensure compliance.	Agreed. Contracted timescales will be emphasised to all parties concerned and compliance thereto monitored.	Capital and Estates Executive Director of Finance	01.07.2024		Medium	In progress	May/June 2024 Update - Ongoing dialogue with NWSSP Accounts Payable to resolve repeated issues with late payments.
Internal Audit/2024/173	03.04.2024	PCH Redevelopment Programme: Financial Assurance Final Internal Audit Report_April 2024 (Review reference: CTM-SSU-2324-06)	4. Management should engage with the Supply Chain Partner to ensure that subcontractors are promptly paid for certified work.	Agreed. Further dialogue will be had with the SCP to ensure compliance with PBA terms.	Capital and Estates Executive Director of Finance	01.07.2024		Medium	In progress	May/June 2024 Update - Dialogue undertaken with the Contractor. The date in the month when payment is made into the PBA being variable makes it difficult, the Contractor states, to schedule payment to sub-contractors. Notwithstanding, the Contractor does schedule payments in line with the contract, which differ to PBA requirements. Discussion ongoing.

Appendix 2 - Audit Tracker Development Work Programme

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
1. Requirement for additional fields within the AMaT System to capture "Revised Dates" and rationale. Revised dates currently captured in progress update narrative.	**External Development led by AMaT**. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	January 2025 May 2024 Update – DevLog 507 to be presented to AMaT Inspection Workshop July 2024 (email 26/04/2024)
2. Inspection actions to be defined as High Medium or Low in the system.	**Local Development led by Clinical Audit Team.** The current RAG Rating field can be customised to meet requirements.	CTMUHB Clinical Audit Team	June 2024 May 2024 Update – Complete
3. Introduce theming across inspections.	**Local and External Development** Quality Assurance & Compliance Team to add theme criteria list and share with Clinical Audit for inclusion. AMaT to design a report that captures recommendations by theme.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team AMaT System/Report Developers	June 2024 May 2024 Update – Work has been completed in relation to theming on AMaT (email 30/04/2024). Theming work to actions to be commenced in AMaT. January 2025
4. Read only access for Audit & Risk Committee Members to view full reports as and when required.	**Local Development** If Audit & Risk Committee members will find this beneficial individuals will be added as read only users.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	June 2024 May 2024 update – Assistant Director of Governance & Risk email to Committee members 30/04/2024 in relation to AMaT registration.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
5. Requirement for additional fields / coding to capture "Paused" recommendations or individual actions	**External Development** To be added to AMaT's Development Log and if supported will be taken forward	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025
6. Requirement to capture in the system where recommendations have not been accepted generating a text box for rationale narrative to be added.	**External Development** To be added to AMaT's Development Log and if supported will be taken forward.	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025
7. Notification Alerts – further refinement of sign off stages and at what delegated level	**Local Development** CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team to define what is required in terms of escalation and approval levels and set permissions accordingly.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	July 2024 May 2024 Update – DevLog 262 & 371 to be presented to AMaT Inspection Workshop July 2024 (email 26/04/2024)
8. Fully Automated report in pdf design style addressing all the above requirements.	**Local and External Development** Quality Assurance & Compliance Team to confirm report criteria AMaT to design a report that captures recommendations by theme.	CTMUHB Quality Assurance & Compliance Team	March 2025
9. Internal Audit Reports – Tracker introductory Sheet to include assurance rating	**Completed** – now added.	CTMUHB Quality Assurance & Compliance Team	Complete May 2024 Update – Complete. This detail is now included manually into reporting.

Agenda Item
5.3

Audit & Risk Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) CLINICAL AUDIT FORWARD PLAN FOR 2024-2025

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit and Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford – Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Quality & Safety Committee	14/03/2024	Noted

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
NCA&ORP	National Clinic al Audit & Outcome Review Plan
CA&QI	Clinical Audit and Quality Informatics

1. Situation /Background

1.1 The purpose of this report is to provide the Audit & Risk Committee with the CTMUHB Clinical Audit Forward Plan 2024-2025. Welsh Government (WG) did not release an All Wales NCA&ORP for 2023-24 and no date has been set for release of the All Wales 2024-2025 plan therefore the CTMUHB forward plan is based on information from the HQIP directory of United Kingdom wide agreed audits. (See Appendix 1: Clinical Audit Forward Plan 2024-25).

2. Specific Matters for Consideration

The clinical audit team are currently working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

3. Key Risks / Matters for Escalation

3.1 The challenging backdrop of reduced budget, decreased staffing and increased demand to deliver an increasing programme of tier 1 national audits resulting in reduced capacity to support tier 2 essential organisation priority clinical audits.

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**	Learning, Improvement & Research
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
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: Efficient, Safe
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: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	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: This is not a policy or service review
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 That the Committee **NOTE** the CTMUHB Clinical Audit Forward Plan for 2024-2025.

6. Next Steps

6.1 To ensure delivery of the full CTMUHB Clinical Audit Forward Plan for 2024-2025, by the end of March 2025.

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Cwm Taf Morgannwg
University Health Board

Knowing How Well We Are Doing

Clinical Audit Forward Plan 2024-25

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

NCEPOD

Please click here for the NELA Patient Data Entry tool

HQIP Healthcare Quality Improvement Partnership

Standard 3.1:
Safe and Clinically Effective Care
Effective Care

Version 1.0, 07 February 2024

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

A Welsh Health Circular and Annual Plan is due to be published in June 2024 to clarify the mandatory audit list. The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by WG.

Compliance Key

RED	Cause for concern. Full compliance not achieved by audit deadline.
AMBER	Tier 1: **National audit** delayed, backlog exists but plan in place to comply with national audit deadline. Tier 2: **Organisation priority audit** delayed by one quarter, but plan in place to comply with revised audit deadline.
GREEN	Audit on track at 31/03/2024 or completed, evidence of audit compliance documented on AMaT system.
BLUE	Audit and action plan completed by clinical audit leads and signed off on AMaT system.

Submission deadlines and planned report release deadlines are constantly changing and in most cases being delayed.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2024/25

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
Acute						
National Joint Registry (NJR)	operates continuous data capture	**February 2025**	September 2024	Trauma and Orthopaedics	Fully compliant RGH and PCH, PoWH compliance affected by clinical pressures, work ongoing to ensure full compliance	AMBER
National Emergency Laparotomy Audit (NELA)	operates continuous data capture	**June 2024**	November 2024	Surgery / Anaesthetics	Organisation wide compliance	GREEN
Case Mix Programme (CMP) ICNARC	operates continuous data capture	**Monthly**	March 2025	Anaesthetics	Organisation wide compliance	GREEN
Major Trauma Audit # (TARN)	operates continuous data capture	**Awaiting details at time of reporting**	TBC	Emergency Medicine	National TARN System unavailable for data submissions due to a cyber-attack. DHCW and NHS England developing a new data collection systems for 2024/25	**N/A**
Long Term Conditions						
National Diabetes Audit * **Note this covers the following areas :** • National Diabetes Foot Care Audit (NDFCA)	operates continuous data capture	**N/A**	May 2024	Therapies	Organisation wide compliance	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2024/25

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
• National Diabetes Inpatient Audit (NDISA)	operates continuous data capture	Participation commencing March 2024	N/A	General medicine	Organisations in Wales not required to participate	**N/A**
• National Pregnancy in Diabetes Audit (NPID)	operates continuous data capture	**February 2024**	TBC	Obstetrics and Gynaecology	Organisation wide compliance	**GREEN**
• National Core Diabetes Audit (NCDA)	Data capture from Primary Care at specific intervals	**Pending agreement**	N/A	Primary Care	Organisation unable to participate due to a technical anomaly / outlier	**RED**
National Diabetes Paediatric Audit (NPDA) * #	operates continuous data capture	**N/A**	July 2024	Paediatrics	Organisation wide compliance	**GREEN**
National Respiratory Audit Programme (NRAP)* # **Note this covers the following areas:** Adult Asthma Secondary Care	operates continuous data capture	**May 2024**	June 2025	General medicine	Organisation wide compliance	**GREEN**
COPD Secondary Care	operates continuous data capture	**May 2024**	June 2025	General medicine	Organisation wide compliance	**GREEN**
Paediatric Asthma Secondary Care	operates continuous data capture	**May 2024**	June 2025	Paediatrics	Organisation wide compliance	**GREEN**

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
Pulmonary Rehabilitation	operates continuous data capture	**Due to restart participation in 2024/25**	TBC	General medicine / Therapies	Service not operational	**N/A**
National Early Inflammatory Arthritis Audit * # (NEIRT)	N/A	**May 2024**	October 2024	Rheumatology	Action being taken to improve compliance	**AMBER**
All Wales Audiology Audit #	operates continuous data capture	**N/A**	TBC	Ears, Nose and Throat	Organisation wide compliance	**GREEN**
Older People						
Sentinel Stroke National Audit Programme (SSNAP) (SSNAP) *	operates continuous data capture	**N/A**	TBC	General medicine / Therapies	Organisation wide compliance	**GREEN**
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls * (NAIF)	operates continuous data capture	**March 2025**	TBC	General Medicine / Trauma & Orthopaedics	Support arrangements under review to ensure compliance by end of March 2024	**AMBER**
• National Hip Fracture Database (NHFD)	operates continuous data capture	**January 2025**	TBC	General Medicine / Trauma & Orthopaedics	Organisation wide compliance	**GREEN**
• Fracture Liaison Service Database (FLS-DB)	operates continuous data capture	**Participation April 2024**	N/A	General Medicine / Trauma & Orthopaedics	N/A	**N/A**

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
National Dementia Audit * (NDA)	Completed 5 Year cycle	**N/A**	N/A	Mental Health / Care of the Elderly	Organisation wide compliance	GREEN
End of Life						
National Audit for Care at the End of Life (NACEL) *	Data collection to commence January 2024	Data collection to commence January 2024	TBC	Palliative Care / Medicine	N/A	**N/A**
Heart						
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * (NHFA)	operates continuous data capture	**June 2024**	TBC	Cardiology	Action being taken to improve compliance	AMBER
• Cardiac Rhythm Management * (CRM)	operates continuous data capture	**N/A**	TBC	Cardiology	Organisation wide compliance. (excludes Bridgend)	GREEN
• Myocardial Ischaemia National Audit Project (MINAP)*	operates continuous data capture	**June 2024**	TBC	Cardiology	Action being taken to improve compliance	AMBER
Cardiac Rehabilitation Audit (CRA)	operates continuous data capture	**N/A**	December 2024	Cardiology	Organisation wide compliance	GREEN
Cancer **						

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
National Bowel Cancer Audit (NOGCA) *	operates continuous data capture	**N/A**	TBC	Surgery	Organisation wide compliance. Managed through cancer services.	**GREEN**
National Oesophago-Gastric Cancer Audit (NOGCA) *	operates continuous data capture	**N/A**	TBC	Surgery	Organisation wide compliance. Managed through cancer services.	**GREEN**
National Audit of Metastatic Breast Cancer (NAoMe) *	operates continuous data capture	**TBC**	TBC	Surgery	N/A	**N/A**
National Audit of Primary Breast Cancer (NAoPri) *	operates continuous data capture	**TBC**	TBC	Surgery	N/A	**N/A**
National Lung Cancer Audit (NLCA) *	operates continuous data capture	**N/A**	TBC	Respiratory Medicine	Organisation wide compliance. Managed through cancer services.	**GREEN**
National Prostate Cancer Audit (NPCA) *	operates continuous data capture	**N/A**	TBC	Surgery	Organisation wide compliance. Managed through cancer services.	**GREEN**
Women's and Children's Health						
National Neonatal Audit Programme Audit * # (NNAPA)	operates continuous data capture	**N/A**	October 2024	Paediatrics	Organisation wide compliance.	**GREEN**

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
National Maternity and Perinatal Audit *# (NMPA)	operates continuous data capture	**N/A**	TBC	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
National Perinatal Mortality Review Tool (PMRT)	operates continuous data capture	**N/A**	The PMRT is available for continuous use	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
Other						
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *# (NASECYP)	Series of data collection cohorts within the audit	Various deadlines for cohorts	July 2024	Paediatrics	Organisation wide compliance.	GREEN
National Clinical Audit of Psychosis * (NCAP) EIP Audit	February – July 2024	**N/A**	July 2024	Mental Health	Organisation wide compliance.	GREEN

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)
(** It is anticipated that there will be a number of additional cancer audits added to the programmed during 2024/25).

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

Clinical Outcomes Review Programme (2024/25)

The Clinical Outcome Review Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2023/24	RAG Status 2023/24
• Juvenile Idiopathic Arthritis	operates continuous data capture	**March 2024**	November 2024	General Medicine	N/A	**N/A**
• National Confidential Inquiry into Suicide and Safety in Mental Health	operates continuous data capture	**N/A**	April 2025	Mental Health Programme	Organisation wide compliance.	**GREEN**
• NCEPOD – Transition from Child to Adult Services	Completed	**N/A**	N/A	Child Health Clinical Outcome Review Programme	Due to limited clinical resources only partial compliance achieved. Report published June 2023	**AMBER**
• NCEPOD – Crohn's Disease	Completed	**N/A**	N/A	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved. Report published July 2023	**AMBER**
• NCEPOD – Testicular Torsion	Completed	**N/A**	N/A	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved. Report published February 2024	**AMBER**
• NCEPOD – Community Acquired Pneumonia	Completed	**N/A**	N/A	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved. Report published December 2023	**AMBER**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2024/25

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2023/24	RAG Status 2023/24
• NCEPOD - Endometriosis	Completed	**N/A**	June 2024	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved.	**AMBER**
• End of Life	2023/24	**TBC**	November 2024	Medical & Surgical programme	In progress at time of reporting	**N/A**
• Rehabilitation after Critical Illness	2023/24	**TBC**	January 2025	Medical & Surgical programme	In progress at time of reporting	**N/A**
• Blood Sodium	2024/25	**TBC**	TBC	Medical & Surgical programme	N/A	**N/A**
• MBRRACE – Perinatal Mortality Surveillance	operates continuous data capture	**TBC**	October 2024	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	**GREEN**
• MBRRACE – Saving Lives Improving Mothers Care	operates continuous data capture	**TBC**	November 2024	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	**GREEN**

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/2024
Case Note Documentation Audits:	Revised methodology TBC					
• Acute Hospital Documentation Audit		**TBC**	TBC	Acute inpatient activity	Limited Clinical Audit resources focused on national audit compliance.	**RED**
• Community Hospital Documentation Audit		**TBC**	TBC	Community hospital inpatient activity	Limited Clinical Audit resources focused on national audit compliance.	**RED**
• A&E Documentation Audit		**TBC**	TBC	Emergency Medicine	Limited Clinical Audit resources focused on national audit compliance.	**RED**
Consent to Treat Audit	TBC	**TBC**	**TBC**	Surgery	Organisation wide compliance.	**GREEN**
Do Not Attempt Cardiopulmonary Resuscitation Audit	TBC	**Quarter 3**	**March 2025**	Critical Care	Organisation wide compliance.	**GREEN**
National Ophthalmology Audit (Adult Cataract surgery) * (NOD)	operates continuous data capture	**TBC**	TBC	Ophthalmology	Participation in RGH and PCH only.	**AMBER**
Appendectomy Audit	Prospective audit methodology TBC	**TBC**	TBC	Surgery	Limited Clinical Audit resources focused on national audit compliance.	**RED**

Cwm Taf Morgannwg University Health Board Organisation (Tier 2) Priority Annual Audit Programme 2024/25

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/2024
Tracheostomy Care Audit	**TBC**	**TBC**	TBC	Surgery	Limited Clinical Audit resources focused on national audit compliance.	**RED**

Leadership and Management Development Programme

Internal Audit Report

June 2024

Cwm Taf Morgannwg University Health Board

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

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

Contents

Review reference:	CTMUHB-2324-01
Report status:	Final
Fieldwork commencement:	02 February 2024
Fieldwork completion:	15 April 2024
Debrief meeting:	19 April 2024
Draft report issued:	13 May 2024
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Final report issued:	06 June 2024
Auditors:	Ken Hughes, Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Hywel Daniel, Executive Director for People
Distribution:	Helen Watkins – Deputy Director for People George Shouler, Strategic Lead for People Development
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 provide assurance on the management of the Leadership & Management Development programmes, including the uptake and evaluation process.

Overview

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

- There are no programme specific objectives and performance indicators.
- Completion rates for the programmes are relatively low, with limited or no feedback sought from those registrants not actively engaged with the programme.
- Monitoring and reporting of the programmes need to be improved.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance Arrangements	Reasonable
2	Programme Content	Reasonable
3	Running of the Programmes	Substantial
4	Programme Resources	Substantial
5	Evaluation, Monitoring & Reporting	Limited

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

Key Matters Arising

		Objectives	Control Design or Operation	Recommendation Priority
1	Programme specific objectives and performance indicators	1	Design	Medium
2	Evaluation, monitoring and reporting	1,2,5	Design	High

1. Introduction

1.1 Our review of the leadership and management development programme was undertaken in line with the 2023/24 Internal Audit Plan for the Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board').

1.2 In response to the Targeted Intervention status placed upon maternity services and following the demands that the Covid 19 pandemic placed on managers, the Health Board identified that if services and the wider health economy are to perform to their best, effective leadership now, and a strong pipeline of developing leaders for the future, is crucial. While the Health Board had some leadership development offerings and some stand-alone courses, there had been no clearly defined learning pathways for the diverse leadership and management population of the Health Board.

1.3 In 2021 the Health Board began to develop a leadership and management development programme designed to shape a culture of compassionate, collaborative leadership. A series of three programmes were subsequently developed:

- Ignite - supports managers and leaders to understand the fundamental concepts that underpin great management.
- Aspire - builds on the Ignite foundations, enabling leaders to move away from managing towards leading their teams with impact and influence.
- Inspire - empower leaders to influence within a healthcare setting, leading within complex systems and across multi-disciplinary teams.

1.4 Our review sought to provide assurance on the management of the programmes, including the uptake and evaluation process.

1.5 The relevant lead for this review is the Executive Director for People.

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

- The Health Board fails to train current and future managers and leaders and empower the workforce leading to potential retention issues.
- Managers and leaders lack confidence to allow informed decision making.

2. Detailed Audit Findings

Objective 1: Appropriate governance arrangements are in place to oversee the programmes, and short, medium and longer term objectives of the programme have been established that align to the Health Board's 'Inspiring People' strategic goal.

2.1 The leadership and management development programmes were designed in response to the Health Board moving into 'targeted intervention' as part of being placed in 'special measures' in 2019/20 for specific areas, including leadership and culture.

2.2 Following the move into targeted intervention, a Maternity & Neonatal Leadership & Culture plan was drawn up which contained a number of objectives designed to meet three key strategic objectives:

- To create a sustainable level of leadership accountability and oversight which delivers a positive patient and employee experience.
- To create a positive culture where staff feel valued, psychologically safe and clear on expectations.
- To lead and inspire individuals and teams to be at their best by providing them with the tools, skills and knowledge.

2.3 In January 2021 the Health Board approved its CTM2030: Our Health, Our Future strategy. This set out the strategic goals of: Creating Health; Sustaining Our Future; Improving Care; and Inspiring People. The leadership and management development programmes align to the Inspiring People strategic goal.

2.4 The proposal for a leadership management development programme was first presented to the People & Culture Committee in April 2021. This set out the rationale and ambition for the programme, which was to create an organisation that is well led, through leadership that is purposeful, compassionate and inclusive, and will meet the organisational challenges of the future.

2.5 An update was provided to the People & Culture Committee in December 2022 stating that the continued development of the leadership and management development programmes sought to meet the targeted intervention objectives of:

- Developing a health board with sufficient leadership capacity and capability to deliver high quality care.
- Collective leadership is strong. There are clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership.
- Leaders understanding the unique qualities and needs of their team(s).
- There are clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and there is a leadership strategy or development programme, which includes succession planning.

2.6 As such, the leadership and development programmes were designed to help achieve the Health Board's strategic goals and the objectives set as part of the target intervention status, the Maternity & Neonatal Leadership & Culture plan, along with the organisation's Values and Behaviours framework and the Compassionate Leadership programme.

2.7 We understand that a project group was set up to oversee the initial design phase of the programmes, which included People Directorate staff and external consultants. The programmes were approved by the CTM Board. Prior to this, they were reviewed and approved by the People & Culture Committee.

2.8 At the time of our fieldwork some of the initial objectives that the programme was designed to help address had been achieved, including removal from targeted

intervention status for leadership and culture. As the programme evolves and moves forward, the current and longer-term objectives need to be reviewed. For example, what the Health Board's expectations are around which staff should be participating in the programme. There has been an indication that all senior management are now expected to complete the Inspire programme, which is a move away from the previous 'strategy' which had targeted middle and senior managers. However, we have not seen where this has been set out. Furthermore, we have not seen performance indicators for the programme that would allow monitoring of success to take place. **(Matter Arising 1)**

2.9 The initial project group, to establish the programmes no longer meets. However, while there is no specific group to monitor activity and progress of the programmes, reporting is now to the People Directorate Senior Team. We have seen limited reporting to the People & Culture Committee. **(Matter Arising 2)**

Conclusion:

2.10 An initial range of objectives for the leadership and management development programmes that derived from various sources, were established. However, there does not appear to have been any refresh or update of these, and there are no leadership and management programme specific objectives in place. Governance arrangements are in place, and we have provided reasonable assurance for this objective.

Objective 2: Programme content is based on recognised practices and is periodically reviewed, taking into account participant feedback and Health Board requirements.

2.11 The leadership and management development programme is made up of three separate programmes - Ignite, Aspire and Inspire. Prior to the start of the programmes the Health Board had a 'management essentials' programme in place, which became the Ignite programme. No changes were made to the content of the programme, which is completed on-line at the learner's own pace. The programme aims to help managers and leaders understand the basic concepts that underpin good management.

2.12 The Aspire programme aims to build on the foundation provided by Ignite and enable leaders to move away from managing, towards leading their teams with impact and influence. The Inspire programme aims to empower leaders to influence within a healthcare setting, leading within complex systems and across multi-disciplinary teams.

2.13 In 2020 an initial scoping document was developed setting out the Health Board's expectations from the programme. In 2021, following a tender exercise, a contract was awarded to Q5 management consultants for the 'Provision of a Leadership Development Programme for Developing and Senior Leaders within CTM'.

2.14 The initial design for the Aspire and Inspire programmes consisted of eight modules in total, with each one delivered over four sessions. The first five modules made up the Aspire programme, and modules six to eight completed the Inspire

programme. The learning outcomes and areas covered in each module were documented in a module overview, and a timeline was drawn up for the completion of each module.

2.15 The Aspire and Inspire programmes went live in March 2022, and the existing 'managing essentials' programme became the Ignite programme.

2.16 Feedback collected during the first six months of the programmes resulted in changes to the Aspire and Inspire programmes, and these were re-launched in October 2022. A second refresh of the programmes is imminent following a recent review by the L&D team against a newly developed leadership competency model. We note that while the programmes' approach to delivery has evolved, the course content has remained unchanged.

2.17 Data from December 2023 shows the completion rates for the Aspire and Inspire are low at 11.5% and 0% respectively. We understand that the approach to gathering feedback is done informally through the facilitated learning sessions that, until recently formed part of the Aspire programme. There is no feedback sought from those on the Ignite programme, nor is feedback sought from those not actively engaging in the programme to establish what are the potential barriers to completion. **(Matter Arising 2)**

Conclusion:

2.18 The course content for the new Aspire and Inspire programmes has been developed in conjunction with external consultants and has been specifically designed to meet the needs of the Health Board. Some feedback has been obtained since the launch of the programmes that has resulted in changes to the way the programmes are delivered, however the approach to gathering feedback requires strengthening. We have provided reasonable assurance for this objective.

Objective 3: Suitable processes are in place for the running of the programmes including promotion to staff, application and booking process and ongoing support for learners.

2.19 The programmes were initially set up and run on CTM's Learning Management System (LMS). In 2022, Ignite was moved from the LMS to HEIW's Gwella learning system portal. Subsequently, the Aspire and Inspire programmes were also transferred to the Gwella portal.

2.20 This provided a number of benefits to CTM users such as an easier registration and log-in process, improved functionality and networking and links to wider HEIW leadership and management resources and support. The move was also cost effective as it removed the need for software licences.

2.21 As part of the initial launch in March 2022 the availability of the programmes was promoted to staff through a series of e-mail communications and roadshows by the Wellbeing and Employee Experience Team. These were held at various locations during the summer of 2022. Information could also be obtained through the intranet where staff could access a promotional slideshow.

2.22 At that time, in order to encourage senior managers to participate in the Inspire programme, executive members were asked to provide support, which included recording a short video and attending an Inspire kick-off session. However, this initiative did not progress as hoped.

2.23 More recently, the PDR process and form has also been redesigned. Potential participation in the programme is now embedded in the standard form and is part of the PDR conversation.

2.24 There are no restrictions or qualifying criteria for registration on the programmes. However, a registration form is completed by staff, which is to be discussed with line managers before being reviewed by the L&D team.

2.25 At the time of our fieldwork there were just over 600 active learners on the Ignite programme. Learners complete the training at their own pace through e-learning modules.

2.26 The Aspire and Inspire programmes currently have 300 active learners combined, though completion rates to date are low. These programmes are also modular, and learning is delivered through a combination of self-learning, on-line e-modules and facilitated learning sessions. The Aspire programme should take learners five months to complete, whilst Inspire will take nine months. Both are based on 3.5hours learning a month. The facilitated sessions are delivered by the L&D team who provide support to learners. However, the level of support provided for the Ignite programme is not clear as there are no in-person sessions.

2.27 At the current time there is no qualification for completing the course, but the L&D team is in discussion with the Institute of Leadership and Management (ILM) for the programme to have ILM accreditation and count towards ILM qualifications.

Conclusion:

2.28 The programmes are run on the HEIW Gwella portal which provides learners with easy access to register and undertake the programmes and is cost effective for the Health Board. However, whilst the numbers signing up for the programmes are healthy, the number of learners moving on to actively study and complete the programmes are very low. We have provided substantial assurance for this objective.

Objective 4: Suitable resources have been identified to ensure delivery of the programmes.

2.29 Responsibility for delivering the Leadership and Management Development programme has been assigned to the Learning and Development Team. The team comprises of a Learning and Development Manager, a Leadership and Learning Development Officer and a recently appointed Learning and Development Lead.

2.30 With regard to future planning, the numbers enrolled on the programme have no financial implications to the L&D team as there are no variable costs associated with the programmes. The only resource implications are on staff time to participate in the programme.

Conclusion:

2.31 Resources have been made available to ensure delivery of the programme. We have provided substantial assurance for this objective.

Objective 5: Evaluation, monitoring and reporting takes place in relation to uptake and completion rates, and to establish how well the programmes are meeting the needs of participants and the requirements of the Health Board.

2.32 The June 2022 Leadership and Management Programme progress update set out the agreed framework that would be used to evaluate the engagement, effectiveness and impact of the programmes. A four-stage model was to be used looking at: experience (initial learner reaction to and experience of the programme); learning (impact on skills and knowledge); behaviour (changes in behaviour as a result of the programme); and organisational impact (the lasting cultural impact on the Health Board).

2.33 The evaluation of the programme was to be undertaken on a monthly and/or quarterly basis and would report on:

- The volume of registrations by ILG and staff groups.
- Levels of engagement with both programmes.
- Feedback from participants regarding their experience.
- Feedback from group coaching sessions focused on mindset shifts.
- Reports on action learning projects and the potential impact at organisational level.

2.34 A Learning and Development report is prepared monthly that includes a Leadership and Management programme section. There was a pause in reporting during the early part of 2024 while the programme was re-launched. An April 2024 was provided. Our review of the April 2024 and October to December 2023 reports identified that they all contained the same data.

2.35 The reports show there are 1,024 registrations across the three programmes, of which 903 people became active learners. The reports state this is a 71% conversion rate of registrants into active learners. Our review of the report shows inaccuracies in the data, as registrations total 1034, active learners is 909, and the conversion rate is 88%. **(Matter Arising 2)**

2.36 It appears that the registrations data does not include staff that have completed the three programmes, however this is not clear. The reports also contain a breakdown of participants status across the modules that make up the Aspire and Inspire programmes. However, the data in these tables is difficult to understand in relation to other data reported. Furthermore, it is difficult for the reader to get a full understanding of what the total registration and completion rates are for each level of the programme. We understand that the reports show that to date only 34 learners from 295 registrations have completed the Aspire programme and from 119 registrations no learners have yet completed the Inspire programme. The lack

of performance targets also makes it difficult to determine if the programmes are successful. **(Matter Arising 2)**

2.37 In addition to the monthly reports, we have also sighted a Leadership & Management Programmes Evaluation and Impact Report was submitted to the People & Culture Committee in November 2022. This updated the committee on the impact that the Leadership and Management Programmes were having on the Health Board. The report stated that it would be published on a quarterly basis to measure ongoing impact and performance. However, no evidence was provided that any further reports have been produced or presented to the People & Culture Committee. **(Matter Arising 2)**

2.38 It is acknowledged that the development of the programmes is taking place in a dynamic environment which is constantly changing and evolving. However, the monthly reports and Evaluation and Impact report do not contain all the agreed elements set out for reporting on. For example, there is no feedback from participants (active or otherwise) regarding their experience, and there is no reporting on action learning projects and the potential impact at organisational level. **(Matter Arising 2)**

Conclusion:

2.39 Whilst some evaluation of the programmes is being undertaken, the evaluation results are not being reported at an appropriate level within the organisation. The content and accuracy of the reports should also be improved to provide greater clarity to readers. We have provided limited assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Programme objectives (Design)	**Potential Impact**
The original objectives of the leadership and management development programmes derived from a range of sources: strategic goals and strategies including the targeted intervention (TI) objectives; CTM2030: Our Health, Our Future; the Maternity & Neonatal Leadership & Culture Plan; and the Compassionate Leadership Programme. Many of the original objectives of the programme were long term and linked to the Health Board's TI status. However, it is unclear if the objectives of the learning and management development programme have been revisited since the Health Board has been moved out of TI for leadership and culture. We have not seen documentation setting out the current objectives of the programme or medium or longer-term objectives. Furthermore, at the time of our fieldwork we did not see any performance indicators linked to the programme. The lack of clearly set out objectives and performance indicators will make it difficult for management to determine if the programme is a success.	The leadership and management development programmes fail to deliver the required benefits to the organisation.

	Recommendations	**Priority**
1.1	Short, medium and long-term objectives should be developed that are specific to the leadership and management development programmes.	**Medium**
1.2	Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1.1	Short, medium and long-term objectives have been redeveloped and set out in a paper to go to the Executive Leadership Group. This has also been briefed to Care		

	Group Leads at the Care Group Launch Event May 2nd 2024, as well as a series of socialisation meetings detailed in the paper. Actions: • Take leadership paper to Executive Leadership Group for approval of objectives and overall approach. • Re-share objectives with participants of Inspire Cohort 1, as part of launch communications.	 July 2024 July 2024	 George Shouler, Strategic Lead for People Development George Shouler, Strategic Lead for People Development
1.2	These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a). Actions: • Develop new programme dashboards with HEIW, using functionality in Gwella. • Report dashboards and programme performance indicators to People and Culture committee. Note regarding timeframes: These actions are dependent on two factors – Inspire being live and HEIW designing the dashboards. As such, timeframes are not reflective of audit guidelines, as we are unable to action immediately due to reliance on HEIW resources and programme timeframes.	 November 2024 December 2024	 George Shouler, Strategic Lead for People Development (facilitated by HEIW), George Shouler Strategic Lead for People Development

Matter Arising 2: Evaluation, Monitoring and Reporting (Operation)	**Potential Impact**
In June 2022 a Leadership & Management programmes update document set out the programme evaluation criteria. We have seen reporting against some of these criteria through the monthly Learning & Development report. However, our review of recent reports identified that the same data was included in the October, November, December 2023 and April 2024 reports. We also identified inaccuracies in the registrations and active leaners numbers and the conversion rates. It appears that the completion rates for the Aspire and Inspire programmes are low. The report shows the Aspire programme has 295 registrations, 240 of which remain active learners. A separate table states 34 people have completed the programme which is reported as being 19% of active learners. From 119 registrations for the Inspire programme only 49 were still active and no one had yet completed the programme. No completion rates were provided for the Ignite programme which had 620 registrations all of which remain active learners. At the current time completion of the programmes does not provide learners with accredited qualification, though this is being explored further with the Institute of Leadership and Management. In addition to the monthly reports, a quarterly Evaluation and Impact report was presented to the People and Culture Committee in September 2022. However, this report has not been produced since. During our fieldwork we saw evidence of feedback obtained from the first cohort of learners for the Inspire programme. However overall, there was little documented evidence of other feedback. We understand it is often received verbally during facilitated learning sessions. Furthermore, we saw no evidence of attempts to gain feedback from learners that had started the programme but were no longer active. As such the process for gathering feedback from learners does not appear to be comprehensive. In summary, whilst some information is being reported each month, it is not comprehensive and at times is inaccurate. It is difficult to ascertain a clear understanding of the success of the programme to date. The lack of reporting at a Health Board level may mean a lack of scrutiny and challenge.	The programmes fail to meet the needs of the organisation, but this is not reported at an appropriate level within the organisation and consequently corrective action is not taken. The reasons why learners that register for the programmes but do not start or complete the programmes are not understood and completion rates fail to improve.

Recommendations		Priority
2.1a	The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure: • Data is accurate. • Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme. • Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme.	**High**
2.1b	The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight.	
2.2a	Given the apparent low completion rates, an exercise should be undertaken to contact learners that have registered for a programme but have not started the programme, and learners that have started a programme but have not completed to ascertain the reasons why they are not actively participating in the programme. Where appropriate, the feedback obtained should be used to make changes to the delivery or content of the programmes.	**High**
2.2b	Consideration should be given to how to better capture feedback received from active learners and how that can be used to improve the current learning approaches.	
2.2c	It may also be beneficial for the L&D team to contact other NHS organisations who run similar programmes for advice on how completion rates could be improved.	
2.3	In an attempt to incentivise learners to complete the programmes, previous dialogue with the ILM should continue in order to try and achieve an accreditation status.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1a	Actions: • As per 1.2, develop new programme dashboards with HEIW, using functionality in Gwella. Ensure inclusion of evaluation data from 2.1b.	November 2024	George Shouler, Strategic Lead for People Development (facilitated by HEIW)
2.1b	Actions: • In-line with the relaunch of Inspire, apply HEIW's Kirkpatrick Bronze evaluation framework. This will supersede and replace any previous evaluation methods/ reporting, and will be reported to Inspiring People Board and People and Culture Committee.	Development already started, but live from programme launch September 2024	Designed by Rehana Begum, Head of Organisational & Inclusion implemented by Nikita Tucker, Learning and Development Lead
2.2a	Actions: • Design MS forms to capture data and send out to all participants who registered but did not complete the programmes.	June 2024	Nikita Tucker, Learning and Development Lead / Adam Pritchard, Leadership & Learning Development Officer
2.2b	This will be actioned via the evaluation framework associated to 2.1b.	September 2024	Designed by Rehana Begum, Head of Organisational & Inclusion implemented by Nikita Tucker, Learning and Development Lead
2.2c	Meetings already held with colleagues from Cardiff and Vale, Betsi Cadwaladr, Aneurin Bevin and the Welsh Ambulance Service. This is alongside engagement at an All-Wales level through HEIW's compassionate leadership working group. Actions: • We would suggest that further targeted engagement is not necessary, but will continue to engage more widely as part of our existing networks.	Completed	George Shouler, Strategic Lead for People Development

2.3	Discussions on accreditation of programmes with USW Commercial Services are ongoing as part of regular meeting cycle. Actions: • We would suggest that this objective has been completed, but will continue to raise with USW with a view to securing their resources and support to accredit programmes.	Completed	George Shouler, Strategic Lead for People Development

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Welsh Risk Pool Claims
Final Internal Audit Report

June 2024

Cwm Taf Morgannwg University Health Board

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

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

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Executive sign-off:	Greg Dix, Executive Director of Nursing, Midwifery & Patient Care
Distribution:	Stephanie Muir, Assistant Director of Concerns and Claims Kellie Jenkins Forrester, Head of Concerns & Business Intelligence Bahar Chowdhury, Head of Claims and Inquest Carla Snook, Legal Services Manager
Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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 provide assurance that the correct processes have been followed and reimbursements are compliant with the Welsh Risk Pool standard and claims are accurate.

Overview

The matters requiring management attention include:

- Ensuring the completion of documentation in line with WRP timeframes.
- Ensuring information is saved to Datix accurately and consistently.
- Finalising the standard operating procedures

Further advisory points are detailed within the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2022/23

Assurance summary[1]

Objectives		Assurance
1	Completed documents within set timescales	Reasonable
2	Evidence to support costs incurred	Substantial
3	Appropriate authorisation	Substantial
4	Accurate claims data within Datix	Substantial
5	Action to address historic LFERs	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	Accuracy of information	1	Operation	Medium
3	Compliance with submission timeframes	1	Operation	Medium
5	Finalisation of operating procedures	5	Operation	Medium

1. Introduction

1.1 Our review of Welsh Risk Pool Clinical Negligence, Personal Injury and Redress cases was completed in line with the 2023/24 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 The processing of a claim against the Health Board in relation to a clinical negligence or personal injury case can take several years between the initial claim and the final settlement. Although the redress process is notably quicker, each case still requires a large amount of documentation to be completed and retained. Financial transactions, in some instances of extremely high value, are also administered in relation to each case. These factors increase risks with respect to errors or omissions that may occur during the processing of such claims.

1.3 Welsh Risk Pool (WRP) Services requires that claims for reimbursement and repayment are made within specific timescales.

1.4 WRP Services has developed a standard: The Compensation Claims Management Standard, to ensure that NHS bodies:

- Have an effective process for managing concerns raised by patients and staff.
- Have an effective process for managing legal claims for financial compensation.
- Ensure that there is good organisational learning from all events.

1.5 Reimbursement of settled claims are either under NHS indemnity, or through redress cases.

1.6 The WRP standard requires Internal Audit to review the accuracy of a representative sample of closed compensation claims for reimbursement by Welsh Risk Pool Services.

1.7 In recent years, a new cloud based 'Once for Wales' Datix system has been introduced, referred to as DCIQ. Our testing spanned both the old web based Datix system and the new system, due to the historic nature of some cases.

1.8 As part of our review, we have followed up on the progress made implementing recommendations from our previous audit and where necessary updated recommendations have been made.

1.9 The potential risk considered in this review is that claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Health Board's senior management.

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

2. Detailed Audit Findings

Objective 1: An appropriately completed learning from events report, case management report, case financial record and a schedule of costs has been completed for each reimbursement claim within set timescales.

2.1 Datix reports of 'closed' cases were received for Clinical Negligence (CN), Personal Injury (PI), and Redress cases in respect of the financial year 2023/24. There were 156 cases listed, comprising of 44 CN, 20 PI and 92 Redress. Our review of a sample of cases identified that the 'current stage' field in Datix was not always accurately completed as some cases showed the reports as 'awaiting reimbursement'. The correct classification of each case ensures that management information produced using the Datix system is accurate and meaningful. **(Matter Arising 1)**

2.2 In line with WRP guidance, we reviewed a sample of 27 cases across the three areas of, CN, PI and Redress. We ensured that each case had an appropriately completed Learning from Events Repot (LFER), Case Management Report (CMR), a Finance Case Record checklist (U1/U2), and that a Losses and Special Payments Register (LASPAR) schedule of costs had been completed. We confirmed that in all instances the required documentation had been produced. However, in a small number of instances, a copy of the LFER had not been saved in the Datix system. **(Matter Arising 2)**

2.3 The WRP standards require LFERs to be submitted within 60 working days of a 'decision to settle' date. This requirement became effective for claims received after October 2019. In recent years, a practice of submitting blank or partially complete LFERs to WRP services has been in place. This allowed the 60-day target to be met whilst the additional information to fully complete the form was obtained. We are aware that WRP stopped this practice mid-2023. For the cases we sampled, 15/27 initially had submitted blank LFERs. For the purposes of our testing, we have calculated the timeliness of submitting completed LFERs, as these are required by WRP to allow reimbursements to be made to the Health Board.

2.4 For our sample of 27 cases, 15 were received after October 2019 and therefore subject to the 60-working day LFER deadline. We found that only four cases, all Redress, had their LFER submitted within 60-day target **(Matter Arising 3).** For the remaining 12 cases, which were received before October 2019, the LFER submission timeframes varied between 6 months and 4 years. **(Matter Arising 3)**

2.5 Claims management teams must complete and submit a CMR and Finance Case Record (U1/U2) to WRP within four months of the final payment date. In all of the cases that we tested, while the relevant forms were saved to Datix, for 2/27 cases the four-month target was not achieved. Whilst this represents a significant improvement since our previous audit, the Health Board is still at risk of incurring WRP penalty charges if it continues to not meet the target submission dates. **(Matter Arising 3)**

2.6 We tested a sample of cases to confirm if key milestone dates recorded on the LFER, CMRs, and U1/U2 Finance Checklist forms agreed to the data in Datix. We found a number of discrepancies between the sources of information. We also found instances where date fields within Datix were not complete. Missing information and differences could impact on the monitoring of the target dates. **(Matter Arising 1)**

Conclusion:

2.7 Most documentation in respect of the cases that we tested had been completed and retained appropriately. However, there were instances where forms or information was not correctly captured. There remains an ongoing issue in submitting LFE reports within the timeframe required by WRP. We have provided **reasonable** assurance against this objective.

Objective 2: There is appropriate evidence to support the costs incurred.

2.8 From our sample of 27 cases, just under £1.5m was paid against 137 invoices. All payment information had been uploaded to Datix. However, in two sampled CN cases, invoices totalling £2,780 had not been saved to Datix. **(Matter Arising 2)**

2.9 We also reviewed the LASPAR schedules for each case in our sample to ensure that they reconciled to the amounts reimbursed from WRP. In all cases there was evidence to support that the costs were accurate, and values reconciled to the LASPAR schedule.

Conclusion:

2.10 We confirmed that for all the cases that we tested, payments had been appropriately made, and in the majority of cases supporting invoices had been saved to Datix. As such, we have provided **substantial** assurance against this objective.

Objective 3: Forms have been appropriately authorised aligning with delegated limits within the organisation.

2.11 For the 27 cases that we tested an appropriate governance and case manager declaration form was completed, which had been authorised to request the reimbursement from WRP prior to submitting to them. However, we note that in one instance the same person had signed the governance declaration twice and it had not been signed by the Chief Executive as required. **(Matter Arising 4)**

Conclusion:

2.12 All of our sampled cases had been appropriately authorised. As such, we have provided **substantial** assurance against this objective.

Objective 4: Claims submitted are accurately entered onto the Datix risk management database.

2.13 Reimbursements that we tested were appropriately approved by WRPS, and the amounts received reconciled to the U1 checklists and the finance schedules that were submitted to WRPS.

2.14 A return e-mail from WRP Services, to confirm that reimbursement had been approved, had been uploaded to the Datix case file in relation some cases. Including a reimbursement confirmation e-mail in the Datix case file allows reimbursement details to be checked more easily, and reduces the risk that errors or omissions may occur with respect to the reimbursement process. **(Matter Arising 2)**

2.15 We identified that in a small number of instances, the total values of payment information listed in Datix did not reconcile to the LASPAR report. The differences were either the result of an error when information was transferred from the old Datix system to the current one, or where VAT had not been properly accounted for. While these errors did not have an impact on the payments made, should the Health Board wish to produce financial information from Datix in the future, it will need to be ensure that accurate financial information is captured in Datix.

Conclusion:

2.16 The claims for reimbursement submitted to WRPS in respect of the 27 cases that we tested were accurately entered onto the Datix risk management database. As such, we have provided **substantial** assurance against this objective.

Objective 5: An action plan has been developed to address outstanding historic learning from events reports. Monitoring against the action plan takes place.

2.17 For a number of years, the Health Board has had a backlog of historic LFER that required submission, whilst also trying to achieve the 60-working day target for more recent cases. Our testing of 2023/24 closed cases identified that the delays encountered in submissions mostly relate to historic cases. In May 2023 WRP imposed a financial penalty of £42,500 on the Health Board.

2.18 The Health Board continues to work closely with WRP to resolve issues and has developed an action plan to help address the issues faced in submitting timely LEFRs. We are also aware that since September 2023 the 60-working day target has been extended by WRP and is now four calendar months.

2.19 Some of the key points included in the action plan relate to:

- development of a 'How to Guide' and standard operating procedure (SOP) for LFERs.
- preparing weekly reports on LFER status and the status of deferred cases.
- weekly Executive Patient Safety team meetings to reviews reports.
- reconciliation of WRP data and data held in Datix.

2.20 We reviewed the SOPs for LFERs, managing PI claims, Redress claims and CN claims. All of these documents were in draft at the time of our fieldwork and did not always provide clarity to the reader on some of the key dates in the process. **(Matter Arising 5)**

2.21 We saw evidence of a reconciliation of WRP and Datix records for closed cases in late 2023, and we understand that ongoing monitoring and reconciliations will take place.

2.22 Reports are taken to the weekly Quality and Safety team meetings which report the number of LFERs due, submitted and outstanding each month. The same report also sets out the number of deferred LFERs. These relate to cases that have been submitted to WRP, but following review, have not been approved and returned for additional information to be provided. We understand that further work is underway to develop a dashboard that will allow monitoring of CMR submissions.

2.23 Our review of data from the end of April 2024 suggests that the actions taken by the Health Board is having a positive impact. The report shows that there are 35 outstanding LFERs of which three are overdue, one relating to November 2023. There were also 41 deferred LFERs, 15 of which had a red rating meaning a greater amount of information was needed by WRP, than the 26 classified as amber. The Health Board has 6-months to re-submit deferred LFERs (subject to a maximum of 12 months from the trigger date). We acknowledge that seven had already been resubmitted, however two that are yet to be resubmitted are over the 6-month target (they were due in March and April 2024).

2.24 We note that updates against the action plan have been reported to both the Audit and Risk Committee and the Quality and Safety Committee.

Conclusion:

2.25 Good progress has been made in implementing a number of the agreed actions and the reported number of outstanding and deferred LFERs past their submission date has reduced since our previous audit. Some further work is needed to formalise the various SOPs. We have provided **reasonable** assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Accuracy of information (Operation)	**Potential Impact**
As cases progress though the claims process, their status on Datix should be updated. We were provided with reports of closed Clinical Negligence (CN), Personal Injury (PI) and Redress cases. Our review of a sample of cases identified that the 'current status' in Datix was incorrect for 8/27 cases. These cases were still showing as being at LFER submission stage or awaiting reimbursement from WRP. The correct classification of each case ensures that management information produced using the Datix system is accurate and meaningful. Furthermore, when undertaking our testing we noted: • For 6/27 cases the 'decision to settle' date information on the LFE report was either missing, or different to that recorded on Datix. • For 9/27 the 'date all payments made' field had not been completed, and for a further 4/27 cases the entry in the 'date all payments made' field on Datix did not match the final payment date on the CMRs.	Incorrect reporting of data could impact on decision making and statutory reporting requirements.

Recommendations		**Priority**
1.1a	Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures).	**Medium**
1.1b	Regular monitoring should be carried out to ensure compliance.	

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	Staff have been reminded of the importance of completing Datix. The SOP will be updated to provide guidance to ensure accurate data is recorded. An audit is being developed with support from the BI team to easily identify and monitor accurate data recording.	September 2024	Head of Concerns & Business Intelligence, Head of Claims & Inquests

1.1b	Regular monitoring is currently carried as part of the payment approval process. To support regular monitoring, a regular opened and closed cases audit is being developed with support from the BI team.	September 2024	Head of Concerns & Business Intelligence, Head of Claims & Inquests

Matter Arising 2: Completeness of information (Operation)	**Potential Impact**
Our testing identified that documentation was not always saved to Datix. We note: • 2/27 instances, which were CN cases, a copy of the LFER was not on file. Although we confirmed that a submission to WRP had been saved to file. • 4/137 invoices totalling £2,780 relating to two different CN cases were not on file. Although we note that other information on file confirmed that an appropriate payment had been made. • For 13/27an email from WRP confirming that reimbursement had been approved was not saved to Datix. Whilst not essential, saving the confirmation emails to Datix allows reimbursement details to be checked more easily and reduces the risk that errors or omissions may occur with respect to the reimbursement process.	Financial loss to the Health Board if an appropriate evidence trail is not available.

	Recommendations	**Priority**
2.1	Management should reiterate to staff the importance of ensuring all documentation relating to a case is saved to the Datix file.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
2.1	Management have emphasised to staff at the Legal Services team meeting the importance of saving documentations to the Datix file. This will be emphasised on a regular monthly basis. Discussions will also be undertaken in 1:1s to emphasise this point further and raised on an ad hoc basis.	July 2024	Head of Claims & Inquests
	The email following WRPC outcomes confirming reimbursement contains personal information on all cases, which does not allow saving this email to an individual file. A work-around to this will need to be implemented.	July 2024	Legal Services Manager

Matter Arising 3: Timeliness of submission to WRPS (Operation)	**Potential Impact**
We tested a sample of 27 cases closed in 2023/24. The sample was made up of 8 Clinical Negligence, 4 Personal Injury and 15 Redress cases. Learning from Events Report (LFER) The claims management team complete and submit several documents to WRP within specified timeframes. For cases received by the Health Board after October 2019 LFERs should be submitted within 60-days of the decision to settle date. Our calculation of timeliness has been based on submission of completed LFEs as opposed to blank ones. For cases received before October 2019 the 60-day target was not in place though WRP requires a timely submission. • CN: 2/8 cases were post October 2019 but neither were submitted within 60-working days (184 and 367 days). In addition, the six older cases were not submitted in good time, with some taking up to four years to be submitted. • PI: 3/4 cases were post October 2019, but were not submitted within 60-working days. (Times varied between 356 and 464 days). In the remaining older case, the LFER was submitted more than a year after the decision to settle date. • Redress: 10/15 were post October 2019. 6/10 were not submitted in 60 days (Times varied between 77 and 198 days). 3/5 of the remaining older cases did not have their LFE reports submitted in a timely manner. Case Management Reports (CMR), U1/U2 Finance Checklist A CMR and U1/U2 checklists should be submitted to WRP within four months of the final payment date. In 2/27 cases the target was not achieved and was exceeded by 28 days and 83 days, respectively. We acknowledge that the cases in our sample mostly relate to older claims and that current reporting suggests the Health Board is now meeting the WRP timeframes more frequently.	Financial loss to the Health Board.

Recommendations		Priority
3.1	Management should continue to remind staff of the importance of working towards the timeframes specified by WRP and should continue to monitor to ensure compliance with this requirement.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	Management have implemented weekly Business meetings for the Quality & Safety and Legal Teams, where reporting in respect of LFERs is undertaken to ensure timeframes are met. LFERs are reviewed weekly in the Executive Director Led Patient Safety Meeting. A CMR due report is run monthly by management to ensure CMRs are submitted in a timely manner. A regular opened cases audit is being developed with support from the BI team to facilitate a more thorough check on when a CMR should be triggered.	September 2024	Head of Concerns & Business Intelligence, Head of Claims & Inquests

Matter Arising 4: Authorisation of forms (Operation)			**Potential Impact**
The Clinical Negligence Case Management Forms should be *'signed by two senior officers of the Responsible Body – both of whom must be authorised signatories and one of whom must be the Chief Executive.'* From our testing we identified one form that had been signed by a senior officer in the absence of the Chief Executive, but had been countersigned by the same officer.			Inappropriately authorised documentation submitted causing delays in reimbursement.
Recommendations			**Priority**
4.1	Case Management Forms should be appropriately authorised.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Standard Operating Procedure will be updated to clarify that the Case Management Review needs to be signed by two separate individuals and that it is not acceptable to be signed by the same person in a different capacity. This has also been reiterated at the Legal Services team meeting.	August 2024	Legal Services Manager

Matter Arising 5: Standard Operating Procedures (Operation)		**Potential Impact**
Over a number of years, the Claims Management team have been working to update their Standard Operating Procedures (SOPs) to reflect changes brought in by WRPS, and to reflect recommendations made in our previous audit reports. The current iterations of the Redress, CN, PI and LFER SOPs are in draft format. In our previous audit report, we recommended the CN SOP was updated to provide greater clarity on what constitutes the final payment date, and the process to follow should an invoice be disputed. This detail does not appear to have been incorporated in the new draft SOP. We also recommended that a review of the key stages within Datix was carried out, so staff had clarity on the 'stage' to be used as cases progress, ensuring accurate reporting takes place. Some work has started on this and a list of Datix stages has been created. However, we understand a task and finish group was to be set up by Once for Wales to provide guidance on the stages. As such the closure sections within the respective SOPs are still to be updated. We have also noted from our testing differences between what the CN and PI SOPs says in relation to authorisation of CMRs to what the forms themselves say about who should authorise.		Inconsistent approaches are in place to recording and capturing information meaning inaccurate reporting.
Recommendations		**Priority**
5.1a	The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed.	**Medium**
5.1b	Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix.	
5.1c	It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.	
5.1d	All SOPs should be finalised and made available to staff.	

	Agreed Management Action	Target Date	Responsible Officer
5.1a	The relevant section of the Standard Operating Procedure (SOP) will be reviewed to ensure that it clearly outlines what constitutes final payment and the process that should be followed if an invoice is disputed. Training will be provided once the SOP has been updated. This action will need to be aligned with the all-Wales approach and completion will be dependent on this	September 2024	Legal Services Manager
5.1b	Management will attend or delegate staff to the WRP's Task and finish group to ensure the key stages are clearly defined. The SOP will be updated once the work has been finalised.	August 2024	Head of Claims & Inquests
5.1c	The SOP will be reviewed and updated to ensure authorisation details align to the information contained in the CMRs. Staff will be informed of the updates at the Legal Services team meeting	September 2024	Legal Services manager
5.1d	SOPs are available to staff in and accessible in the local drive. Finalisation is dependent of ongoing work and updates on from the all-Wales Task and Finish Group and updates to the DCIQ system.	August 2024	Head of Claims & Inquests

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Risk Management
Final Internal Audit Report

June 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

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Report status:	Final
Fieldwork commencement:	6 March 2024
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Draft report issued:	23 May 2024
Management response received:	30 May 2024
Final report issued:	3 June 2024
Auditors:	Stuart Bodman – Principal Internal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Gareth Watts – Director of Corporate Governance & Board Secretary
Distribution:	Cally Hamblyn – Assistant Director of Governance and Risk
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

Our review looked to identify the existence of effective risk management processes following the introduction of organisational Care Group structures.

Overview

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

- Ensure that every risk review undertaken is fully recorded on Datix and in a consistent manner.
- Risk escalation is consistently recorded in departmental and Care Group Quality and Safety forums, and an escalation audit trail recorded within Datix.
- Monitoring of risk management is regular, robust, and consistent across all Care Group Quality and Safety forums.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

2021/22

Assurance summary[1]

Objectives		Assurance
1	Identification of risks and mitigating actions	Reasonable
2	Escalation and escalation of risks	Reasonable
3	Risk management training	Substantial
4	Monitoring and reporting	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	Datix record keeping	1	Operation	Medium
2	Recording and reporting of risk escalation	2	Operation	Medium
4	Monitoring governance arrangements	2,4	Operation	High

1. Introduction

1.1 Our review of risk management was completed in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board ('CTMUHB or 'the Health Board').

1.2 Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational objectives. Risk management consists of defined steps which help us understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice.

1.3 CTMUHB's organisational risk register captures the operational risks (scoring 15 and above) affecting the Health Board's ability to achieve its objectives and deliver services on a day-to day basis. Care Group and Corporate Directorate risk registers sit beneath the organisational risk register, with escalation and de-escalation as appropriate.

1.4 We looked at the following care groups and central/corporate departmental areas during our review were:

- The Diagnostics, Therapies, Pharmacies & Sciences (DTPS) Care Group:
  - Pathology – Microbiology and Cellular Pathology
  - Therapies
- The Children & Families Care Group:
  - Maternity and Obstetrics & Gynaecology
- Quality & Patient Safety Department - Corporate Directorate

1.5 The relevant lead for this review was the Director of Corporate Governance & Board Secretary.

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

- Where risks are not identified, assessed, or included on the relevant risk registers and are not being actively managed, this may impact on the achievement of the Health Board's objectives.
- If risks are not escalated through the Health Board, appropriate action may not be taken to mitigate.
- Where there is lack of awareness of the Health Board's risk management policy and procedure, risks are not properly managed.

2. Detailed Audit Findings

Objective 1: Effective processes are in place for identification of risks and mitigating actions, with mechanisms to ensure consistency in capturing, scoring and mitigation of common risks across Care Groups.

2.1 The Health Board has a current risk management policy, which is supported by a risk management strategy and risk assessment procedure. These outline the processes in place to identify, record, mitigate and report risks. Risk Management information and documents are accessible via the Health, Safety & Fire intranet pages.

2.2 When new risks are created in Datix, we understand that the risk owner is expected to check to ensure the risk does not already exist for their service area, or more widely, and ensure consistency in scoring if necessary. While in the areas we sampled we did not identify any cases of duplicate risks or similar risks with scoring variations, this is not set out in current guidance.

2.3 Risks captured in Datix should include a future review date. The frequency of the review, to be undertaken by the risk owner, is set out in the risk management policy and is determined by the risk score. Our review of a sample of risks across five departments identified a small number of cases where the future review date did not align to the required frequency, given the current risk score. **(Matter Arising 1)**

2.4 The risks that we tested were regularly reviewed. However, there was an inconsistent approach to recording the detail of the review in Datix. For example, some service areas updated the Datix notes with information on changes or stating there had been no change following the review. However, most service areas did not capture information in the Datix notes section following a review. There is no information in the risk management policy or Datix user guide setting out the Health Board's expectation in relation to capturing review information in Datix, although we understand this is being considered in the development of a new risk module in Datix.**(Matter Arising 1)**

Conclusion:

2.5 Processes are in place to identify, score and mitigate risks and these are formalised in the risk management policy and associated documents. However, the outcomes of risk reviews are not always recorded in Datix. We have provided reasonable assurance against this objective.

Objective 2: Effective processes are in place for the escalation and de-escalation of risks through the Health Board, including within Clinical Service Groups, Care Groups, and Corporate directorates.

2.6 The processes for escalation and de-escalation of risks from risk-holding departments up to the organisation risk register (ORR) are clearly outlined in the risk management strategy. This identifies the risk scoring necessary for escalation and the tiers of responsibility for review and oversight of the escalated risk.

2.7 At a Care Group and service area level, we saw evidence of the risk escalation process in the DTPS Care Group. We saw risks being discussed during service area Governance meetings with onward escalation to the Care Group Quality, Safety, Risk & Experience (QSRE) meeting. However, we did not see clear evidence of risk monitoring and escalation in the Children & Families Care Group. The governance structure in the Quality and Patient Safety department is in its infancy, although we saw evidence of risk escalation to the ORR. **(Matter Arising 4)**

2.8 For the high scoring risks (those greater than 15) that we sampled, we saw evidence of review by the Operational Management Board (OMB) to determine if escalation from Care Group to the ORR was necessary. However, this information was not captured in Datix to show the risk had been considered for escalation. Similarly, no information is captured in Datix to record when risks are escalated from service areas to Care Groups for monitoring. **(Matter Arising 2)**

Conclusion:

2.9 Processes are set out to allow the escalation of risks and their monitoring and we saw appropriate processes applied in some of the areas we visited. However, more work needs to be done to provide a comprehensive evidence trail within some Care Groups and in relation to the narrative held within Datix to support escalation decisions. We have provided reasonable assurance against this objective.

Objective 3: Training in relation to the risk management approach continues to be delivered to relevant staff at all levels within the Health Board.

2.10 The Health Board's risk management strategy sets out the risk management training expectations for staff. In 2023, a risk management training needs analysis was developed, outlining the staffing groups requiring basic risk management training and those that require a higher level of training. The higher level of training is aimed at managers and those staff completing risk assessments via the Datix risk management module.

2.11 Whilst not a statutory and mandatory course, the health board has been proactive in establishing monthly online training sessions delivered by the Assistant Director of Governance and Risk. The staff newsletter is used to raise awareness of the training sessions. The process for booking on the risk training is also captured on the dedicated risk page on the staff intranet. We note that additional bespoke training is provided if requested by a particular service area.

2.12 Information on training uptake is included in the risk register updates taken to the Board and committee meetings. We note that since the current risk management training was introduced in 2021, 600 staff have been trained.

2.13 Whilst the onus is on care group management and directorate leads to ensure relevant staff are identified to attend training, currently no information is provided to them regarding the levels of uptake within their service areas. Records are maintained of training session attendees, but to date, there has not been an analysis of this data. Since early 2024, the ESR system has been used by staff to book training sessions. We understand that this will provide the opportunity for

management to analyse training data and share this with service areas, so that training can be targeted at those areas where rates are low. **(Matter Arising 3)**

Conclusion:

2.14 The Health Board has an established risk management training programme and is clear on those staffing groups that require training. Whilst staff continue to be trained each month, to date there has been no analysis of uptake by service area to allow training to be targeted where attendance is low. We have provided reasonable assurance against this objective.

Objective 4: Effective monitoring and reporting of risks take place at the various tiers within the Health Board, including at committee level.

2.15 Monitoring and reporting of risk takes place at various levels within the Health Board. We looked at this within two Care Groups and one Corporate Directorate. Each Care Group had a Quality, Safety, Risk and Experience (QSRE) Group in place, that reported to the Health Board's Quality and Safety Committee.

2.16 We saw regular monitoring of high scoring risks at the DTPS Care Group QSRE meetings. Within the Care Group, the Pathology service area service pressures meant the Clinical Governance Group had not met since October 2023, although meetings were due to restart in May 2024. We could not evidence where service level risks had been reviewed during this period, although higher scoring risks will have been reviewed in the QSRE meetings. We note that there is formal upward reporting of risks from the eight constituent Pathology departments that feed into the Pathology risk register. **(Matter Arising 4)**

2.17 The Therapies Integrated Governance Meeting meets regularly and reviews its risk register, and specifically high scoring risks. It also discusses the risk issues presented from its five constituent departments. Our testing of their risk register identified that there is a large number of medium scored risks and we could not evidence their review. **(Matter Arising 4)**

2.18 We saw no evidence of a recent review of the risk register for the Children & Families care group at their QSRE meetings. Furthermore, the Service Wide Assurance Group that oversees risk management within the Maternity and Obstetrics & Gynaecology departments was not operational. As such, we saw no evidence of medium scoring risks being reviewed. **(Matter Arising 4)**

2.19 The Corporate Directorate for Quality & Patient Safety has recently implemented a Business Team meeting following organisational change. The group reports into a wider Quality & Safety Improvement meeting, that has been operational for a few months. Both forums have risk register monitoring responsibilities, and we saw that some agenda meetings contained verbal updates on risk. **(Matter Arising 4)**

Conclusion:

2.20 We saw evidence of risk monitoring and reporting within the majority of areas that we sampled. However, further work is needed to improve consistency of monitoring, and evidence comprehensive monitoring, especially within the Children & Families Care Group. We have provided reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Datix record keeping (Operation)		**Potential Impact**
We reviewed a sample of risks on the Datix system from the DTPS and Children & Families Care Groups, and the Quality & Patient Safety Corporate Directorate. We checked to ensure risks were subject to regular review in line with the timeframes set out in the Risk Management Policy. DTPS Care Group We looked at twelve risks across three departments. While all of the Datix risk records had been opened by the risk owners, Datix was not updated consistently, so the level of review was not clear. For example, some departments input narrative following each review to explain changes the risk score, the actions taken, or document 'no change'. However, most of the risks we reviewed did not include review narrative. We noted the frequency of review for one risk had been set as annual review, however moderate scored risks should be reviewed quarterly. Children & Families Care Group We tested a sample of 5 Datix risk records from Maternity and Obstetrics & Gynaecology and confirmed that they had been recently opened by risk owners. However, similar to the DTPS care group, level of review was not clear. We noted the frequency of review for one risk had been set as annual review, however moderate scored risks should be reviewed quarterly.		Where risks are not identified, assessed, or included on the relevant risk registers and are not being actively managed, this may impact on the achievement of the Health Board's objectives.
Recommendations		**Priority**
1.1	In order to provide a comprehensive record of each risk over its lifetime, as risks are reviewed in Datix, risk owners should capture brief narrative in the notes section to explain any changes since the previous review and actions that have been taken. Where no changes are made, this should also be captured. Datix user guidance should be updated to incorporate information on the Health Boards expectation on what narrative should be recorded in the notes section in relation to demonstrating review of risks.	**Medium**

	Information should also be included in the guidance notes on the process to follow to check for duplicate risks.	
1.2	User guides and training sessions should be used to remind risk owners that future risk review dates should align to the timescales set out in the Risk Management Strategy, based on risk score.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Datix Risk Module User Guidance to be updated to outline the approach to managing the review of risks and where review updates should be captured in the Datix Risk module.	31st July 2024	Assistant Director of Governance & Risk Head of Concerns and Business Intelligence, Patient Care & Safety
1.2	a) Risk Management Training Slides to include the guidance on review dates linked to scoring. b) Datix Risk Module User Guidance to signpost risk leads to the Risk Scoring Domain Matrix to assist them in identifying an appropriate review period.	31st July 2024	Assistant Director of Governance & Risk Head of Concerns and Business Intelligence, Patient Care & Safety

Matter Arising 2: Recording and reporting of risk escalation (Operation)	**Potential Impact**
We reviewed a sample of risks from the DTPS and Children & Families Care Groups, and also the Quality & Patient Safety Corporate Directorate, to determine the process followed and documentation retained to support the escalation / de-escalation of risks. DTPS Care Group We confirmed that the agendas and minutes from departmental governance groups and the Care Group QSRE demonstrated appropriate escalation of risks from departmental risk registers to the Care Group risk register. However, where risks had been escalated, there was no information in Datix to reflect this. For our sample of risks scoring 15 or above, we saw that the Operational Management Board (OMB) reviewed these risks to determine if they should be included on the Organisational Risk Register (ORR), but this information was held in minutes and email, and not recorded in Datix. Children & Families Care Group As reported under Matter Arising 5, we did not see evidence the risk register being reviewed. Without risk management and reporting arrangements within the Maternity and Obstetrics & Gynaecology departments, we were unable to determine local, formal processes for the escalation of risks up to the Care Group risk register. For our sample of risks scoring 15 or above we did not see evidence in Datix of the OMB escalation decision process. Patient Quality & Safety – Corporate Directorate At the time of our fieldwork the governance arrangements within the directorate were still being finalised. There was little information in the documentation of the meetings that have been held to date in relation to directorates risks and any escalation required. Whilst a number of risks had been escalated to the ORR, evidence of review at the OMB was not captured within Datix.	If risks are not escalated through the Health Board, appropriate action may not be taken to mitigate.

Recommendations		**Priority**
2.1a	Management should ensure that minutes of the service area and care group governance meetings accurately capture the escalation of risks between the tiers of the risk register.	**Medium**

2.1b	In absence of an 'escalation field' in the current Datix System, management should explore ways to improve the current system that will allow information to be recorded when risks are escalated or de-escalated between the various tiers of risk registers. Information should also be captured when the Operational Management Board have determined that a risk should not be escalated to the ORR.	

	Agreed Management Action	Target Date	Responsible Officer
2.1a	Risk to be a routine agenda item at the appropriate Care Group/Corporate risk meetings that directs members to consider escalation and note the resolution as part of a decision log. A template will be shared with the leads of the groups to ensure consistency of approach.	31st July 2024	Care Group Directors Central / Corporate Assistant Directors Assistant Director of Governance & Risk
2.1b	Assistant Director of Governance & Risk to explore with the Business Intelligence Team whether any additional prompts / fields could be added to Datix to record escalation of risks through the various stages of Service to Board.	31st July 2024	Assistant Director of Governance & Risk Head of Concerns and Business Intelligence, Patient Care & Safety

Matter Arising 3: Risk Management training uptake (Operation)			**Potential Impact**
Since the introduction of the current risk management training programme in 2021, 600 staff have attended the training sessions run by the Assistant Director of Governance and Risk. We note department information is now captured relating to the trainees. However, a switch in early 2024 to ESR as the training booking platform, and ongoing changes to the organisational operating model, has meant undertaking analysis of uptake by department, service area, or Care Group has not yet been possible. Once analysis can be carried out, we understand that information will be available to Care Group management on uptake in their areas of responsibility, so they can target areas with low uptake.			Where there is lack of awareness of the Health Board's Risk Management policy and procedure, risks are not properly managed.
Recommendations			**Priority**
3.1	Analysis of training attendance by Care Group and service area should be carried out and shared with the relevant managers to allow them to monitor uptake within their areas and promote attendance.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Analysis by Care Group / Central Function will be shared at the Operational Management Board via the "Risk" agenda item and Executive Leadership Group through the Corporate Governance Dashboard.	31st July 2024	Assistant Director of Governance & Risk

Matter Arising 4: Risk monitoring governance arrangements (Operation)	**Potential Impact**
We reviewed the arrangements in place for monitoring risks within DTPS and Childrens & Families Care Groups and the Quality & Patient Safety Corporate Directorate. We also looked at the arrangements within a sample of service areas within the two Care Groups. We identified: DTPS Care Group, Pathology and Therapies Service areas • Updates on risks scoring 15 and above are provided from each service area during the DTPS QSRE meetings. Though we note the risk management policy states care groups should have risks scoring 12 and above escalated to them. • Pathology service area is also reviewing their 15 plus scoring risks during their Clinical Governance Group, which could be a duplication of the review taking place at QSRE. The group should meet quarterly, but has not met since October 2023, with the next meeting scheduled for early May 2024. Our review of the October minutes identified that the same risks were reviewed as were reviewed at the QSRE meeting held in October. We could evidence risks scoring 12 and below being monitored during departmental meetings. • Therapies service area review their risks scoring 15 or more at their Integrated Governance Meeting. However, the current risk register shows 12 risks with a score of 12, but we could not see where these risks are being monitored. Children & Families Care Group, Maternity and Obstetrics & Gynaecology • 'Managing risk' is a standard section on the care group's QSRE agenda, however there was little evidence of risks being reviewed at the last two meetings held. At the time of our review, there were 23 risks scoring 12 and above on the care group's risk register, it was unclear where the majority of these risks are being discussed, as only four are above 15 and on the ORR. • We understand that monitoring of risks at a departmental level should take place at the Service Wide Assurance Group. However, at the time of our fieldwork the terms of reference for the group were in draft and the group had not meet. As such, we did not see evidence where Maternity and Obstetrics & Gynaecology departmental risk registers were being monitored.	If risks are not escalated through the Health Board, appropriate action may not be taken to mitigate.

Quality & Patient Safety - Corporate Directorate • At the time of our audit, the Quality & Patient Safety team were in the process of finalising their governance arrangements following a recent restructure. Despite the terms of reference for the Quality and Safety Business Team Meeting not being finalised, the group has already started meeting weekly. Our review of the last three agendas identified there had been one verbal update on the risk register. Similarly, there had been a verbal update at the wider Quality and Safety Improvement Business meeting relating to risk. We note that the directorate has six risks, four of which are scored 15 or above and are reviewed as part of the ORR.		
Recommendations		**Priority**
4.1	Clarity should be provided to Care Groups on the requirements of the risk management policy in relation to where risks of certain scores should be monitored. The information on the level of risk monitoring in the terms of reference for the care group QSRE meetings should align to the risk management policy.	**Medium**
4.2	DTPS The Pathology service area Clinical Governance meetings should be re-stablished and held on a regular basis to ensure an appropriate forum in in place for reviewing their risk register. Therapies Integrated Governance meetings should ensure that it has oversight of the risks scoring 12 and above as we could not determine where these were being monitored.	**Medium**
4.3	Children & Families The terms of reference for the Maternity, Gynaecology and Integrated Sexual Health Service Wide Assurance Group should be finalised, meetings should commence, and departmental risk register should be routinely reviewed by the group. In line with their terms of reference, the Children & Families Care Group QPSE meeting should regularly review the high and extreme risks on their risk register. The minutes from the meetings should record	**High**

	discussions and actions relating to the management of the Care Group risk register, as well as those risk issues that are reported to it by its constituent departments.	
4.4	Quality and Safety Corporate Directorate The terms of reference for the Quality and Safety Business Team Meeting should finalised as soon as possible, so as to formalise the responsibility in relation to risk register monitoring and the process for escalation or risks. It should be ensured that department risk register is routinely discussed at the Quality and Safety Business Team Meeting with onward reporting and escalation to the Quality and Safety Improvement Meeting where necessary. Minutes or action logs from each meeting should be retained to allow clarity on what was discussed and actions that need acting upon.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	A proposed approach will be shared with Care Groups / Central Functions to ensure a consistent management of this activity is achieved at meetings on the monitoring of risk.	31st July 2024	Assistant Director of Governance & Risk Care Group Directors
4.2	a) Pathology Service Clinical Governance Meetings to be restarted. b) Therapies Integrated Governance meetings to ensure that it has oversight of the risks scoring 12.	31st July 2024	DTPS Care Group – Service Director / Clinical Director
4.3	a) The terms of reference for the Maternity, Gynaecology and Integrated Sexual Health Service Wide Assurance Group to be finalised incorporating risk as a routine agenda item. b) The Children & Families Care Group QPSE meeting to regularly review the high and extreme risks on their risk register and minutes and decision log reflect action taken.	31st July 2024	Children and Families Care Group – Director of Midwifery

4.4	The terms of reference for the Quality and Safety Business Team Meeting to be finalised incorporating the monitoring of risk as a routine item. Minutes and decision log reflect action taken.	31st July 2024	Assistant Director of Quality & Safety

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: *

Agenda Item
5.4.6

Audit & Risk Committee

Update on Decarbonisation Internal Audit Report

Dyddiad y Cyfarfod / Date of Meeting	20/06/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Vicki Wallace Deputy Director of Strategy and Partnerships
Cyflwynydd yr Adroddiad / Report Presenter	
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Audit & Risk Committee	18/04/2024	Recommended revision

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board

1. Situation /Background

1.1 At the April 2024 Audit and Risk Committee, the Decarbonisation Internal Audit Report was presented.

1.2 The purpose of the report was to consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan and the Health Board's Decarbonisation Action Plan.

2. Specific Matters for Consideration

2.1 Many of the recommendations made by Internal Audit and the Management Responses were agreed to be appropriate by the Audit and Risk Committee.

2.2 However, concern had been raised regarding recommendations 4.1 and 4.2, as it was felt by the Committee that the Health Board would not be able to Implement them as set out within the report.

2.3 The Deputy Director of Strategy and Partnerships was tasked with working with Internal Audit to update these two recommendations, to reflect the initial context, but in a form that could be addressed by CTMUHB.

2.4 Recommendations 4.1 and 4.2 and the associated Management Responses within the attached report have been updated and the report is attached as Appendix 1 to this paper.

3. Key Risks / Matters for Escalation

3.1 None to note

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	Starting Well
	If more than one applies please list below: Growing Well Living Well Ageing Well Dying Well
	A Globally Responsible Wales

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(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: Learning, Improvement and Research
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)	Yes - Refine
	If more than one applies please list below: Reuse Reduce Recycle Repurpose

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

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	There could be a negative reputational impact if the health board were not able to deliver on the recommendations set out within the audit report	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Each recommendation relates to an area of work which has a resource impact.	

5. Recommendation

5.1 The Committee are asked to **NOTE** the update set out within this cover paper and **APPROVE** the updates made to the Recommendations and Management Responses to Items 4.1 and 4.2 set out within the attached report.

6. Next Steps

6.1 The Environmental Sustainability Group will oversee delivery against the audit recommendations.

Decarbonisation
Final Internal Audit Report (revised)

May 2024

Cwm Taf Morgannwg University Health Board

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

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

Contents

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Executive sign-off:	Linda Prosser Executive Director of Strategy & Transformation
Distribution:	Vicki Wallace - Deputy Director Strategy and Partnerships
Committee:	Audit & Risk Committee

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

Acknowledgement

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

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Executive Summary

Purpose

To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan and the Health Board's Decarbonisation Action Plan. Following on from the advisory review delivered in 2022/23, the proposed scope includes governance, strategy progress and implementation.

Overview

Whilst a decarbonisation action plan is in place and there is a governance structure to support implementation, significant matters require management attention including:

- A lack of dedicated decarbonisation resourcing.
- The action plan is currently not costed as such a funding strategy has not been developed.
- Monitoring and reporting requires greater clarity.

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance	Reasonable
2	Localised strategies	Limited
3	Funding Strategy	Limited
4	Monitoring and Reporting	Limited
5	Project Delivery	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	Environmental Sustainability Group governance arrangements	1	Operation	Medium
3	Dedicated resources	1	Design	High
4	Costed plan and funding strategy	2 & 3	Design	High
5	Carbon consideration in decision making	2	Design	Medium
6	Monitoring and reporting	4	Operation	High

1. Introduction

1.1 The Welsh Government (WG) is party to international agreements to reduce carbon emissions and control climate change, most notably as arising from the 2016 Paris Accord. Accordingly, they have sought to create a framework of controls, guidance and support to achieve these aims.

1.2 Targets include waste reduction, and reductions in supply chain carbon as part of the overall carbon footprint.

1.3 To support these aims, the Welsh Government published a number of strategic documents entitled *Prosperity for All – Economic Action Plan, Prosperity for All – A Low Carbon Wales* and *Prosperity for All – A Climate Conscious Wales.*

1.4 In March 2021, the Welsh Government approved a net zero target for the public sector of 2030. Net zero means balancing the greenhouse gas emissions with the amount of gases being removed from the atmosphere. For NHS Wales, an accompanying '*Strategic Delivery Plan*' was published, setting interim targets (from a 2018/19 base) of:

	Carbon budget reduction
2025	16%
2030	34%

1.5 Category targets were also set for:

- buildings;
- procurement;
- fleet and business travel; and
- staff, patient, and visitor travel.

1.6 All Wales activity support streams have been created, including estates planning, and approaches to healthcare.

1.7 In 2023/24 the Welsh Government made funding available of *circa.* £19.9m via the Estates Funding Advisory Board (EFAB). A similar amount will be available for 2024/25. Approximately £3m of the funding in each year will be for decarbonisation schemes, though there may be decarbonisation elements identified from other schemes funded by EFAB. This funding is based on each organisation matching 30% of the WG contribution from their own discretionary programme.

1.8 This audit is part of the Cwm Taf Morgannwg University Health Board (CTMUHB or the 'Health Board') 2023/24 audit plan. It seeks to build upon our 2022/23 all Wales advisory review, which identified that the implementation plans across Wales had not been sufficiently developed to allow meaningful testing to be able to provide an assurance rating to respective audit committees. Accordingly, we provided an overview of the overarching position across NHS Wales and an action plan of common themes which were considered by the Health Board. Noting the

advisory nature of the report, the recommendations were not included formally on the Health Board's Internal Audit recommendation tracker.

1.9 All NHS organisations now report progress against their own Decarbonisation Action Plan (DAP), supporting delivery of the national NHS Wales decarbonisation strategic delivery plan.

1.10 The risks considered during this review were:

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions.
- Reputational risk by failing to meet emission targets.
- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health. In so doing, not meeting the requirements of the Wellbeing of Future Generations Act (2016).

1.11 The wider role of NHS Wales Shared Services Partnership (NWSSP) Procurement, in the decarbonisation agenda, has not been audited as part of this review. Additionally, verifying the accuracy of carbon emission declarations and estimates was excluded from the scope of this audit; and we note that the baseline position for CTMUHB has not been adjusted to take account of the impact of the significant boundary/area change that has occurred to the Health Board since the baseline figures were established.

2. Detailed Audit Findings

Objective 1: Governance – appropriate governance arrangements have been established in relation to decarbonisation that integrate with existing organisational accountability and reporting structures.

2.1 The 'NHS Wales Decarbonisation Strategic Delivery Plan 2020-2030' published in March 2021 lays out 46 initiatives across six work streams that will facilitate reducing carbon emissions. These initiatives should form the basis of health board decarbonisation action plans. Each health board has to implement actions to achieve these initiatives in support of the NHS Wales carbon reduction targets as part of the Welsh Government's 'Net Zero' agenda.

2.2 The 'CTM Decarbonisation Strategy 2022-2030' was approved by the Board in March 2022. The Health Board's strategy identifies five themes and sets out the current work in relation to sustainability and its future vision for each goal. The strategy identifies an executive team member responsible for the delivery of each of the five themes.

2.3 In June 2023 the executive team and Independent Members had training from the Centre for Sustainable Healthcare which focused on the need to embed sustainability into all areas of Health Board operations and make sure sustainability goals fully align with organisational goals.

2.4 The Learning and Development team have developed an ESR training module on 'Achieving Net Zero in Wales'. The module is available to all staff and was launched

in November 2022 to coincide with Wales Climate Week. We note that the Health Board has not monitored the level of uptake of the module. **(Matter Arising 2)**

2.5 In 2022 the Health Board set up an Environment Sustainability Group (ESG). The group's remit is wider than just decarbonisation. However, they are the Health Board's primary driver for its decarbonisation agenda, and they play a key role in advising, guiding and monitoring the development and implementation of:

- CTM's decarbonisation strategy and implementation plan.
- Programmes and projects delivering decarbonisation and environmental sustainability.
- Annual carbon emission (CO2e) reporting to Welsh Government.

2.6 The terms of reference (ToR) for the ESG is dated November 2022. The ToR identifies a broad range of members from across the Health Board, but some of those named no longer work for CTMUHB, and other roles are recorded as 'TBC'. We note that while executive team members have responsibility for the five decarbonisation themes, none attend the ESG although some have appointed representatives to attend. **(Matter Arising 1)**

2.7 Our review of minutes of the group identified that many of those identified as members were not in attendance. While other staff were in attendance, their role and the area of the Health Board and the theme they represented was not clear. **(Matter Arising 1)**

2.8 Information about the group's activities, reporting requirements and governance structure is contained within the ToR. We note reference to bi-annual reporting to the Planning, Performance and Finance Committee, but we have seen that reporting takes place via the Population Health and Partnerships Committee. As environmental sustainability is one of the Health Board's transformation portfolios, we understand there is quarterly reporting to the CTM Transformation Board. We have also seen reporting on decarbonisation into the CTM Board.

2.9 The Health Board has representation on other forums that are intended to promote and support the decarbonisation agenda. For example, the Health and Social Care Climate Emergency National Programme - Community of Experts, which is a forum where peers from across NHS Wales can learn from each other by either sharing good practice or raising issues for discussion. We are aware of a range of other all-Wales sustainability groups specific to certain topics, such as travel and transport. However, we have been unable to determine if the Health Board is represented.

2.10 Although responsibilities within the decarbonisation strategy have been assigned at Board level, there are relevant groups within the Health Board, and there are links with relevant external groups that are intended to drive decarbonisation, there is no specific resource dedicated to decarbonisation within the Health Board. Despite 2025 being the date set by WG for achieving a 16% reduction in carbon emissions, up to now responsibilities for overseeing the decarbonisation work have been undertaken in addition to existing responsibilities. **(Matter Arising 3)**

2.11 The Health Board has identified a strategic risk, 'Fulfilling our Environmental and Social Duties and Ambitions', which relates to decarbonisation. We note that the Health Board has recognised there is an element of tolerating this risk, especially in terms of the pace of mitigation to its desired level due to workforce and financial capacity constraints. There are however ongoing risk treatment activities to mitigate the risk, especially around the Health Board's decarbonisation plans.

Conclusion:

2.12 The Health Board has taken steps to establish a strategy and plan for decarbonisation. Governance arrangements have been established to provide oversight on the overall environmental and sustainability goals, however these need to be reviewed. At the time of our fieldwork the Health Board did not have dedicated specialist staff to drive the decarbonisation strategy. We have provided reasonable assurance against this objective.

Objective 2: Localised Strategies – a tailored decarbonisation strategy and action plan has been developed in accordance with available legislation and guidance. Documents have been appropriately scrutinised and approved prior to submission to Welsh Government. The strategy and plan are adequately reflected within wider organisational documentation such as the IMTP.

2.13 In addition to the 'CTM Decarbonisation Strategy 2022-2030', a 2022-24 Decarbonisation Action Plan (DAP) is in place. This lists 137 actions, each linked to one of 30 of the 46 referenced initiatives identified in the NHS Wales Decarbonisation Action Plan. We note that 16 initiatives do not apply to the Health Board as other parties, such as NWSSP Procurement services, are responsible for their delivery.

2.14 The 2022-24 DAP was prepared and agreed by members of the Strategy Implementation Group (former name of the ESG) ahead of submission to Welsh Government. We understand that wider approval was not sought due to the timescales needing to be adhered to for submission. A revised DAP for 2024-26 was presented to the March 2024 Population Health and Partnership Committee meeting for endorsing, ahead of submitting to Board approval in late March 2024. The format of the Welsh Government monitoring return template is used to capture the Health Board's DAP.

2.15 We note that decarbonisation reporting to the Board makes reference to the need for a significant investment to achieve decarbonisation plans and targets. However, we have not seen a value identified in the reports. We understand that as the financial impact of implementing the DAP has not been identified. **(Matter Arising 4)**

2.16 Whilst each action captured in the DAP does not have an expected carbon emission saving attributed to it, for each initiative, early iterations of the template identified a carbon impact score, providing guidance to the Health Board on the actions that may have the greatest impact. Awareness of the impact is important as many of the initiatives indicated that their implementation would have a minimal impact on directly reducing carbon emissions.

2.17 The Health Board's 2023-2026 IMTP contains a 'Green 2030' commitment as part of its 'Sustaining our Future' strategic goal. Reference is made to the decarbonisation strategy and key priorities for the period are set out as:

- Establish a clear learning and development support offer for staff focused on embedding climate change action into continuous service improvement.
- Develop tools and support mechanisms to help individuals and teams set and achieve localised decarbonisation goals setting for group work.
- Continue to expand our apprenticeship scheme in order to grow our workforce locally, reducing commuting and establishing CTMUHB as an anchor stone to the local economy.

The ongoing delivery of the DAP and the Biodiversity and Ecosystem Resilience plan are also listed as key areas of focus for 2023/24.

2.18 In addition to the specific information within the 'Green 2030' section of the IMTP, some consideration is also given to the decarbonisation agenda at other points in the document. However, there is no reference to decarbonisation in the overview of the major transformation schemes. If targets are to be achieved, a Health Board wide approach is needed. We would expect major transformation schemes and future projects of the Health Board to include greater consideration of impact on decarbonisation. **(Matter Arising 5)**

2.19 We note that over the past year a number of wider strategies and policies have been published that have given consideration to the decarbonisation agenda. This includes the Active Travel Charter and the Transport, Travel and Car Parking Policy.

2.20 To help embed the decarbonisation ethos among staff and encourage local work, the Health Board has established an informal 'green team' which meets periodically to discuss environmental issues. This group has around 80 members of staff from all areas and levels of the Health Board. The purpose of the group is to keep decarbonisation at the forefront of peoples thinking and to challenge staff to think of new and better ways of working that will help patients improve their health outcomes while reducing waste and variation across the healthcare system.

2.21 The Health Board has created a SharePoint site, 'Green CTM', which is home to the Health Board's climate change work and is accessible to staff.

Conclusion:

2.22 The Health Board has actively engaged with relevant staff to produce a DAP and therefore local initiatives that align with decarbonisation and sustainability objectives. Whilst there is a detailed plan that contains aims, objectives and initiatives, the initiatives do not identify the investment required. We have provided limited assurance against this objective.

Objective 3 Funding Strategy – There is an appropriate funding strategy targeting discretionary, EFAB and All-Wales funding.

2.23 Our 2022/23 report recommended that the DAP should be costed and supported by funding strategies. While we acknowledge that a costed DAP was not a requirement of the initial plans submitted to Welsh Government, the lack of a costed DAP means a strategy setting out how initiatives will be funded is not in place. **(Matter Arising 4)**

2.24 The Health Board has an ongoing programme of three major decarbonisation projects. These are being delivered through £1.06m of funding from EFAB. We note that the Health Board's Estates Capital Management Group (ECMG) have approved the £0.42m Health Board share of the projects from discretionary funds.

2.25 Other funding has also been made available from the Health and Social Care Climate Emergency Programme funding scheme and has been used by the Health Board to deliver smaller scale projects.

2.26 The Health Board is also working with Re:Fit, a government run local partnerships scheme, to tender for a service provider under the 'National Framework Agreement for Energy Performance'. The Health Board aims to appoint a provider by April 2024. They will aid the Health Board in its decarbonisation work including helping in optimising the energy efficiency of selected premises and improving the energy performance of its assets.

2.27 We understand that the service provider also will supply the expertise to aid the costing of initiatives and then identify and apply for external funding sources to support the Health Board's in implementing those initiatives.

Conclusion:

2.28 The Health Board has successfully obtained funding for some larger and smaller scale projects and is seeking to procure a specialist service provider to aid its decarbonisation work. However, the lack of a costed DAP and the financial shortfalls and wider financial pressures across NHS Wales, impacts the development of a long-term financial model and the ability to deliver the decarbonisation agenda. We have provided limited assurance against this objective.

Objective 4: Monitoring & Reporting – appropriate monitoring and reporting arrangements are in place to provide ongoing assurance on the implementation of the strategy and action plan.

2.29 Monitoring progress on implementing the DAP is the responsibility of the ESG, which meets quarterly. While reviewing each action on the DAP may not be practical, we did not see a report to ESG providing an overview of progress against the DAP. We acknowledge that updates are provided on specific activities, and understand that for each area of the DAP the relevant responsible team will assess their completion percentage for input on monitoring returns. But we did not see how this is fed back to the ESG. It is unclear who has oversight of the DAP at an operational level. **(Matter Arising 6)**

2.30 Each workstream of the ESG should provide a highlight report to the ESG twice a year. Whilst there were regular updates from departments such as pharmacy,

facilities corporate and ICT, we did not see clear alignment between the reports received and all six workstreams. **(Matter Arising 6)**

2.31 We note that the work required to produce the 2024/26 refreshed DAP was regularly discussed at ESG meetings.

2.32 Quarterly monitoring returns are submitted to Welsh Government using a template. Our testing of a sample of returns confirmed that they were submitted in line with the required timeframes. The most recent monitoring return is structured with the 46 initiatives grouped on tabs under the prescribed six workstreams, such as carbon management, buildings, estates and planning and transport. Each initiative may have one or more actions to complete. The return identifies information such as the action owners, responsible officers and accountable officers, comments on delivery and the RAG status and overall delivery confidence per action and initiative.

2.33 Early iterations of the returns were supported by a summarised narrative report setting out overall RAG status on progress and delivery confidence and made comparisons to the previous reported position. Key achievements and risks to delivery were also captured. For the most recent version of the DAP return template, the narrative report is no longer a requirement. We acknowledge this is the prescribed format set by WG, however the loss of the narrative report and the lack of a summary page in the monitoring report, makes it difficult for the reader to decipher the Health Board's current overall position.

2.34 The Executive Leadership Group receive a quarterly report and a copy of the monitoring return (DAP), for approval ahead of submission to Welsh Government. The report is submitted via the NWSSP Decarbonisation Coordination Reporting (DCR) team. While the quarter two 2023/24 monitoring return cover report refers to 'varying degrees of success' for individual actions and notes the main risks (finance, people, time) to delivery, a high-level view of current position is not clear from the current reporting format. We have not seen reported anywhere, how far off the 16% reduction the Health Board is. Our analysis of the monitoring return shows that for 12/30 initiatives that are relevant to the Health Board, the overall delivery confidence for 12 initiatives (40%) has been classed as 'feasible'[1] or 'in doubt'[2]. **(Matter Arising 6)**

2.35 While the 2022/23 quarter four monitoring report was presented to the Population, Health and Partnership Committee in May 2023, we have not seen evidence of subsequent quarterly reports to the Committee. We acknowledge that related reports have been presented at the committee during this time such as the previous all-Wales Internal Audit report and a presentation on a recycling project. **(Matter Arising 6)**

[1] WG Definition of 'feasible': Successful delivery appears feasible but significant risks and issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly.

[2] WG Definition of Successful delivery of the action / initiative is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed and establish whether resolution is feasible.

2.36 The Health Board is required to produce an Annual Carbon Report. The last annual report was presented to the Board in September 2023 ahead of being submitted to WG. The report contained data on the Health Board's carbon emissions and included comparisons to previous years. The report is clear in stating that despite the reported reduction, which may be due to changes in the reporting template, the Health Board will not meet its 16% carbon reduction target by 2025 or 34% reduction by 2030. We are aware that is in line with what other health boards and trusts reported in their 2022/23 annual reports.

2.37 The baseline carbon emission positions for all health boards were established in 2018/19. This predates the boundary changes to the Health Board area. We understand that Welsh Government have confirmed there will be a move to a different reporting methodology to allow for the boundary change.

Conclusion:

2.38 The Health Board has appropriately completed its monitoring returns to WG on time. While we have seen some reporting internally, we have not seen evidence that detailed reporting of progress against the DAP is reported to the ESG, who are the key group responsible for overseeing its implementation. Furthermore, we have not seen reported anywhere, how far off the 16% reduction the Health Board is. We have provided limited assurance against this objective.

Objective 5: Project Delivery - suitable progress has been made on projects included within the 2023/24 funding commitments, and that appropriate arrangements are in place to secure available funding during 2024/25.

2.39 In 2022/23, using funding from the Health & Social Care Climate Committee Programme scheme, the Health Board has established a 'Sustainable Innovation Scholar Programme'. Staff were invited to suggest initiatives to be implemented that would start to address the healthcare contribution to the climate crisis. A number of potential schemes were considered with six initiatives selected and delivered. For example, a pilot partnership between the Health Board and a local third sector employer to reduce cardboard waste and CO2e by providing a sustainable and ongoing solution to cardboard waste management. The costs, primarily staff time of one day per week for six months, were appropriately recorded and allocated back to the staff member's main departmental cost centre.

2.40 These appear to have had a positive and direct impact on the Health Board activities and their success has been shared with staff via newsletters on the intranet. Reports have also been presented at the Population Health and Partnerships Committee. However, we have been informed that there were no further programmes or initiatives in 2023/24, but work is underway to identify funding steams for 2024/25.

2.41 There were three EFAB funded projects during 2023/24. The projects use the Health Board's capital programme management structure with scheduled budget, performance measures, and progress reports produced and considered by the group. In relation to the EFAB funding, we note that the funding approach intentionally does not compare full VFM and cost per tonne of carbon emission

saved. The Health Board considers EFAB as appropriate for the longer-term projects that do not necessarily deliver instant returns and benefits, but have long term value to achieving decarbonisation, such as solar panels to generate electricity.

2.42 We saw evidence of benefits realisation being monitored and tracked and where necessary a project being suspended to allow a full review to take place where a scheme appeared to be failing in producing the proposed carbon saving.

Conclusion:

2.43 There is enough evidence to confirm proper use of EFAB project funding and monitoring of the realisation of the benefits of those projects. We consider substantial assurance appropriate for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Environmental Sustainability Group governance arrangements (Operation)	**Potential Impact**
The Health Board has established an Environmental Sustainability Group (ESG) whose remit includes overseeing the implementation of the Health Board's decarbonisation strategy and action plan. We note that the terms of reference for the group were due to be reviewed in November 2023, but had not been. Our review of the terms of reference identified: • Members of the group are no longer Health Board employees. • Roles had 'TBC' recorded against member name. • Not all of the Executive leads with responsibility for aspects of the decarbonisation strategy had named representatives on the group. • The reporting structure states the group reports to the Planning, Performance and Finance Committee, when this should say the Population, Health and Partnerships Committee. Our review of minutes of the group identified that many of the named members were not in attendance, however in contrast numerous other staff were in attendance, but it was not always possible to determine their role or the area of the Health Board or workstream that they were representing.	Inappropriate governance arrangements are in place leading to lack of ownership and oversight of decarbonisation work and failure to achieve Welsh Government targets.

Recommendations		**Priority**
1.1	The terms of reference for the Environmental Sustainability Group should be reviewed in line with the frequency set out in them to ensure they remain current in relation to membership details and reporting arrangements. The review should ensure that there are named representatives for each of the Executive leads with decarbonisation responsibilities.	**Medium**
1.2	The minutes of the ESG should capture the department / workstream that members are representing to ensure there is clear representation.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	This recommendation is accepted and the terms of reference for the Environmental Sustainability Group will be updated to reflect this.	July 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships
1.2	This recommendation is accepted and changes will be made to how the minutes record representation.	July 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 2: Training and awareness (Operational)			**Potential Impact**
The Health Board used Green Scholar funding to aid the development of an ESR training module on 'Achieving Net Zero in Wales'. The module was launched in November 2022, however we have been unable to determine if any monitoring has been undertaken of the uptake of the module.			Training is not undertaken and staff awareness on decarbonisation is not raised.
Recommendations			**Priority**
2	Data in relation to the uptake of the 'Achieving Net Zero in Wales' ESR training module should be obtained reviewed to determine if additional work needs to be carried out to raise awareness of the availability of training module.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	This recommendation is accepted. Work will be done with the People Team to understand the uptake of the ESR training module.	December 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 3: Dedicated resources (Design)			**Potential Impact**
The breadth and depth of the decarbonisation requirements are complex and far reaching. At the time of our fieldwork the Deputy Director Strategy and Partnerships had responsibility for overseeing the Health Board's decarbonisation work in addition to existing responsibilities. We understand that there are no resources dedicated to the decarbonisation strategy or action plan delivery.			Lack of exclusive resource could mean that projects and initiatives are not delivered and further opportunities for decarbonisation are missed.
Recommendations			**Priority**
3	Management should review the resource dedicated to decarbonisation to identify if it can meet the Health Board's requirements.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Additional resources have now been identified from within the Deputy Director of Strategy and Partnerships team with the establishment of a Sustainability Manager post which is currently being recruited to.	July 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 4: Costed plan and funding strategy (Design)			**Potential Impact**
Whilst reports to the Board inform them of the investment that will be required to implement the initiatives and achieve the targets set out in the Decarbonisation Action Plan, a costed plan is not in place. The Health Board has not identified the likely future commitment needed to meet the requirements of decarbonisation.			The Health Board is unable to invest sufficient resources to achieve the decarbonisation programme meaning they fail to achieve the WG targets.
Recommendations			**Priority**
4.1	To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed and approved in line with organisational governance. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not.		**High**
4.2	For those initiatives that can be quantified, a long-term model for the funding required to support the decarbonisation programme should be developed.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Action will be undertaken to cost appropriate elements of the plan as resources and available information allows. However budgetary constraints are such that it is unlikely that all elements will be affordable and as for 4.2 we will stay in close dialogue with Welsh Government regarding priorities.	March 2025	Vicki Wallace – Deputy Director of Strategy and Partnerships
4.2	This recommendation needs to be undertaken in partnership with Welsh Government (through Directors of Planning/Directors of Finance channels) as the UHB works within its revenue and capital resource limits. For example, a key component of the UHB's capital planning is maximising access to funds available from Estates Funding Advisory Board for decarbonisation (which provided £0.9m in 23/24).	March 2026	Linda Prosser – Executive Director of Strategy and Transformation

Matter Arising 5: Carbon consideration in decision making (Design)			**Potential Impact**
There is a developing consensus that the decarbonisation goals for NHS Wales and those portions of it assigned to the individual health boards cannot be achieved simply by funding decarbonisation projects and initiatives; the carbon savings required are too great. What is needed is for decarbonisation to be considered for each action and activity undertaken by the health boards in their daily operations, as opposed to decarbonisation actions being thought of in isolation. Whilst the Health Board's IMTP references decarbonisation as a key priority in the 'Green 2030' section of the document, there is an opportunity to make greater emphasis on it throughout. For example, when discussing the major transformation schemes.			Decarbonisation is not considered in all activities and decision making and the Health Board fails to achieve the Welsh Government targets.
Recommendations			**Priority**
5	Carbon impact assessments should form part of the decisions made and actions taken by the Health Board, especially in larger scale transformational projects.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5	This recommendation is accepted by the Health Board. Work on this recommendation will commence following the recruitment of the Sustainability Manager as this will create additional capacity needed to better understand how this can be enacted systematically across the health board.	March 2025	Vicki Wallace – Deputy Director of Strategy and Partnerships

Matter Arising 6: Monitoring and reporting (Operation)	**Potential Impact**
Environmental Sustainability Group meetings The terms of reference for the ESG state that they are responsible for monitoring progress in implementing the Health Board's DAP. We acknowledge that it would not be practical to review each initiative during these meetings. However, from our review of minutes for the group, it was not clear how the ESG is actively managing and overseeing the progress of implementation of the 30 initiatives it is responsible for that make up the DAP. The DAP is structured around the six Welsh Government workstreams. Highlight reports from three of the six workstreams should be presented at alternate ESG meetings. Whilst we could see regular updates from a number of departments, such as facilities, pharmacy and ICT, these did not clearly align to the workstreams. As such, we were unable to confirm if there was appropriate reporting on the workstreams. Board and Committee reporting Reporting progress against implementation of the DAP does not appear to be taking place bi-annually, as set out in the ESG terms of reference. Our fieldwork identified one instance of the DAP / monitoring return being submitted to the Population Health and Partnership Committee since returns began in quarter two of 2022/23. The report that we saw used the Welsh Government monitoring return format, so did not include narrative for the reader to gain an overarching view of the position of the Health Board against its targets. Whilst the cover report referred to 'varying degrees of success' and the risks to achievement of the target, there did not appear to be reporting against the Health Board's overall carbon reduction target of 16% by 2025.	Effective monitoring and reporting of progress against the DAP does not take place, meaning corrective actions cannot be taken and the Board are unable to gain appropriate assurance.

	Recommendations	**Priority**
6.1	Reporting arrangements for the Environmental Sustainability Group should be reviewed to ensure that it receives the necessary information to have oversight of the DAP implementation, including clear reporting from each workstream, to allow meaningful updates on progress to be reported to the Board and its committees.	**High**
6.2	The reporting format should be supplemented to include a narrative report that allows readers to gain a clear understanding of the current position of the Health Board in achieving the initiates in place for each workstream and the overall position against the Welsh Government targets. Reporting on progress in	**High**

	implementation of the DAP to the Population Health and Partnership Committee should take place at regular intervals, as set out in the ESG terms of reference.	

Agreed Management Action		Target Date	Responsible Officer
6.1	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	September 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships
6.2	The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	September 2024	Vicki Wallace – Deputy Director of Strategy and Partnerships

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Adult Mental Health CSG review
Final Internal Audit Report

June 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

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Committee:	Audit & Risk Committee

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

Acknowledgement

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

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Executive Summary

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Adult Mental Health CSG in relation to key assurance areas.

Overview

We identified a number of areas as outlined in Appendix A, that require improvement. The key points relate to:

- Capturing the governance structures in place within the Care Group and ensuring clarity of remit of the various groups and committees.
- Ensuring risks are reviewed in line with required timeframes and evidence is captured with Datix.
- Reviewing workforce arrangements including the approach to calculating annual leave entitlements and ensuring relevant staff have up to date job plans in place.
- Reviewing budget reports and staff in post reports to identify staffing errors that are impacting on budgets.

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

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Governance Arrangements	Reasonable
2	Risk Management	Reasonable
3	Workforce	Reasonable
4	Planning and Performance	Reasonable

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

Matters Arising		Assurance Area	Control Design or Operation	Recommendation Priority
Governance Arrangements				
1	Committees and groups structure and terms of reference	1	Design	Medium
2	Conduct of committees and groups	1	Operation	Medium
3	Declarations of interest	1	Operation	Medium
Risk Management				
4	Risk information in Datix	2	Operation	Medium
5	Risk monitoring	2	Operation	Medium

Matters Arising		Assurance Area	Control Design or Operation	Recommendation Priority
Workforce				
6	Managing sickness absence	3	Operation	Medium
7	Managing Annual Leave	3	Operation	High
8	PDR compliance	3	Operation	Medium
9	Mandatory training	3	Operation	Medium
10	Rosters	3	Operation	Medium
11	Job planning	3	Operation	High
Planning and Performance				
12	Consistency in workforce monitoring arrangements	4	Operation	Low
13	Budget monitoring	4	Operation	Medium

1. Introduction

1.1 Our review of the Adult Mental Health Clinical Service Group (CSG) management arrangements was completed in line with the 2023/24 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation').

1.2 Adult mental health forms part of the Mental Health & Learning Disabilities Care Group. A leadership quad consisting of a Service Director, Nurse Director, Medical Director and Head of Psychology and Psychological Therapies are in place to provide the strategic leadership to the care group.

1.3 At the start of our fieldwork, there was a Mental Health CSG for each of the three localities: Bridgend; Merthyr Cynon; and Rhondda Taf Ely (RTE). Each CSG had a manager, lead nurse and clinical director.

1.4 We note that recently the care group structure has changed. There is no longer a CSG for mental health at each of the three localities, these have been replaced by an Adult Mental Health Directorate and an Older Adult Mental Health Directorate which cover all three localities. The main services provided across the CSGs are for inpatients, including rehabilitation, day services, primary and community services. Our work focused on Adult Mental Health inpatient services, which are provided at the Bridgend and Rhondda Taf Ely localities. We also considered their wider relationship with the care group.

1.5 The relevant Executive Director lead for this review was the Chief Operating Officer (COO), with delegation to the Deputy COO for Primary, Community and Mental Health.

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

- The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Services are not effectively planned.
- Risks materialise as they have not been identified and / or addressed.
- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.
- CSG objectives are not achieved because of demand and capacity data failing to be effectively use and monitored.
- Financial expenditure unnecessarily incurred.

2. Detailed Audit Findings

Area for assurance 1: Governance Arrangements

Governance Committees and Groups

2.1 There are a number of groups and committees with responsibility for governance arrangements within the mental health area of the care group. At the time of our

fieldwork the Care Group was restructuring as part of the Health Board's revised operating model plan.

2.2 The Care Group's Quality, Safety, Risk and Experience (QSR&E) Group has responsibility for overseeing quality governance. The Nurse Director is the dedicated lead for quality governance and is the chair of QSR&E. There are lead nurses in each CSG who oversee quality governance in their area and each CSG has its own QSR&E group that feeds into the Care Group QSR&E Group. The Care Group is supported by a Head of Quality and Patient Safety who provides advice and guidance.

2.3 The Care Group's Planning, Performance and Finance (PP&F) Board has responsibility for overseeing operational governance at a Care Group level. These meetings are chaired by the Service Director. Finance and workforce business partners are members of the group as are colleagues from other areas of the Health Board such as pharmacy and occupational therapy.

2.4 Structure diagrams set out the committees and groups that feed into each of these two main groups and in turn, their onward reporting forums. We were provided with the terms of reference for both QSR&E group and PP&F board. The QSR&E terms of reference have recently been updated and PP&F were in draft and in need of reviewing. **(Matter arising 1)**

2.5 Our review of the agendas, minutes and action logs for QSR&E and PP&F confirmed that the content and frequency of meetings was in line with their terms of reference. However, for two of the three QSR&E meetings that we looked at the meeting did not appear to be quorate, as there was not a representative from each CSG. **(Matter arising 2)**

2.6 In addition to the PP&F, performance is also considered at Care Group Integrated Performance Meetings (IPM) and CSG IPMs. However, we did not see a terms of reference for the Care Group IPM, so its remit is not clear. Similarly, we did not see a terms of reference for the Senior Leadership Team Corporate Leadership Team meetings held within the CSGs that we sampled. As such, we were unable to determine if the was any overlap or gaps in coverage of governance matters. **(Matter arising 1)**

2.7 While we acknowledge that a number of groups have been established within the care group to oversee governance, their inter-relationships are not clear. **(Matter arising 1)**

Declaration of Interest

2.8 We tested a sample of staff within the Mental Health Care Group that were required to complete either a declaration of interest or a 'nil' return, but for the majority of staff these were not complete. **(Matter arising 3)**

Conclusion:

2.9 We note that management are undertaking work to define the governance structures within the Care Group in light of the revised operating model. This ongoing work will provide an opportunity to clearly set out the functions of each

committee and group through a terms of reference or similar, setting out the roles, responsibilities, membership and inter-relationship between groups which will strengthen the governance arrangements. We have provided Reasonable Assurance in this area.

Area for assurance 2: Risk Management

2.10 The Service Director has overall responsibility for managing risk in the Care Group, with more local risk management delegated to CSG managers. Risks are recorded in the Datix risk management module. At the time of our fieldwork there were 49 risks on Datix relating to the Mental Health side of the Care Group. Of these, nine related to the Bridgend Adult Mental Health CSG and 13 to the RTE Adult Mental Health CSG. Two risks were categorised as a 'high risk' (scoring above 15) both related to RTE. The remaining 20 risks were classified as 'moderate' risks (scoring 8-12).

2.11 We reviewed the risks in Datix for the Bridgend and RTE CSGs and confirmed that these were assigned to appropriate risk handlers. The risks had been recently reviewed within Datix, but for a number of risks the form of review was not clear as the narrative outlining the controls that are in place had not been updated for some time. We also note for a small number of risks in RTE, the future review date did not follow the review timeframes that are required by Health Board's risk management policy. **(Matter Arising 4)**

2.12 At a local level we saw evidence of risks discussion in both the Bridgend and RTE local IPMs. While both groups discussed the top five risks for their CSG, it was not clear how the top five were identified as more than five had the same score. Furthermore, we could not establish where the risks not within the top five were monitored. **(Matter Arising 5)**

2.13 While we understand that the local QSR&E groups monitor risk by exception and provide highlight reports to the Care Group QSR&E group, we did not see evidence of the papers for the local QSR&E meetings to confirm this.

2.14 However, responsibility for monitoring of risk at a Care Group level was not clear. The terms of reference for both PP&F and QSR&E groups refer to responsibilities in relation to risk management. We note that the QSR&E terms of reference state they will *'Monitor the arrangements in place to assess, control and minimise risk and regularly review the high and extreme risks included on the Mental Health Risk Register (risks of 12 and above)'*. Whereas the PP&F terms of reference refers to them embedding core reviews of risk on each meeting agenda.

2.15 Our review of the meeting minutes from both groups established that the QSR&E group are provided with updates at each meeting from the CSGs via highlight reports. Whilst risk was referred to via the highlight reports, detailed updates of risks scoring 12 and above was not evident. In contrast, individual risks were discussed in detail during PP&F meetings. However, we did not see evidence that high scoring risks from across the Care Group were reviewed at these meetings. As such, it is not clear where this monitoring happens. **(Matter Arising 5)**

Conclusion:

2.16 We can see that the Datix system is used to manage risk. However, without narrative updates within the system and evidence of review of risk registers in meetings it is difficult to confirm the level of review and how risks are escalated and de-escalated through the service. We have provided Reasonable Assurance in this area.

Area for assurance 3: Workforce

Sickness Absence

2.17 We tested a sample of staff absences from across two wards to ensure compliance with the All Wales Managing Attendance at Work policy. Generally, there was compliance with the policy, but we note a small number of instances where information was missing or had not been completed. **(Matter Arising 6)**

2.18 We also identified that information to evidence the management of repeated absences in line with the policy was not always in place. Whilst we acknowledge managers can use their discretion to decide not to apply a warning, these decisions and the reasons were not recorded. **(Matter Arising 6)**

Managing Leave

2.19 At both of the wards that we visited, managers require staff to submit the majority of their annual leave requests ahead of the financial year starting. This enables better forward planning. At the start of each year, the ward managers calculate the staff leave entitlement and input this information on Health Roster. However, we identified differences when comparing to leave entitlement information held on ESR. **(Matter Arising 7)**

2.20 To minimise the need for bank or agency staff usage, both wards have a maximum number of staff that can take annual leave at the same time. Whilst in the main we could see these principals being followed, we note that on one ward, a higher number of staff were allowed leave during school half term period. This resulted in some shifts remaining unfilled which may have impacted on the safe staffing levels and skills mix required. We also note some staff working many bank shifts or overtime during the period they had booked annual leave. **(Matter Arising 7)**

2.21 Our review of the TOIL arrangements established that one ward does not allow TOIL, instead staff are paid overtime. Whilst TOIL is used in the other ward visited, a review of sample of records confirmed that its use is limited and well controlled.

PDR & Mandatory Training Compliance

2.22 At the time of our fieldwork, compliance rates for PDR and mandatory training for the Care Group was 72% and 76% respectively, a little below the WG target of 85%.

2.23 However, within our two sample wards PDR compliance rates varied. We understand that for one ward ESR is not used to capture key PDR date information. For this ward there was a compliance rate of 22% of staff having an in-date PDR

captured in ESR. This compared to 74% compliance in the other ward that we sampled. **(Matter Arising 8)**

2.24 In relation to mandatory training, while we understand that ward managers encourage staff whose compliance levels are low and set aside study days to allow staff to participate in training, clinical pressures and limited access to IT equipment impacts on the ability of staff to undertake training. Our testing identified a number of staff whose compliance rate was below 50%. **(Matter Arising 9)**

Staff Rosters

2.25 The Health Roster system is used to prepare staff rosters. Both of the sample wards prepare rosters six-weeks in advance to allow enough time for any gaps to be filled by either existing staff, bank staff or finally agency staff. We note that both wards require staff to have undertaken specialist training before being able to work on the wards.

2.26 We reviewed ward rosters for a four-week period to confirm that they were generated in line with the agreed ward template. We note that both wards had a daily reliance on bank staff to meet the template roster, and to provide staff to meet additional demand. Where additional staff were required to meet demand, the rationale appeared reasonable. For example, needing staff to escort patients on visits, increased acuity levels and increased demand.

2.27 Our testing identified a number of minor differences between the data captured in Health Roster to the information contained on the worked rotas. Differences included absence not being recorded in Health Roster, differences in the hours worked and the overtime input into Health Roster, and staff swapping shifts, which were not reflected in Health Roster. **(Matter Arising 10)**

Consultant Job Plans

2.28 Overall job planning compliance for the Mental Health & Learning Disabilities Care Group was 66% as at February 2024. The Care Group has an action plan in place to support the improvement of this rate and to achieve the 90% compliance target that has been set by the Health Board.

2.29 We tested the data captured in the Allocate system for our two sampled CSGs. This showed that while 75% (12) of the consultant staff had job plans, half had been agreed more than a year ago, and so were not in date. The remaining plans were recorded as 'in discussion'.

2.30 We understand that there are some issues with mangers not being able to access the Allocate system to update the plans for their staff. We also identified some inaccuracies with the staffing lists within Allocate. **(Matter Arising 11)**

Conclusion:

2.31 Our testing in relation to workforce across the two wards that we sampled identified a number of issues, as identified above. We have provided Reasonable Assurance in this area.

Area for assurance 4: Planning and Performance

Planning Arrangements

2.32 The Health Board's 2023/26 IMTP has a Mental Health & Learning Disabilities section where a list of improvement areas for the forthcoming years are captured. The IMTP also contains a number of Ministerial priorities, two of which relate to mental health services.

2.33 The development of the relevant elements of the IMTP was carried out by the Deputy COO with responsibility for mental health services, and the members of the planning department. At that time, the Service Director for Mental Health was not in post.

2.34 Each Care Group was required to prepare finance templates setting out the schemes they intended to implement to achieve their savings target for the year. We note that the Deputy COO worked with CSG managers and the finance business partner to develop and populate the finance templates.

2.35 We understand, unlike previous years, there was no requirement to prepare detailed Care Group workforce plans for the current year. This was partly linked to the ongoing organisational change process taking place across the Health Board. Going forward, Care Groups will be required to provide workforce data to help inform education training information required by HEIW.

2.36 At the time of our fieldwork, the Health Board was developing the 2024/27 IMTP. We note that Care Groups were required to submit detailed information on priorities for 2024/25 and to complete a 'plan on a page' template, setting out key information such as key actions, workforce enables, digital enables and measures of success.

Non-Financial Performance Monitoring

2.37 Performance in relation to key metrics of the Mental Health Act, Health Board mental health priorities, such as follow ups not booked, and patients waiting to access the memory assessment service, are reported in a monthly performance and quality scorecard. We saw evidence of the scorecard being reported at the Care Group PP&F meeting. Detailed reports were also presented on specific performance metrics such as the Ministerial Priorities. We saw onward reporting to the Planned Care Recovery Board.

2.38 We also confirmed that more detailed performance monitoring is undertaken at both the Care Group IPM and the CSG IPM. The performance metrics reported incorporate demand and capacity data where appropriate.

2.39 Other non-financial performance metrics are reported at the IPMs. This includes quality metrics, such as national and locally reportable incidents, complaints metrics, and workforce metrics in relation to staff sickness, mandatory training, PADRs and job planning. We identified some variation in the way in which workforce data was presented during the CSG IPMs. For example, one CSG set out 'focus areas' (wards/departments) where PDR completion rates needed improving,

whereas another CSG set out the compliance rates for all departments. If appropriate, a standard approach may be beneficial.

2.40 Every other month, Bridgend CSG have meetings dedicated to discussing workforce metrics and matters where key indicators such as absence, PDR completions and training compliance are discussed, in addition to wider vacancy, recruitment and retention, and employee wellbeing matters. We are unaware of similar meetings taking place within RTE CSG. **(Matter Arising 12)**

Financial Performance Monitoring

2.41 Financial monitoring for the Care Group takes place during the bi-monthly PP&F Board meetings, which is attended by CSG managers for each area and the finance business partner. Matters such as the monthly finance report and the Care Group savings programme are discussed.

2.42 Monitoring also takes place during the monthly Care Group IPMs. The financial focus is on staffing costs and savings targets. More detailed monitoring at a CSG level is undertaken in the CSG IPMs.

2.43 CSG managers are provide with a monthly financial summary report and a finance pack. The summary reports provide a break-down of the in-month and year to date spend against pay and non-pay and income for each cost centre in the CSG and performance against the CSGs CRES target. The format of the reports allows managers to drill down into the values being reported and interrogate the data making up those values. In contrast, the finance packs provide a high-level overview of the financial position of the CSG, highlighting material variances and including explanations for these. Updates against the identified savings schemes are also included in the finance packs.

2.44 There are monthly meetings between the finance business partner, CSG Manager and other key staff from the CSG. While we saw evidence of this for Bridgend, which included a review of the current financial position, including the performance against savings targets and the key issues and risks facing the CSG. We were not provided with copies of agenda or minutes for the RTE finance meetings to confirm the same level of scrutiny taking place. **(Matter Arising 2)**

2.45 As part of our workforce testing, we identified a number of staffing discrepancies. For example, one person who had left the organisation five months prior, but employment had not been terminated, one person who had reduced their contracted hours, and a number of staff coded to the wrong wards. The majority of these findings related to the RTE ward, but we identified some mis-codings in relation to the PoW ward that we tested. These findings suggest that detailed reviews of 'staff in post' reports are not routinely taking place. **(Matter Arising 13)**

2.46 We reviewed a sample of ten savings schemes identified by both Bridgend and RTE CSG. Through meetings with the CSG managers, the finance business partner and documentation provided, we could evidence the reported savings and RAG status at that time. Though our workforce testing, we also saw evidence of additional controls being put in place linked to the savings targets. For example, to help

achieve the saving target linked to Health Care Support Worker (HCSW) spend, if wards need to roster above their agreed establishment for acuity reasons, or needs to use bank or agency workers, prior approval from the Care Group Director of Nursing is required.

Conclusion:

2.47 Our testing has established that there are good arrangements in place for both financial and non-financial performance monitoring within the Mental Health aspect of the Care Group. However, some improvements are needed to ensure localised monitoring takes place at ward and department levels to prevent errors in establishments not being detected. We have provided Reasonable Assurance for this area.

Appendix A: Management Action Plan

Governance Arrangements

Matter Arising 1: Terms of reference and structure for committees and groups (Design)	**Potential Impact**
At time of our audit, the Care Group was restructuring as part of the Health Board's revision of its operating model. We saw evidence that some work had commenced to map out the groups, committees and boards within the Care Group and its CSGs and their inter-relationship with each other. However, this work was ongoing. In relation to the key groups within the Care Group and CSGs, we identified: • No terms of reference in relation to the Care Group Integrated Performance Meeting, the CSG Integrated Performance Meetings, or the Senior Management Team / Core Leadership Team meetings within CSGs. • The terms of reference for the Planning, Performance and Finance Group were to be reviewed annually, but was in draft and dated September 2022. Without a complete committee structure diagram and terms of reference all key groups means that oversight and governance arrangements are not clear.	The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.

Recommendations		**Priority**
1.1a	The mapping exercise that identifies all of the Mental Health committees and groups that currently exist within the Care Group should be completed. The remits, attendees, and frequency of all meetings should be considered along with the relationship and flow of information between the groups, to identify if there is any overlap or gaps in the current governance arrangements.	**Medium**
1.1b	Up to date terms of reference for each committee and group should be in place and include information such as purpose and remit of the group, frequency of meetings, attendees and quoracy arrangements.	

Agreed Management Action		Target Date	Responsible Officer
1.1a	Under the new Care Group structure, meetings have been mapped and restructured to enable alignment between the meetings, to ensure flow of information and that there are no gaps in the current governance arrangements.	Complete	Service Director
1.1b	The Terms of Reference for the current established Care Group meetings have been drafted and will be reviewed and amended where required to reflect the audit findings, these will be taken to the relevant meetings for sign off. The Terms of Reference will be saved in the Care Group Teams channel and reviewed annually.	August 2024	Directorate Manager for BISC
	Directorate meeting TORs and Organograms are in place in each of the Directorates. These have been part of the initial development of the new operational structures.	Complete	Directorate Managers

Matter Arising 2: Conduct of committees and groups (Operation)	**Potential Impact**
Through our review of agendas, minutes and action logs of the key groups we identified: • QSR&E –2/3 meetings that we reviewed did not appear to be quorate as there was not a representative from each CSG. • Care Group IPM and CSG IPMs – the lack of terms of reference meant we could not determine if the meetings were covering all of the group's responsibilities. Furthermore, we were unable to establish who should attend and if there is a quoracy requirement. The meeting documentation was in a slide deck format, with no minutes or action logs. As such confirming who is in attendance and that all actions a captured and followed up at future meetings, was not possible. • Lack of documentation in relation to the RTE finance meetings held between the CSG and finance business partner.	The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.

	Recommendations	**Priority**
2.1	Consideration should be given to the format of capturing meeting information. Whilst slide decks are a useful platform for presenting information, an appropriate mechanism to capture attendees, key points discussed, decisions made and actions to take forward should be in place.	**Medium**
2.2	Where the terms of reference for a group set out quoracy arrangements, then these should be adhered to. If the lack of key attendees means the meeting is not quorate, a decision should be made as to whether the meeting should take place.	**Low**
2.3	Documentation in relation to the meetings held between the CSG and finance should be retained.	

	Agreed Management Action	**Target Date**	**Responsible Officer**
2.1	The Integrated Performance Meetings Terms of Reference will be updated to ensure that key actions and decisions are documented and included for future meetings.	August 2024	Directorate Manager for BISC

2.2	The audit findings from this review have been shared with the chairs of the relevant meetings and they are responsible for checking the meeting is quorate prior to meetings starting.	Completed	Meeting Chairs
2.3	Directorate & Finance Meetings are in place throughout the directorate. The meeting matrix is found in the meeting Governance reporting SOP for Adult Directorate. Meetings are not routinely documented in Directorates however formal finance meetings are held and documented at Care Group level on a monthly basis.	Completed	Directorate Manager & Finance Business Partner

Matter Arising 3: Declarations of interest (Operation)			**Potential Impact**
On an annual basis the Corporate Governance team contact relevant staff as set out in the Standards of Behaviour policy and request a Declaration of Interest or nil return to be completed. We identified 88 members of staff within Mental Health who should have completed a return, however, we were only able to confirm returns for 6 staff.			Personal interests are not considered meaning inappropriate decisions could be made.
Recommendations			**Priority**
3.1a	Relevant staff within Mental Health should be reminded of the importance of the Standards of Behaviour policy and the requirement to comply with it and complete an annual declaration of interest return. Where individuals fail to make a return, managers should continue to prompt staff to do so including through the PDR process.		**Medium**
3.1b	Management should liaise with the Corporate Governance team to identify any gaps in the declaration of interest records for their staff.		
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	An email has been sent to remind colleagues of the need to complete an annual declaration of interest. This will be reviewed through the Quarterly Directorate Integrated Performance Meeting.	Completed	Service Director
3.1b	Management and Corporate Governance have liaised regarding the existing Declaration of Interest gaps and will maintain this approach on a quarterly basis after the Integrated Performance Meetings.	Completed	Service Director

Risk Management

Matter Arising 4: Risk information recorded in Datix (Operation)	**Potential Impact**
At the time of our fieldwork there were 49 mental health care group risks on Datix, of which 22 related to the Adult Mental Health CSGs in Bridgend and RTE. Of these 22 risks, 3/9 for Bridgend and 4/13 for RTE did not have narrative to explain how the risk had been reviewed at their last review date. We also note that for 3/13 RTE risks, the dates for next review did not follow the risk management policy for risks of that category. For example, moderate risks should be reviewed quarterly, but were scheduled to be reviewed after six-months.	Risks materialise as they have not been monitored and action taken not taken to address them or escalate where necessary.

	Recommendations	**Priority**
4.1a	When risks are reviewed within Datix, the narrative in the 'controls in place' or notes section should be updated for changes since the previous review.	**Medium**
4.1b	The future review dates for risks should align to the timeframes set out in the Risk Management Policy.	

	Agreed Management Action	**Target Date**	**Responsible Officer**
4.1a	Under the new care group structure, risks will be aligned to the new Directorate and relevant managers. The findings from this audit have been shared with Directorate Leads and risk managers have been reminded to use the narrative in the controls in place and note sections to update once a review has taken place.	June 2024	Head of Nursing
4.1b	Risks will be monitored through the QRSE structure of the Directorate and risk managers have been reminded of the frequency of reviews in line with the scoring of the risk.	June 2024	Head of Nursing

Matter Arising 5: Risk monitoring (Operation)	**Potential Impact**
The terms of reference for the QSR&E group and PP&F Board both contain information in relation to monitoring risks. The QRS&E terms of reference state that risks scoring 12 and above will be monitored. The PP&F terms of reference are broader and refer to having reviews of core risks on the agenda of each meeting. Whilst we could see regular reports on core risks to the PP&F Board, and general updates on risks at QRS&E, via highlight reports from CSGs, there was no evidence of monitoring of all of the Care Group's higher scoring risks at these forums. At a local level, risks were monitored during the CSG IPM groups. For both RTE and Bridgend, the top five risks for the CSG were discussed. However, as more than five risks had the same score should have been monitored it is unclear where the remaining risks were reviewed. We understand that the local QSR&E groups also monitor risk by exception and provide highlight reports to the Care Group QSR&E group, we did not see evidence of the papers for the local QSR&E meetings to confirm this.	Risks materialise as they have not been monitored and action not taken to address them or escalate where necessary.

Recommendations		**Priority**
5.1	There should be greater clarity in the responsibilities of the Care Group PP&F Board and QRSE Group in relation to monitoring risks. It should be ensured that one of these forums has oversight of all higher scoring Care Group risks on a regular basis.	**Medium**
5.2	Where CSG IPMs have more than five risks with same high score, consideration should be given to reviewing all during the meetings or reviewing all across alternate meetings.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	All risks are now monitored and managed through the Care Group QRSE governance. Any risks approved which score 15 or higher are then escalated to the Operational Management Board for consideration and adding to the Organisational Risk Register where approved.	June 2024	Nurse Director

5.2	Terms of Reference for IPM will be updated to enable Directorates to raise more than five risks if they have the same high score to ensure these are reviewed and considered by the Care Group.	August 2024	Directorate Manager for BISC

Workforce

Matter Arising 6: Absence management (Operation)		**Potential Impact**
To ensure compliance with the All Wales Managing Attendance at work policy, we looked at sample of absences across two wards from Adult Mental Health CSGs, based on their levels of sickness. We tested 13 episodes of sickness relating to nine employees: • Self-certification documents: In 2/13 cases there was no self-certificate on file, for 1/11, dates did not agree to the Health Roster system and for 2/11, the employee had not signed the form. • Return to work documents: 2/13 were not signed by the employee. • Medical certificates: 2/13 episodes were not fully covered by medical certificates. Both were for the same person but were for different periods of absence. Across the two periods, there was a total of 49 not covered by the medical certificate. • Absence prompts: 4/13 of the absence periods resulted in the employee triggering an absence prompt. However, we did not see evidence of action in line with the policy. such as issuing informal warnings. Whilst we acknowledge managers can apply their discretion to not apply a warning, such decisions and the reason was not recorded. • Long-term sickness: We identified two episodes of long-term sickness. For one case there was no evidence of regular contact with the employees during their absence, as required by the policy.		Sickness is not properly recorded resulting in incorrect pay. Sickness is not properly managed resulting in additional costs as shifts have to be covered by agency or bank staff. Sickness is not well managed so effecting staff wellbeing.
Recommendations		**Priority**
6.1	For absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed. All periods of absence should be fully covered by self-certification forms or medical certificates.	**Medium**

6.2	Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	**Medium**
6.3	Long-term absence should be managed in line with the policy in order to prevent absences being longer than necessary	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
6.1	An email to be sent to all managers as a reminder that comprehensive and accurate documentation is a requirement when managing sickness and absence.	Complete	Directorate Manager
	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	July 2024	Lead Nurse
	Sickness and absence will be a core component of supervision discussion and template.	Complete	Lead Nurse
	Return To Work interviews will be held on day of return to work, if this is not possible as soon as is possible following staffs return as per CTM Policy.	Complete	Directorate Manager
	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate Integrated Performance Meeting Quarterly.	August 2024	Lead Nurse
6.2	All decisions to exercise discretion will be discussed and duly documented in staff personal file. This will be agreed by the Senior Nurse for compliance.	Completed	Lead Nurse
	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	July 2024	Directorate Manager
	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting Quarterly.	August 2024	Lead Nurse

6.3	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	July 2024	Directorate Manager
	Sickness and absence metrics will be discussed and is agenda on the monthly Ward Managers meetings.	Completed	Lead Nurse
	Following any Long Term Sickness absence discussion the Ward Manager or Deputy Ward Manager must refer the staff member to the 'Return to Work Sickness Programme' to provide extra support for staff as directed by the Head Of Nursing. All Long Term Sickness absence will be escalated and managed by the senior nurse following 3 months of absence.	Completed	Lead Nurse
	A sample audit of 5 staff files for sickness absence documentation will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting.	August 2024	Lead Nurse

Matter Arising 7: Annual Leave (Operation)	**Potential Impact**
We reviewed the process for managing annual leave within two wards. Both areas use the Health Roster system so annual leave is not requested via ESR. Regular feeds between Health Roster and ESR ensure that ESR is updated with annual leave data. The ward managers manually calculate staff annual leave entitlement and do not refer to ESR. The calculated hours are input into Health Roster and used to monitor leave balances. We reviewed the leave entitlement for staff that had been recorded in Health Roster and compared this to ESR information. We identified a number of differences, including differences in the names of staff listed as working on the wards. We report the discrepancies in relation to staff in post in Matter Arising 13. For current staff on the wards, we note: <u>PoW - PICU</u> • 6/17 staff had more annual leave entitlement on Health Roster than shown on ESR. This varied between 3 and 50 hours. • 6/17 staff had less annual leave entitlement on Health Roster than shown on ESR. This varied between less than one hour and 30 hours. Our testing in relation to rosters identified two occasions where staff had booked annual leave yet worked bank shifts for the ward whilst on leave. In one case an individual worked on 11 of their 14 days annual leave, the other worked on 4 of their 7 annual leave days. <u>RGH - Ward 21</u> • 3/14 staff had more annual leave entitlement on Health Roster than shown on ESR. This varied between less than one hour and 81 hours. • 11/14 staff had less annual leave entitlement on Health Roster than shown on ESR. This varied between less than one hour and 66 hours. Whilst both wards have determined how many staff are able to take annual leave at the same time, in ward 21, over school half term week numbers were exceeded. A maximum of three staff per day should be allowed leave, but five or six had leave approved. We note that for two of those days, shifts were unfilled, leaving the ward without the required number of staff and skills mix.	Inaccurate records exist resulting in staff taking too much or not enough leave in a year. Services are not effectively planned. Staff wellbeing is effected if staff do not have breaks from work.

Recommendations		Priority
7.1	The annual leave entitlements calculated by managers should be reconciled to the entitlements calculated by the ESR system with any discrepancies investigated. Should ESR calculations be confirmed as accurate, these should be used going forward.	**High**
7.2	Management should be mindful of staff wellbeing when allowing staff to work numerous bank shifts whilst on annual leave.	**Low**
7.3	Management should ensure that the principals they have established relating to the number of staff that can take leave at the same time are followed.	**High**

Agreed Management Action		Target Date	Responsible Officer
7.1	The Ward Managers will cross reference the annual leave entitlement for staff on the ESR and Health Roster systems to ensure accuracy.	Completed	Directorate Manager
7.2	The health roster system limits staff to working 60hrs a week. The ward manager will monitor additional bank shifts on the ward and will check wellbeing of staff when booking additional hours.	Completed	Lead Nurse
7.3	A protocol for the booking and allocating of annual leave will be agreed across all teams in the Adult Unscheduled Care Directorate.	Completed	Directorate Manager
	The agreed protocol will be shared with all staff via email and discussed in ward team meeting.	Completed	Directorate Manager
	Any leave requested following the publication of the health roster will be discussed and agreed by the Ward Manager and considered by the Senior Nurse so consideration can be given to both annual leave capacity and any financial impact.	Completed	Lead Nurse

	Monthly Health Roster monitoring meetings will be arranged for Ward Managers/Senior Nurses.	Completed	Lead Nurse

Matter Arising 8: PDR compliance (Operation)	**Potential Impact**
The April 2024 PDR compliance report shows that 72% of staff within the Mental Health & Learning Disabilities Care Group had a PDR that had been completed within the last year. The WG target for PDR compliance is 85%. Our analysis identified: <u>PoW - PICU</u> • 6/23 (26%) of employees had no PDR in the last year. Of those 4/6 had no PDR date information captured in ESR, two of which we understand were new starters. The remaining two had PDRs that were over a year ago, with one being dated 2021. • Four staff who have increment dates in 2024, either did not have a PDR in the last year or did not have a planned date. <u>RGH - Ward 21</u> We understand that ESR is not updated with key PDR date information. We also note that PDR compliance rates had not been input on the monthly monitoring returns for the Head of Nursing. The information that is contained within ESR shows: • 14/16 (88%) of employees had no evidence of a PDR being carried out in the last year. Of those 3/14 had no PDR date information captured in ESR. Of the remaining 11, four had PDR dates of between 2019 and 2021 recorded, whilst the other seven had future dates recorded. We are unclear why this would be. • 10 staff, who have increment dates in 2024, either did not have a PDR in the last year, or did not have a planned date. It is our understanding that the automatic progression through increment points is ceasing, and progression will not happen if ESR is not showing that a PDR has been completed within the last year.	Staff performance is not effectively assessed and addressed. Issues around staff wellbeing are not discussed.

Recommendations		**Priority**
8	In line with Welsh Government and Health Board targets, all staff should participate in a PDR on an annual basis. The dates when PDRs are carried out should be recorded in ESR to allow accurate reporting of compliance rates and to ensure relevant information is available for those staff in pay increment years.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
8	Ward managers will update the ESR system with any completed PDRs.	Completed	Directorate Manager
	A base line audit of PDR compliance will be undertaken for all teams.	June 2024	Directorate Manager
	PDR's compliance will be discussed as part of planned supervision with the Senior Nurse	June 2024	Lead Nurse
	PDR compliance will be reported into the Directorate Integrated Performance meeting with clear counter measure plan in situ as required.	August 2024	Directorate Manager

Matter Arising 9: Undertaking mandatory training (Operation)	**Potential Impact**
Welsh Government has identified ten core training modules that NHS staff must complete. Organisations have been set an 85% compliance target. In April 2024, the Mental Health & Learning Disabilities Care Group had an overall compliance rate of 75% against the 10 core modules. For certain roles, additional levels of training is required against some of the core modules. For example, Infection, Prevention and Control has four levels of training. Our analysis of the two wards identified that staff have between 14 and 16 core training modules to complete. Within PoW PICU, the overall compliance rate was 65%. 5/23 staff had completed 50% or less of their required training modules, with one member of staff completing none. Within RGH Ward 21 the overall compliance rate was 74% and 2/16 staff were below 50% compliant. We are aware of some difficulties experienced by both wards in accessing in-person training. In addition, each of the two wards have difficulties accessing on-line training as each ward only has one computer, which is used during the day.	Staff performance is not effectively assessed and addressed.

Recommendations		**Priority**
9	It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
9	Mandatory training compliance is currently being recorded on and reported from the 'training matrix' as an interim measure due to inaccuracies of the ESR system. All staff will be reminded of their responsibility to complete the core skills mandatory training	Completed Completed	Lead Nurse Lead Nurse

	A base line audit of compliance will be undertaken by Ward Managers and reported to the senior nurse with a trajectory plan in place to achieve and achieve 85% by 30.08.24.	June 2024	Lead Nurse
	The Ward Manager will ensure that time is protected for staff to complete training modules.	August 2024	Directorate Manager & Lead Nurse
	A laptop will be made available which can be booked for the purpose of completing e-learning modules.	August 2024	Directorate Manager
	Mandatory training compliance will be reviewed and discussed as part of monthly Ward Manager supervision with the Senior Nurse.	June 2024	Lead Nurse
	Mandatory training compliance will be reported into the Directorate Integrated Performance meeting.	Completed	Lead Nurse
	Senior Nurses will review the ESR system and ensure that the correct core skills are allocated to each staff group.	July 2024	Lead Nurse

Matter Arising 10: Rosters (Operation)	**Potential Impact**
We compared the paper copies of the roster that are used to capture daily changes, to the finalised approved rosters in the Health Roster system for both ward for a four week period. Our testing identified a number of minor errors: • Overtime shifts recorded in Health Roster that were not showing on the paper rosters. • Variations between the length overtime hours shown in Health Roster than the paper roster. • Staff marked as 'sick' on the worked roster not reflected in Health Roster. • Staff swapping shifts on the paper roster, but Health Roster not being updated with this. • Variations between annual leave captured in the paper roster and what was recorded in Health Roster. Whilst the variations were all minor, some have the potential to impact pay and sickness records and mean that Health Roster is not giving a true reflection of which staff worked and for how long each day.	Inaccurate information is captured resulting in discrepancies in pay, and other records.

Recommendations		**Priority**
10.1	Care should be taken to ensure data is accurately transferred from the worked roster to the Health Roster system on a weekly basis.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
10.1	Email to be sent to remind Ward Managers that the Health Roster system is our 'live' system and that any changes to the paper roster need to be updated onto the system immediately when agreed.	Completed	Directorate Manager
	Senior Nurses check the Health Roster each Monday to ensure the previous weeks shifts are accurate and finalised for processing. Any discrepancies noticed are discussed with the Ward Manager as part of the process.	Completed	Lead Nurse

	Any additional annual leave requests following the publication of the Health Roster will be discussed and approved by Ward Manager for consideration of both annual leave capacity and financial impact.	Completed	Lead Nurse
	Health Roster Management is discussed as part of monthly Ward Manager supervision	June 2024	Lead Nurse
	A spot check audit of 2 separate weeks of Health Roster will be undertaken by the Senior Nurse which will compare paper roster and the Health Roster system for accuracy. This will be reported at the Directorate QSRE meeting	August 2024	Lead Nurse

Matter Arising 11: Job Planning (Operation)	**Potential Impact**
We obtained a report from the Allocate system and identified 16 members of staff across the two CSGs that we sampled who have job planning requirements. The report showed six plans had been agreed within the last year, a further six that were out of date, with the remainder 'in discussion'. Two of the four reported as 'in discussion' had been at this stage for over a year. We understand recent changes to the Allocate system have resulted issues in accessing Allocate. We also note a small number of staff on the Allocate report did not appear on the 'Staff in Post' reports. As such, the Allocate system may need to be updated.	Disputes may arise between the Health Board and Consultants where signed contracts are not in place. Splits between clinical sessions and personal development sessions are not in line with WG guidance, leaving the Health Board with a deficit in capacity.

Recommendations		**Priority**
11.1	Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.	**High**
11.2	CSG managers should continue to liaise with the Allocate team to ensure they have the correct access to the system and that staff are correctly set up within the system.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
11.1	All substantive inpatient consultant psychiatrists have had their job-planning meeting and all plans have been mutually agreed. The plans are in the process of being inputted to the Allocate system for formal sign off.	June 2024	Directorate Manager & Clinical Director
	A tracker to manage annual job plans will be in place and compliance will be monitored by the monthly Medical Workforce meetings.	Completed	Directorate Manager & Clinical Director
11.2	A monthly meeting is in place to monitor compliance with Medical Workforce job plans.	Completed	Directorate Manager

	A monthly Medical Workforce productivity group is held to report on medical workforce and includes job planning, performance and compliance.	Completed	Directorate Manager

Planning & Performance

Matter Arising 12: Consistency in workforce monitoring arrangements (Operation)	**Potential Impact**
We identified that reporting of non-financial performance, including workforce metrics, takes place at various groups and committees within the Care Group. We noted that Bridgend CSG has a group that meets bi-monthly and are dedicated to reviewing workforce metrics and other workforce matters. We are unaware of a similar meeting taking place in RTE CSG.	Corrective action is not taken if management are not provided with accurate and consistent performance information.

	Recommendations	**Priority**
12	Consideration should be given to replicating workforce meetings in all CSGs to have a dedicated forum for discussing matters specific to that CSG.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
12	A directorate Performance, Planning & People meeting is held monthly to discuss all metrics.	Completed	Directorate Manager
	A SOP outlining the governance meeting structure across adult mental health is in place.	Completed	Directorate Manager

Matter Arising 13: Budget monitoring (Operation)	**Potential Impact**
As part of our testing of annual leave arrangements we identified a number of discrepancies in relation to the staff names captured in ESR and Health Roster as working on the two wards. We used an Oracle 'Staff in Post' (SIP) document to reconcile the data. We found: • One person who finished with the Health Board in August 2023, but remained on the January 2024 SIP report and was still being paid. A termination form had not been submitted for this individual. This was rectified at the time of our fieldwork. • One person who reduced from full time hours to 0.8 FTE, but this had not been actioned. • 13 staff were either listed on the SIP as working on the wards, but did not appear on Health Roster, or vice versa. In the first two cases, overpayments will have occurred and in the second case annual leave entitlement will have been overstated in ESR. All will have an impact on the ward budget positions, however these discrepancies had not been identified during budget monitoring meetings.	Financial expenditure unnecessarily incurred.

Recommendations		**Priority**
13.1	As part of the budget monitoring process, on a periodic basis, Ward Managers should be provided with 'Staff in Post' lists for reviewing and confirming accuracy.	**Medium**
13.2	All managers should be reminded of the importance of actioning termination forms and change forms promptly to prevent overpayments to staff and impact on budgets.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
13.1	Staff in post for each area will be discussed and reviewed as part of monthly Ward Manager supervision with the Senior Nurse. Completion of relevant documentation i.e. termination forms will be included in these discussions.	June 2024	Directorate Manager

	Staff in post is reviewed at a monthly finance meeting by the Senior Nurse and finance officer. Staff changes will be reported and documented as part of this process. Ward Managers will be invited to attend the monthly finance meeting.	June 2024 June 2024	Directorate Manager & Lead Nurse Lead Nurse
13.2	An email has been sent to all mangers as a reminder that staff change documentation needs to be completed promptly. The Senior Nurse will cross reference all termination forms at the 'staff in post' monthly meetings.	Completed June 2024	Directorate Manager Lead Nurse

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.

Appendix C – Detailed Scope and Objectives

Governance arrangements

- Appropriate governance structures are in place with clear reporting lines that support the key operational functions of finance, workforce, planning and performance, and quality and patient safety.
- The committees and groups within the governance structure are operating effectively with support from business partners.
- Declarations of interest (or nil returns) are submitted for all relevant staff and management aware of the declarations made.

Risk management

- The CSG has applied the Health Board's risk management strategy, ensuring risks are appropriately identified, assessed, and recorded, with risk owners identified for each risk and mitigation plans in place where appropriate.
- Risk is monitored and reported on within key groups in the CSG, with escalation and de-escalation as appropriate.

Workforce management

- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Managing Attendance at Work policy.
- Annual leave is appropriately planned, requested, recorded, and authorised.
- Flexi time and Time off in Lieu (TOIL) is appropriately monitored and managed in accordance with local procedures and processes.
- The PDR (Personal Development Review) process is actively monitored and managed.
- Mandatory training compliance is actively monitored and managed.
- Staff rosters are planned and approved in line with agreed templates to ensure optimum workforce deployment and minimum use of overtime or agency staff to achieve safe staffing levels.
- Consultant job plans are reviewed and agreed annually and monitored to ensure that clinical activity is delivered in line with the agreed job plans.

Planning and performance

- The CSG has appropriate arrangements in place to ensure that its annual plan is developed with engagement from budget holders and other relevant staff and is in accordance with the Health Board's corporate planning framework,
- Workforce planning arrangements exist to establish and plan for known future changes to the CSG. For example, key staff due to retire within three years.

- Budget holders have agreed efficiency plans in place and monitor performance against the targets. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
- The CSG has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes such as workforce and quality. These are formally reviewed and reported on a regular basis. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
- Demand and capacity plans are extensively used as business planning tools for managing the CSG and are monitored and reported on to ensure they remain fit for purpose.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

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

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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.

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Contents

About this document

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

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work and	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2023-24 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2023-24 Annual Report and Accounts.	We started our audit planning in February 2024.	To be considered by the Audit and Risk Committee on 10 July 2024 and by the Board on 11 July 2024. The Auditor General is scheduled to certify the audited Annual Report and Accounts on 12 July 2024.

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Review of Unscheduled Care	Chief Operating Officer	This work examines different aspects of the unscheduled care system and includes analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work includes an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1).	Part 1 – Regional report drafting Part 2 – Fieldwork Underway	August 2024 To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		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).		
Primary Care Services - Follow-up Review (Local Work 2023)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made several recommendations to the Health Board. This work follows-up progress against these recommendations.	Report Drafting	August 2024
Structured Assessment 2023 – Deep Dive – Cost Savings	Executive Director of Finance	This work examines the approach the Health Board is taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Report Drafting	August 2024
Structured Assessment 2024	Director of Digital	This work will examine digital arrangements, with a particular focus on	Scoping	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
– Deep Dive – Digital		how the Health Board is investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.		
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 focusses 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.	Fieldwork underway	August 2024
Quality Governance Arrangements Joint Review Follow-up - Progress update	Chief Executive	In our joint report published in August 2023, we signalled our intention to ask the Health Board for a written update on its progress in addressing the areas the joint review follow-up team felt that further work was necessary. These areas were set out in the report. We will assess the Health Board's progress jointly with Healthcare Inspectorate Wales with the aim of	Fieldwork underway	August 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		determining whether the outstanding recommendations can be closed.		
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Project Brief issued in May 2024	To be confirmed
Structured Assessment – core	Director of Corporate Services / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, • cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements.	Set-up meeting held in May 2024	December 2024

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		• Corporate financial planning arrangements.		

Other relevant publications

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

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

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

Additional information

7 Audit Wales has not published any corporate documents since the last committee update.

8 There are no relevant Audit Wales consultations currently underway.

Archwilio Cymru
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

Cwm Taf Morgannwg University Health Board – 2024 Audit Plan

Audit year: 2023-24

Date issued: May 2024

Document reference: 4198A2024

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer, or other employee in their individual capacity, or to any third party.

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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.

About Audit Wales

Our aims and ambitions

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

Contents

Introduction

I have now completed most of my planning work.

This Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2024.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.

Adrian Crompton
Auditor General for Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the UK's Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

My performance audit work is designed to comply with auditing standards set out by the International Organisation of Supreme Audit Institutions (INTOSAI). This is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Your audit at a glance

My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

The current significant financial statement risk include:

- management's override of the controls in place; and
- not meeting the statutory financial duty to break even over the three years to 31 March 2024.

Other areas of audit focus include:

- changes affecting the Losses and Special Payments Register;
- the valuation of the Health Board's estate;
- the accuracy and completeness of the remuneration report disclosures, relating to members and senior officers;
- the remuneration of any senior officers that is above the Welsh Government's approved pay bands;
- the accuracy and completeness of the related party disclosures; and
- the extent of any property containing reinforced autoclaved aerated concrete (RAAC), and any impact on the accuracy and completeness of the accounting.

My performance audit will include:

- Structured Assessment – core
- Structured Assessment – deep dive review of deep dive review of investment in digital systems to support service resilience and transformation.
- All-Wales Thematic Review – managing demand for urgent and emergency care.
- Local work – Review of Eye Care Services.

Materiality

Materiality	£15.5 million
Reporting thresholds:	
Main materiality	£775,000
Related parties	£500
Remuneration report	£50

Financial statements' materiality

Materiality £15.5m

My aim is to identify and correct material misstatements, that is, those that might other cause the user of the accounts into being misled.

Materiality is calculated using:

- the 2023-24 gross expenditure of based on the draft accounts[1] £2.491billion
- materiality percentage of 0.62%

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality, including for the lower materialities below).

Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

- Remuneration report i.e. each person's[2] disclosed remuneration, per the remuneration report categories (except for the pension benefits) - £1,000, or lower if a misstatement results in the wrong remuneration-banding being disclosed for an individual; and
- Related party disclosures, £10,000; and
- Outturn against the revenue and capital resource limits, £1.

[1] This is reviewed throughout the audit and to the final audited accounts.

[2] Senior managers and members.

Significant financial statements' risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks.

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	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 I may add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.
There is a significant risk that the Health Board will fail to meet its first statutory financial duty to break even over a rolling three-year period; against its revenue and capital resource limits. The reported revenue position at month 12 is a year-end surplus of £109,000 for 2023-24, which results in a deficit of some ££24.2 million for the three years to 31 March 2024. The reported capital position at month 12I is a year-end surplus of £34,000 for 2023-24, which would result in a surplus of £119,000 for the three years to 31 March 2024. The current financial pressures increase the risk that management judgements and estimates could be biased in an effort to meet its resource limits and/or	I will: • monitor the Health Board's financial position for 2023-24 and the cumulative three-year position to 31 March 2024. • consider the cumulative impact of any relevant uncorrected misstatements over the three years to 31 March 2024. • undertake cut-off testing around the year-end; and classification testing across revenue and capital expenditure. If the Health Board fails to meet the three-year resource limit for revenue and/or capital, I would expect to qualify my regularity opinion on the 2023-24 financial statements. I would also expect to place a substantive

Significant risk	Our planned response
other key financial targets agreed with the Welsh Government.	report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.

Other areas of focus

I set out other identified risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

Audit risk	Our planned response
From 1 December 2023, the Losses and Special Payments Register (LaSPaR) which is used to calculate the losses and many of the provisions balances in the accounts has been de-commissioned. For the remainder of 2023-24, a model excel spreadsheet will be used to record losses, special payments and to calculate year-end balances. There is a risk that the transactions and balances related to losses and special payments are materially misstated due to: • the data transfer between the LaSPaR system and the excel model not being complete and accurate; and/or • the excel model miscalculating balances, due to spreadsheet/modelling errors and/or incorrect data entry.	I will: • test the completeness and accuracy of data transfer from the LaSPaR system to the excel based spreadsheets. • consider the design and implementation of controls (if any) in place to mitigate error. • review the year-end spreadsheet to ensure that there are no significant errors or issues in the compilation of figures for the accounts; and • review transactions back to supporting evidence (e.g. Quantum reports) on a sample basis.
I audit some of the disclosures in the remuneration report to a far lower level of materiality, as set out on page 9. The disclosures are therefore more prone to material misstatement. In some of my past audits I have identified material misstatements in the remuneration report, which the Health Board corrected. I therefore judge the 2023-24 disclosures to be at risk of misstatement. There is also the regularity risk that the Health Board remunerates a senior officer(s) above the Welsh Government's approved pay bands, but without the Welsh Government's formal approval for any salaries that exceed its bandings.	I will examine all entries in the remuneration report to verify that they are materially accurate, and that remuneration is at the appropriately Welsh Government approved levels.

I also audit the disclosure of related party transactions and balances to a far lower level of materiality. In some of my past audits I have identified omitted or incorrect disclosures, which the Health Board corrected. I therefore judge the 2023-2024 disclosures to be at risk of misstatement.	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.
Valuation of land and buildings The value of land and buildings reflected in the balance sheet and notes to the accounts are material estimates. Land and buildings are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity depending on the specialist and management assumptions adopted and changes in these can result in material changes to valuations. Assets are required to be revalued every five years (last done for 2022-23), but values may also change year on year and there is a risk that the carrying value of assets reflected in the accounts could be materially different to the current value of assets as at 31 March 2024, particularly in the current economic environment.	My audit examinations will include: • review the information provided to the valuer to assess for completeness. • evaluate the competence, capabilities, and objectivity of the professional valuer. • test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are reasonable, and the revaluations have been correctly reflected in the financial statements; and • test the reconciliation between the financial ledger and the asset register.
Reinforced Autoclaved Aerated Concrete (RAAC) is a material used in construction in many buildings between the 1960s and 1990s. Its presence has been confirmed in a range of public sector properties across the United Kingdom, including hospitals. Its existence can affect the value of properties, remedial costs and/or future remedial liabilities, and the potential cessation of use.	I will be reviewing the actions taken by the Health Board to establish whether any of its properties contain RAAC; and if they do the extent of professional examinations and reporting of affected properties. As part of this work, I will also consider the governance and reporting within the Health Board on this issue. My review is mainly aimed at: • establishing that the valuation of property assets is materially correct; and • that any material costs, whether incurred, or are liabilities at 31

	March 2024, have been captured and accounted for correctly.

Financial statements' audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2024 Detailed Audit Plan	March to April	May 2024
Audit of financial statements work:		
Audit of Financial Statements Report	May to mid-July 2024	Mid-July 2024
Opinion on the Financial Statements	May to mid-July 2024	Certification is scheduled for 12 July 2024
Audit of Financial Statements Addendum Report	August 2024	September 2024

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Area of work	Scope of the work	Planned timescales
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My core 2024 structured assessment work will review the following areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2024 with reporting by the end of October 2024.
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. This work was deferred from	Fieldwork to commence during the spring of 2024 and reporting by the end of March 2025.

Area of work	Scope of the work	Planned timescales
	2023, following my decision to replace the work with a review of the Health Board's approach to financial efficiencies.	
All Wales thematic review of urgent and emergency care – managing demand for urgent and emergency care	In my 2020 audit plan for the Health Board, I set out my intention to undertake work to examine arrangements to manage demand for urgent and emergency care services, as part of my wider work focused on these services. Due to the COVID-19 pandemic, I deferred this work to allow NHS bodies to respond to the pandemic, with a plan to bring the work back online once the impact of the pandemic had subsided and my work on patient flow out of hospital was completed. I am now able to take forward my work on managing demand for urgent and emergency care. The work will be undertaken during 2024 and will be funded from this year's audit fee. Consequently, I have decided to refund the Health Board the fee paid for this work as part of my 2020 audit plan. My 2024 urgent and emergency care work will focus on: • The robustness of plans to manage the demand on urgent and emergency care services; • The effectiveness of arrangements to encourage and enable people to access the right care, in the right place, at the first time; and • The effectiveness of arrangements to monitor the performance of urgent and emergency care services and apply lessons learnt to improve the services further.	Fieldwork commenced in February 2024 and reporting by the end of September 2024.

Area of work	Scope of the work	Planned timescales
Local project work – Review of Eye Care Services and	My audit team will also undertake performance audit work that reflects issues specific to the Health Board. Following on from my report on orthopaedic services review last year, my team will review the Health Board's speciality with the second highest level of elective waits – ophthalmology – as part of a wider review of eye care services that will also consider community-based eye care services. As part of this work, my team will also seek an update from the Health Board on its progress in addressing previous audit recommendations arising from my work on follow up outpatient appointments, particularly in the context of ophthalmology patients My team will share further details of the focus of this review once we have completed our scoping work.	Fieldwork expected to commence in October 2024 and reporting by April 2025

Fee and audit team

In January 2024 we published our Fee Scheme for the 2024-25 year as approved by the Senedd Finance Committee. My fee rates for 2024-25 have increased by an average of 6.4% as a result of unavoidable inflationary pressures and the ongoing need to invest in audit quality.

I estimate your total audit fee will be £487,236, being a 4.2% increase on last year's fee.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Executive Director of Finance or Director of Corporate Governance / Board Secretary.

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee

Audit area	Proposed fee for 2024 (£)[3]	Actual fee for 2023 (£)
Audit of Financial Statements[4]	298,246	280,376
Performance audit work:		
Structured Assessment	101,881	84,606
All-Wales thematic review	44,241	45,632
Local projects	42,794	56,704
Performance work total	**188,916**	**186,942**
Total fee	**487,162**	**467,318**

[3] The fees shown in this document are exclusive of VAT, which is not charged to you.

[4] There will be a separate audit plan and fee estimate for the audit of the 2023-24 charity account.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact details
Dave Thomas	Audit Director (Performance Audit) & Engagement Director	dave.thomas@audit.wales
Anthony Veale	Audit Director (Financial Audit)	anthony.veale@audit.wales
Mark Jones	Audit Manager (Financial Audit)	mark.jones@audit.wales
Darren Griffiths	Audit Manager (Performance Audit)	darren.griffths@audit.wales
Steve Stark	Audit Lead (Financial Audit)	steve.stark@audit.wales
Nathan Couch	Audit Lead (Performance Audit)	nathan.couch@audit.wales
Jon Martin	Senior Auditor	jon.martin@audit.wales

I can confirm that my team members are all independent of the Health Board and your officers.

Staff secondment

Zain Ali, one of our apprentice auditors, was seconded to the Health Board between 6 September 2022 and 3 March 2023. To safeguard against any potential threats to auditor independence and objectivity, the following restrictions apply in line with the FRC's Revised Ethical Standard 2019:

- the secondee did undertake any line management or management responsibilities; and
- the secondment was restricted to a set maximum of six months.

While the secondment period does not directly relate to 2023-24, I can confirm that Zain is not assigned to the 2023-24 audit.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2023.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

Supporting you

Audit Wales has developed a range of resources to support the scrutiny of Welsh public bodies and to support those bodies in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

	our **Good Practice** work where we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.
	our **newsletter** which provides you with regular updates on our public service audit work, good practice, and events.
	our **publications** which cover our audit work completed at public bodies.
	information on our **forward performance audit work programme 2023-2026** which is shaped by stakeholder engagement activity and our picture of public services analysis.
	various **data tools** and **infographics** to help you better understand public spending trends including a range of other insights into the scrutiny of public service delivery.

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Audit Wales

1 Capital Quarter

Tyndall Street

Cardiff CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

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E-mail: info@audit.wales

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