

Audit, Risk & Assurance Committee

Thu 13 February 2025, 10:30 - 12:30

Virtual Via Teams



Agenda

10:30 - 10:35
5 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Patsy Roseblade, Chair

1.2. Apologies for Absence

Information Patsy Roseblade, Chair

1.3. Declarations of Interest

Information Patsy Roseblade, Chair

10:35 - 10:40
5 min

2. CONSENT AGENDA BUSINESS

The Committee Chair will ask if there any items from the Consent Agenda (Item 6)that Committee Members wish to bring forward to the Main Agenda for discussion.

10:40 - 10:45
5 min

3. MAIN AGENDA

3.1. Action Log

Discussion Patsy Roseblade, Chair

3.1 Action Log ARAC 13 February 2025 v1.pdf (2 pages)

3.2. Matters Arising not Captured on the Action Log

Discussion Patsy Roseblade, Chair

10:45 - 11:20
35 min

4. SUSTAINING OUR FUTURE

4.1. Local Counter Fraud Report

Discussion Matthew Evans, Local Counter Fraud Officer

4.1 Local Counter Fraud Update ARAC 13 February 2025.pdf (3 pages)

4.1a Local Counter Fraud Update Report Feb 25.pdf (3 pages)

4.1b Appendix - Counter Fraud Investigations Update.pdf (15 pages)

4.2. Losses and Special Payments Report

Discussion Sally May, Executive Director of Finance

Please note that the Appendices to this report are in Admin Control in the 13.02.2025 folder under Supporting Documents

 4.2 Losses & Special Payments ARAC 13 February 2025.pdf (9 pages)

4.3. Procurements and Scheme of Delegation Report

Discussion Sally May, Executive Director of Finance

 4.3 Procurement and SoD ARAC 13 Feb 2025.pdf (10 pages)

11:20 - 12:15
55 min

5. IMPROVING CARE

5.1. Organisational Risk Register

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

 5.1a Org RR Cover Report - Jan 25 - ARAC.pdf (6 pages)

 5.1.b Org RR ARAC 13 February 2025.pdf (6 pages)

5.2. Audit Recommendations Tracker

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

 5.2a Audit Recommendation Tracker.pdf (9 pages)

 5.2b Appendix 1 - Audit Recommendations Tracker_ARAC 13.02.2025 v2.pdf (19 pages)

 5.2c Appendix 2 - HIW Tracker to QSEC Jan 25.pdf (8 pages)

5.3. Internal Audit Progress Report

Discussion Paul Dalton, Head of Internal Audit

 5.3 IA Progress Report ARAC 13 February 2025.pdf (12 pages)

5.3.1. Internal Audit Report - PCH Supply Chain Partner Management

Discussion Internal Audit

 5.3.1 IA PCH Supply Chain Mmt ARAC 13 Feb 25.pdf (14 pages)

5.3.2. Internal Audit Report - Medical Job Planning

Discussion Internal Audit

 5.3.2 IA Medical Job Planning ARAC 13 February 2025.pdf (9 pages)

5.3.3. Internal Audit Report - Follow up - Service Level Agreements

Discussion Internal Audit

 5.3.3 IA SLA Arrangements ARAC 13 February 25.pdf (13 pages)

5.3.4. Internal Audit Report - Regional Integration Fund

Discussion Internal Audit

 5.3.4 IA RIF Final ARAC 13 February 2025.pdf (8 pages)

5.3.5. Internal Audit Report - Vaccination Policy Implementation

Discussion Internal Audit

 5.3.5 Vaccination Policy Implementation ARAC 13 Feb 25.pdf (9 pages)

5.4. Audit Wales - Audit, Risk & Assurance Committee Update

Discussion Mark Jones, Audit Wales

 5.4 AW Audit Update ARAC 13 February 25.pdf (12 pages)

5.4.1. Audit Wales Annual Report

Discussion *Mark Jones, Audit Wales*

 5.4.1 CTMUHB 2024 Annual Audit Report.pdf (26 pages)

5.4.2. Audit Wales Report - Structured Assessment

Discussion *Nathan Couch, Audit Wales*

 5.4.2 CTM Structured Assessment ARAC 13 Feb 2025.pdf (38 pages)

 5.4.2a CTM Mmt Response ARAC 13 February 2025.pdf (11 pages)

5.4.3. Audit Wales 2025 Outline Plan

Discussion *Nathan Couch, Audit Wales*

 5.4.3 2025 Outline Audit Plan ARAC 13 Feb 2025.pdf (11 pages)

 5.4.3a CTMUHB 2025 Outline Audit Plan.pdf (11 pages)

12:15 - 12:20 6. CONSENT AGENDA

5 min

6.1. Items for Approval

6.1.1. Unconfirmed Minutes of the Meeting held on 17 December 2024

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

 6.1.1 Unconfirmed Minutes 17.12.24 ARAC 13 Feb 25.pdf (13 pages)

6.1.2. Unconfirmed CLOSED In Committee Minutes of the Meeting held on 17 December 2024

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

 6.1.2 Unconfirmed Minutes IC 17.12.24 ARAC 13 Feb 25.pdf (3 pages)

6.1.3. Annual Report Timetable 2025

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

 6.1.3 Annual Timetable 2025 ARAC 13 Feb 2025.pdf (4 pages)

 6.1.3a Annual Report Timetable Final 16.1.2025.pdf (1 pages)

6.1.4. Annual Cycle of Business 2025

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

 6.1.4 Annual Cycle of Business ARAC 1.pdf (3 pages)

 6.1.4a Annual Cycle of Business ARAC 13 February 2025.pdf (5 pages)

6.2. Items for Noting

6.2.1. Committee Forward Work Plan

Discussion *Patsy Roseblade, Chair*

 6.2.1 Forward Work Plan ARAC 13 Feb 2025.pdf (3 pages)

12:20 - 12:25 7. CLOSE OF BUSINESS

5 min

7.1. Any Other Urgent Business

Discussion *Patsy Roseblade, Chair*

7.2. Committee Highlight Report to Board

Discussion *Patsy Roseblade, Chair*

7.3. How Did We Do In This Meeting?

Discussion *Patsy Roseblade, Chair*

12:25 - 12:25 8. PRIVATE/IN COMMITTEE SESSION

0 min

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

Organisational Risk Register - Business Sensitive Risks

Financial Control Procedure - Medical Variable pay - Summary of Authorised Breaches

12:25 - 12:30 9. DATE AND TIME OF NEXT MEETING

5 min

22nd May 2024 at 10:00 am

Audit Risk & Assurance Committee - Action Log (as at 30.01.25)

the action originated from	reference	Reference Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
Audit & Risk Committee December 2024	5,1	6	Organisational Risk Register	To request an update on Risk 5417 Paediatric Dentistry out of the meeting and provide an update	Director of Corporate Governance/Board Secretary	Chief Operating Officer	feb-25	Propose to close	To address the backlog, a cohort of patients has been identified, with plans to allocate funds from the planned care recovery to commission services from a private provider. Currently, we are exploring the scheduling of adhoc theatre sessions, including on weekends.
Audit & Risk Committee December 2024	5,1	6	Organisational Risk Register	To bring an update to the Committee on the Corporate Governance Risk in respect of sustained effective Policy management	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	feb-25	Propose to close	Project Initiation Document – “Non-Clinical Policy Management Review -- received and signed off by Executive Leadership Group. The scope of the project is to undertake a robust review of Non-Clinical Written Control Documents within the Health Board in order to establish a baseline compliance figure. The review will also include a review of the “Policy on Policies”, development of a new system to support robust policy management and a redesign of the Health Boards policy pages on its internal and external web pages. It is anticipated that this programme of work will commence in January 2025 and conclude at the end of the calendar year (31 December 2025). This timeframe is considered realistic due to the resource limitations afforded to the project which will impact upon the pace of delivery. Project monitoring will be undertaken by the Executive Leadership Group via the Corporate Governance Dashboard updates.
Audit & Risk Committee December 2024	5,2	7	Audit Recommendations Tracker	To include the feedback received for the next iteration of the Tracker	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	feb-25	Open	The actions from the last meeting will be built into the improvement programme for the development of the Audit Tracker
Audit & Risk Committee December 2024	5.3.2	10	IA Review - Additional Medical Pay	To discuss the February 2025 timescales with colleagues from the People Directorate and update the Committee following this	Deputy Medical Director	Executive Medical Director	feb-25	Open	A meeting has been held with the People Services team to discuss timescales where it was agreed they were all considered reasonable. A plan is being developed on how the timescales will be met.

Audit & Risk Closed In Committee October 2024	3,1	3	Action Log	Further re-assurance to be sought from the previous Committee Referral to the People & Culture Committee with regard to the Local Counter Fraud Report - Recruitment of Agency Staff	Director of Corporate Governance/Board Secretary	Executive Director for People	des-24	Propose to close	Outcome of the Committee Referral discussed by the People & Culture Committee at their meeting held on 5th December 2024 was received by the Committee at their meeting held on the 17 December 2024/
Audit & Risk Committee December 2024	4,1	3	Local Counter Fraud Report	To add any key items to flag to the risk section of the report so that members are aware prior to the meeting.	Local Counter Fraud Officer	Director of Finance & procurement	feb-25	Propose to close	Nothing to flag within papers for this meeting. Noted for future drafting.
Audit & Risk Committee December 2024	4,1	3	Local Counter Fraud Report	To bring an update to a future meeting of the Committee on the long standing case with regard to the dispensing practice	Local Counter Fraud Officer	Director of Finance & procurement	feb-25	Open	Primary Care review in progress. Update to be brought to next meeting.
Audit & Risk Committee December 2024	4,1	3	Local Counter Fraud Report	To flag any changes to the open cases with a different colour so that Members can easily see the changes.	Local Counter Fraud Officer	Director of Finance & procurement	feb-25	Propose to close	Table has an additional column to highlight actions since last report. Happy to review formatting for future meetings if Committee would prefer different style.
PREVIOUSLY CLOSED ACTIONS									
Audit & Risk Committee October 2024	5,1	6	Organisational Risk Register	To review Risk 5755 - Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit – no correlation between reduced consequence and explanation used for the method of reducing the target risk score.	Director of Corporate Governance/Board Secretary	Director of Corporate Governance	des-24	Closed	Emails have been exchanged between C. Hamblyn and the ARC Chair clarifying the reasons for the residual risk score. Query now resolved and no further work proposed
Audit & Risk Committee October 2024	5.6.2	10	Internal Audit Review - Reasonable offer	To review the management response in relation to staff training with Internal Audit outside of the meeting	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Internal Audit	des-24	Closed	G. Watts and E. Samways have exchanged emails and agreed that the recommendation can be taken off the tracker for 12 months. While there remains 2 systems in place, training for new (and existing staff) still needs to be provided and that is what is happening, tailored to the different WPAS systems at the different sites



Agenda Item

4.1

Audit, Risk & Assurance Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	13/02/2025
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
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

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

1. Situation / Background

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

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

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

4. Assessment

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

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, Risk & Assurance Committee in line with the Committee's work plan.



Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 13 February 2025

Counter Fraud Progress Report

Matthew Evans
Head of Local Counter Fraud Services

1. INTRODUCTION

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

2. BACKGROUND

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

3. RESOURCE UTILISATION

AREA OF WORK	Planned Days	Days to Date
Strategic Governance		
Ensuring that anti-crime measures are embedded at all levels across the organisation	48	45
Inform and Involve		
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public.	100	70
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	148	139
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	310	246
TOTAL	606	502

4. STRATEGIC GOVERNANCE

The Counter Fraud Team currently have a vacancy with a Band 6 Local Counter Fraud Specialist moving to another NHS Wales Organisation. This represents 1 WTE applied to Cwm Taf Morgannwg UHB under the SLA with Swansea Bay UHB. A review of workplan actions has been undertaken and all actions will still be completed in year. This is due to the flexibility built into the plan as well as some reserve resource, approximately 10 days, available within the Counter Fraud Team able to be deployed to support.

CFS Wales have been updated and are available to pick up large scale investigations in the interim period if necessary.

Recruitment will be undertaken and a new member of the Team is anticipated to be on board by early next financial year which, along with effective planning for Quarter 1, should result in extremely limited to no impact on 2025/26 Counter Fraud Work Plan activity.

5. INFORM AND INVOLVE

The Counter Fraud Team have undertaken a strategy meeting in relation to inform and involve work with a view to increasing reach, attendance at general fraud awareness training, and quality of Counter Fraud output. The Team have decided on direction to:

- Increase the availability of face-to-face training sessions from Q4 2024/25 going forward
- Engage with Communications to gain advice on visibility and reach of training booking links
- Revitalise the Counter Fraud Newsletter and align to more up-to-date styling and production methods
- Produce refreshed information booklets and leaflets around NHS Counter Fraud
- Explore use of AI tools to support styling and graphics production to professionalise output

6. PREVENT AND DETER

The matched data reports has been issued to the Health Board via the National Fraud Initiative. Work has commenced to review the matched data sets with an aim to complete first checks and applicable data checks by the end of the financial year. A progress report will be brought for the Committee's attention in summer 2025/26.

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 2

Counter Fraud Investigations Update Report

Summary

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

Cases being actively investigated by the Counter Fraud Team are listed in the [Open Cases](#) table.

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

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

Case Status		
Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2024/25
13	1	18
Case Rates		
Referrals Received 2024/25	Cases Under Investigation for Over 12 Months	
13	4	
Sanctions/Outcomes		
Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
1	1	2

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
WARO/20/00 032	24/01/2020	Alleged theft of petty cash/False representation of employment history and qualifications	The subject has been found guilty in relation to 9 counts faced at Crown Court. The subject received a 5 years immediate custodial sentence. The subject resigned their Health Board position whilst disciplinary proceedings were underway. NMC have been updated of the outcome of the criminal case and are assessing.	The NMC process is ongoing. An interim suspension order for 18 months has been imposed and subsequently confirmed.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/22/01136	18/08/2022	Unknown third party attending to complete an agency shift	Enquiries have corroborated referral information with witnesses with statements and documentation gathered. Digital forensics of mobile devices has been undertaken and evidence analysed. An interview under caution has been undertaken and an account gained. This investigation forms part of a wider investigative strategy with Home Office immigration and Police involvement. A case file has now been submitted to CPS consideration of charges.	CPS review ongoing.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
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.	Analysis identified shift patterns of concern in which it appears that on-call shifts have been claimed at full rate. There will be difficulty demonstrating this to the criminal standard however. Since intervention mitigation has been introduced: No on call work, meaning one standard rate of pay for in hospital work. 10 sessions per week with 2 admin. Consultants now found to be generally finishing at 17:00hrs, where previously they worked until 20:00hrs. A flagging system, where if a rostered doctor cannot be located, senior manager's office is contacted and the doctor is tracked down. Timesheets are now being authorised by a manager instead of an admin officer.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
				This locum no longer provides services to the Health Board.
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.	Analysis identified shift patterns of concern in which it appears that on-call shifts have been claimed at full rate. There will be difficulty demonstrating this to the criminal standard however. Since intervention mitigation has been introduced: No on call work, meaning one standard rate of pay for in hospital work. 10 sessions per week with 2 admin. Consultants now found to be generally finishing at 17:00hrs, where previously they worked until 20:00hrs. A flagging system, where if a rostered doctor cannot be located, senior manager's office is contacted and the doctor is tracked down. Timesheets are now being authorised by a manager instead of an admin officer.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/24/01324	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and various data sources have now been obtained for analysis. Following analysis of available data no discrepancies or outliers established to indicate criminal dishonesty. A meeting was then held with a Senior Manager in this area to outline findings and concerns raised as part of referral. The Senior Manager confirmed that no other data is available to support ongoing investigation. Potential disruptive/preventive actions discussed and counter fraud training to be provided to all in Department. A further reference has been created to separate subjects into individual investigations. INV/24/01334 is the linked reference.	Investigation review meeting to take place to ascertain any remaining lines of enquiry.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/24/01334	23/05/2024	Timesheet Fraud	Allegation received via Fraud and Corruption Reporting Line naming 2 staff members who have not been completing hours but submitting timesheets with full hours inputted. Management for individuals have been approached and various data sources have now been obtained for analysis. Following analysis of available data no discrepancies or outliers established to indicate criminal dishonesty. A meeting was then held with a Senior Manager in this area to outline findings and concerns raised as part of referral. The Senior Manager confirmed that no other data is available to support ongoing investigation. Potential disruptive/preventive actions discussed and counter fraud training to be provided to all in Department. A further reference has been created to separate subjects into individual investigations. INV/24/01324 is the linked reference.	Investigation review meeting to take place to ascertain any remaining lines of enquiry.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/24/02428	30/09/2024	Overpayment of Salary	An existing staff member moved to a new post within the Health Board. Process was intended to be undertaken as an internal transfer but a new ESR record was established for new role that led to subject being paid for both assignments resulting in an overpayment from 07/01/24 to 31/07/2024 with gross value of £10,508.17 and Net £7,216.78. An interview was arranged with the subject. Upon attendance it was clear to the interviewers that the subject did not have a clear understanding of the process and potential outcomes. The interview was postponed to allow subject to properly assess need for legal representation following advice given.	The subject has now engaged a legal representative. New date for interview has been offered via the representative who is confirming with the subject.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/24/03044	28/11/2024	Manager not working their contracted hours	Referral received via the fraud and corruption reporting line. Multiple potential subject matches have been identified from information supplied as part of referral, work underway to formally identify person of interest.	Subject has now been identified and a sample of Health Roster time shift time information analysed. No evidence was established to support ongoing criminal investigation. Liaison with subject's managers established existing concerns with amount of overtime being claimed. Additionally, an ongoing NMC investigation which covers a similar allegation to this fraud matter as well as other concerns.
INV/24/03189	12/12/2024	Allegation that individuals have claimed to be a couple for the purposes of obtaining IVF treatment but are not actually in a relationship together	A meeting has been held with Wales Fertility Institute staff to gain background of the eligibility criteria. Policy is quite clear that they need to be cohabiting, in a stable relationship and trying to conceive for 2 years.	Attempt to obtain Relationship status via open source means to be undertaken

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/24/03275	19/12/2024	Community Pharmacy claiming for excessive amount of out of pocket expenses	Pharmacy in question is the highest claimer of out of pocket expenses across the Health Board by some margin. A meeting has been held with PPV and Community Pharmacy. PPV have obtained claim data and backing information which was shared with Counter Fraud.	No direct link could be established between the pharmacy and their supplier. A meeting will be to review possible next steps.
INV/25/00197	23/01/2025	Non-declaration of criminal convictions	A meeting has been held with subject's manager who has informed that the subject was in fact convicted whilst in Health Board employment and an investigation was undertaken alongside a professional body investigation at that time.	Conviction disclosed and known by Health Board with actions undertaken under disciplinary policy.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
INV/23/02885	18/12/2023	Annual Leave Concerns	Information received from the Fraud and Corruption Reporting line that staff member records only half of annual leave take and works for 2 Health Boards. Enquiries have sought to identify secondary employer. A request for information to potential secondary employer has been issued to seek clarity on role fulfilled there. Annual leave records have been gathered from the ESR system and analysed. Subject's managers have been approached and information for use in further enquiries has been gained including car registration and system access details to request audit logs. Witnesses have been identified and approached to gain account and potential documentary evidence. Analysis of information undertaken this established discrepancies in leave records but this fell short of the criminal threshold due to evidential quality. Advice has been provided to management in this area to strengthen processes for booking and recording annual leave. The subject has also left employment with the Health Board.
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,

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			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 investigated as financial investigator powers are required under agreed criteria. The subject attended for a voluntary interview under caution in June 2024, they made partial admissions to receiving payments from CTM UHB after they left Health Board employment but stated that they thought that these were due to outstanding locum shifts. The subject has now repaid the full amount of the overpayment. An advice file was submitted to CPS for consideration, following a case conference with CPS it was agreed that there was not a reasonable prospect of conviction so no further action will be taken in respect of criminal proceedings.
INV/24/00224	29/01/2024	Non-Completion of Contracted Hours	Allegation that Consultant has not worked job plan sessions following a denied request to drop sessions. Enquiries have established communications confirming what expectations are in relation to sessions. An overpayment of salary arose due to a subsequent job plan reduction and pay remaining the same. There were questions around the start date of the job plan reduction. A date has been settled on by Managers in this case and overpayment calculated on that basis.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			No evidence has been established to support dishonesty on part of the subject in this case. Overpayment of salary to be recovered through normal mechanisms.
INV/24/00465	23/02/2024	Authorisation of hours not worked	Concerns have been raised regarding bank staff submitting timesheets for hours beyond initially agreed shift hours and outside of hours of operation of unit worked at. Claims have been authorised by managers. Meetings have been held with senior managers and People Services colleagues to discuss concerns. Access has been gained to the allocate system and shift data gathered. Analysis is being undertaken. Enquiries established that staff identified had been uplifted in banding and hours authorised were intended to align with the pay of this higher banding. This appears to be a case of poor process rather than dishonesty. An ongoing disciplinary process was exploring the concerns and an audit is now being undertaken in this area. The outcome report has been shared with counter fraud and findings indicate a manager new to the NHS had not followed proper process when uplifting pay via additional hours rather than increased banding. No loss was established in this matter as staff were in fact due the higher pay rate. A recommendation was made in the outcome report that all managers and team leaders who use

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			Health Roster must attend a formal training session provided by the People Function's Health Roster Team before they are permitted to use this system. No loss or criminal dishonesty has been established in this investigation.
INV/24/02125	28/08/2024	Theft of Controlled Drugs	Intelligence report received following contact via the Fraud and Corruption Reporting Line. A named employee has been alleged have stolen boxes of co-codamol from an identified department store. Controlled Drug Investigation Guidelines are being followed and Pharmacy colleagues have been engaged who along with Ward Manager undertook an audit which failed to uncover any evidence of missing controlled drugs.



Agenda Item

4.2

Audit, Risk & Assurance Committee

Losses and Special Payments 01.10.24 to 31.12.24

Dyddiad y Cyfarfod / Date of Meeting	13/02/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Owen James – Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May - Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

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

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

1. Situation / Background

- 1.1 This report advises the Audit & Risk Committee on the losses and special payments made by the University Health Board (UHB) for the 3 month period from 1 October 2024 to 31 December 2024, as required by in Standing Financial Instruction.
- 1.2 The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.
- 1.3 General Medical Practice Indemnity Scheme (GMPI) was introduced in recent years by the Welsh Government as a state-backed scheme within NHS Wales. Legal and Risk Services and WRP operates this scheme and cases settled under the scheme are presented to WRP for reimbursement.
- Scrutiny of the Learning from Events Report is conducted in the same manner as cases settled under NHS Indemnity or as part of the redress scheme.
 - Payments in relation to claims managed under GMPI are made by the defendant Health Board, and reimbursement by the WRP is made to the Health Board.
 - No excess in relation to reimbursement of cases settled under the GMPI will apply to the Health Board and all costs incurred are fully reimbursed.
- 1.4 In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.
- 1.5 There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:



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

2. Specific Matters for Consideration

- 2.1 Standing Financial Instructions require all losses to be reported to the Audit & Risk Committee. This report is therefore a key element of the governance process around losses and special payments.
- 2.2 The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.

a) Losses and Special Payments recorded during period

- 2.3 The losses and special payments recorded during this period totalled £2,629k, with the majority of this comprising of payments in respect of Clinical Negligence, Redress and Personal Injury.
- 2.4 It is important to note that the majority of these losses would have been recorded in the revenue position when the claim was deemed as probable, this is showing the cash impact of the payments made during the period.
- 2.5 The total recovered from Welsh Risk Pool during the period is £1,016k, giving a net cash out position for the period of £1,613k.
- 2.6 The losses and special payments are available in detail on request from the Head of Corporate Finance if required but are summarised in the table below.

	01.10.24 - 31.12.24 £000	Previous Periods	Total 24-25 £000
Medical Negligence Claims	1,105	2,333	3,438
Medical Negligence Costs	932	1,385	2,317
Medical Negligence Defence Fees	200	650	850
Medical Negligence Totals	2,237	4,368	6,605
Redress Medical Negligence Claims	85	67	152



Redress Medical Negligence Costs	6	41	47
Redress Medical Negligence Defence Fees	16	52	68
Redress Medical Negligence Totals	107	160	267
GP Indemnity Claims	31	35	66
GP Indemnity Costs	46	112	158
GP Indemnity Defence Fees	3	13	16
GP Indemnity Totals	80	160	240
Personal Injury Claims	29	48	77
Personal Injury Costs	15	130	145
Personal Injury Defence Fees	15	62	77
Personal Injury Totals	59	240	299
Permanent Injury Benefit	120	119	239
Permanent Injury Benefit Totals	120	119	239
Other:			
Ex-Gratia	25	55	80
Debt Write Off	0	0	0
WRP Penalty Charge	0	0	0
Ombudsman	1	0	1
Employment Matter/Other	0	0	0
Other Totals	26	55	81
TOTAL	2,629	5,102	7,731
Recovered from Welsh Risk Pool	(1,016)	(2,036)	(3,052)
Net Cash Write-Off/(Recovery)	1,613	3,066	4,679

2.7 There are three categories of Decision in relation to cases submitted to WRP:

APPROVE

APPROVE: The learning and case information submitted was accepted by the Committee and where reimbursement is requested it has been approved. Where the case is a review of learning only, the matter will be reconsidered when reimbursement is requested.

DEFER

DEFER: Additional information is requested which should be gathered and supplied to the Safety & Learning Advisor and this will be presented to the next WRP Committee.

We would like to receive this information within 1 calendar month. A maximum of six calendar months applies for the submission of additional information, from the date it was first requested. – after which the reimbursement will be permanently deferred. Details of the additional information requested is outlined in the case detail below



DEFER UNTIL
INFO REC'D

DEFER UNTIL INFO REC'D: The Committee delegated approval of the reimbursement to the Head of Safety & Learning. Additional information is requested which should be gathered and supplied to the Safety & Learning Advisor – who will present it to the Head of Safety & Learning. We would like to receive this information within 1 calendar month. A maximum of six calendar months applies for the submission of additional from, from the date it was first requested. – after which the reimbursement will be permanently deferred.

- 2.8 At its latest meeting, the WRP committee approved the payment of a further £808k of claims (28 claims), this will be paid in February 2025. 7 further claims reviewed by the committee were deferred, and another 21 claims were deferred until further information was received.

b) Provision as at 31 December 2024

- 2.9 A provision reflecting the estimated value of the claim will be made on the balance sheet as a claim is deemed probable. There will also be an estimate for the value recoverable from Welsh Risk Pool, leading to a net provision value on the balance sheet.
- 2.10 The table below shows the provision made for each type of claim and the amount recoverable from Welsh Risk Pool as at the period stated. It could be deemed the lower value the net claim provision the more efficient the health board are at recovering from Welsh Risk Pool i.e. payments have been made out and they have been recovered from Welsh Risk Pool in an efficient manner.
- 2.11 The total claims provision has increased by £16,582k since 31st March 2024, this is mainly due to an increase in value of medical negligence claims.
- 2.12 The net provision at the end of 31st December 2024 was £8,987k which is £983k higher than the previous reported period.

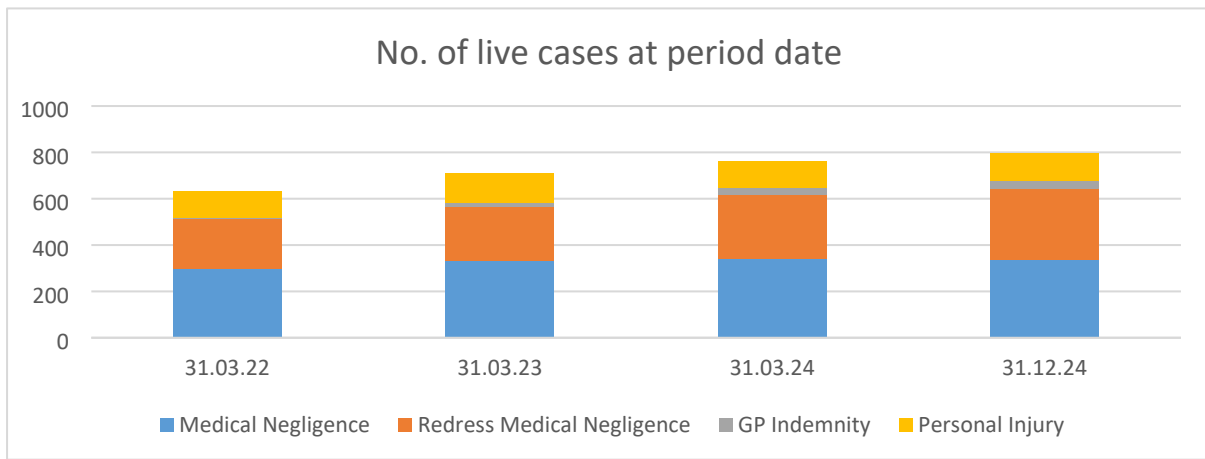
	31.12.24	31.03.24	31.03.23	31.03.22
	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	109,517	94,478	72,198	65,127
Redress Medical Negligence claims/costs	614	372	385	235
GP Indemnity (Note 1)	1,107	612	0	0
Personal Injury claims/costs	1,723	917	701	611
TOTAL CLAIMS/COSTS PROVISION	112,961	96,379	73,284	65,973
Recoverable from Welsh Risk Pool	(125,789)	(106,450)	(83,623)	(93,074)
NET CLAIMS / COSTS PROVISION	(12,828)	(10,071)	(10,339)	(27,101)



Permanent Injury Benefit	3,841	3,755	4,077	6,201
NET PROVISION inc Perm Injury Ben.	(8,987)	(6,316)	(6,262)	(20,900)

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

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



c) Revenue impact for the year to date

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

	Year to
	31.12.24
	£000
Medical Negligence claims/costs	21,643
Redress Medical Negligence claims/costs	509
GP Indemnity	735
Personal Injury claims/costs	1,105
Recoverable from Welsh Risk Pool	(22,390)

Net claim expenditure (Note 1)	1,602
Permanent Injury Benefit	326
Other	81
Total Net expenditure	2,009

Note 1: The annual budget for net claim expenditure for 2024-25 is £1,785k, with a year to date budget of £1,339k, actual expenditure for the year is £1,602k, therefore an overspend of £263k to December 2024. It is important to note that these costs can fluctuate during the year. In previous years there has been a significant overspend at outturn against these costs.

WRP Risk Sharing Agreement

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

3. Key Risks / Matters for Escalation

- 3.1 Note that there is an increase in the net cash write off and net provision of values owed from WRP, which reflects that the amount being paid out is higher than the value being recovered.
- 3.2 This is largely a timing issue, but there is a need to ensure there is timely completion of learning submitted in order from reimbursements to be approved in a timely manner, reducing value owed from WRP.

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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective	
	If more than one applies please list below:	
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Safe	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i>	Yes: ☒	No: ☐
	Outcome for Equality Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15)	If no, please include rationale below: Not applicable for this report



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

5. Recommendation

5.1 The Audit, Risk & Assurance Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 October 2024 to 30 December 2024.

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.



Agenda Item

4.3

Audit, Risk & Assurance Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	13/02/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Owen James - Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May – Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

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

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

RGH	Royal Glamorgan Hospital
YCR	Ysbyty Cwm Rhondda
PoW	Princess of Wales Hospital
PCH	Prince Charles Hospital



1. Situation / Background

1.1 Procurement Matters

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

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

This report provides details of any such transactions within the period 01.12.24 to 31.01.25

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.

1.4



2. Specific Matters for Consideration

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.12.24 to 31.01.25

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

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

The Scheme of Delegation allows the Director of Finance and Procurement to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Tables A and B** below provides details of such actions during the period 01.12.24 to 31.01.25

Table A – Single Tender Actions 01.12.24 to 31.01.25

STA	Revenue / Capital	Division	Contract description	Supplier	Contract Value Exc. VAT	Reason for approval	Date Returned
CTM-STA-1750	Rev	Primary Care	Specialist Orthodontics Service	Q Dental Care Limited	£305,214	(a)	10/12/24
CTM-STA-1751	Other	Pathology	Rental of high capacity digital Pathology Scanner	Leica Biosystems	£83,795	(b)	28/11/24
CTM-STA-1752	Maintenance	Estates	Preventative Planned Maintenance for RGH & YCR	Honeywell Control Systems	£103,093	(c)	07/01/25
CTM-STA-1756	Rev	Ophthalmology	Outsourcing Cataract Procedures	Clear View Surgical	£750,000	(c)	27/01/25



CTM-STA-1757	Rev	Digital	Liberty Contact Centre Messenger and Call Recording Console	Netcall Technology Ltd	£26,321	(b)	27/01/25
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Reasons for approval:

- a) service/work is follow-up, supplier has already undertaken initial work in same area (work undertaken via open competition)
- b) Compatibility issue
- c) Genuine 1 provider
- d) Need to retain particular contractor for real business continuity issues not preferences

Table B - Single Tender Actions - Retrospective CTM - None for this period

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

None for this period

d) Summary of contracts awarded over £500,000

Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. Below is a retrospective summary of contracts awarded between 01.12.24 to 31.01.25

Reference	Title	Supplier	Value	Date Approval Received
CTM-DCO-66	IPHONE 15 PLUS BLACK 128GB-ZDD	Kingsfield Computer Products Ltd	£561,784	N/A (capital purchase)

e) Free of Charge Services

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



commit itself to a single provider or longer term commitment. Below is a summary of free of charge services that have been provided between 01.12.24 to 31.01.25

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

f) Retrospective orders and non-receipting areas

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

Supplier	Area	Retro Orde	Comment
Blue Arrow	544063_LLW DOM TOP B	109	Agency Staffing
	559148_Houskeeping YCC		
	555109_PCH CATERING		
BOC LTD	533041_DENTAL SURGERY Y	52	Industrial Gas and Equipment
	555100_PCH PHARMACY		
	559152_KH Admin Blk2		
PHS GROUP	559148_Houskeeping YCC	48	Hygiene Services
	544042_LLW PHYSIO		
	544063_LLW DOM TOP B		

Top 3 Receipting Areas	Total
533314_POW PAT CATER	141
533170 YGT Patient Caterin	132
555184 PCH CATERING DEP	102

g) Consultancy Contracts

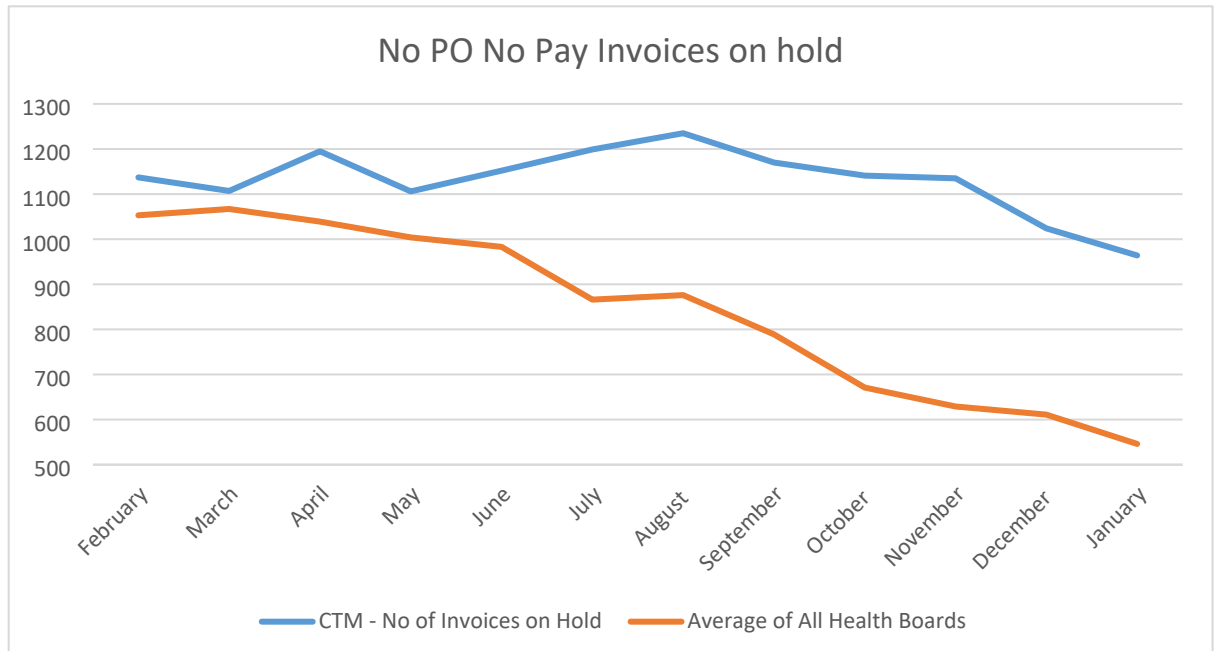
Below is a table detailing consultancy contracts that have been awarded between 01.12.24 to 31.01.25

None for this period

h) Invoices on hold & No PO No Pay Summary

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

The table below shows that the number of CTM invoices against the average across other Welsh Health Boards.



- CTM continue to have a higher number of invoices on hold due to NO PO compared to the average of all Welsh Health Boards.
- In the past two months CTM has seen an improvement of 15%, this follows discussion with Procurement colleagues and a focus on CTM invoices on hold over the December and January period.
- 576 (60%) of the invoices on No PO No Pay holds are relating to just 5 organisations. Procurement are prioritising focus on the category areas which are causing main issues.
- Without a PO an invoice cannot be assigned to a directorate or cost centre, therefore an assessment by directorate cannot be provided.

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to 30th October 2024.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 9 2024-25 achieving 96.1% (value 92.8%). This is below the target of 95%, however it is an improving position and it is projected the target will be met by the end of the financial year.



	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-24	22,578	35,827,302	23,700	38,481,025	95.27%	93.10%
May-24	20,087	37,485,008	20,890	41,651,491	96.16%	90.00%
Jun-24	20,219	38,326,962	20,971	40,869,496	96.41%	93.78%
Jul-24	23,972	39,914,765	24,837	47,066,950	96.52%	84.80%
Aug-24	19,770	44,452,809	20,477	46,830,448	96.55%	94.92%
Sep-24	21,392	45,067,608	22,146	47,512,201	96.60%	94.85%
Oct-24	22,358	43,052,769	23,832	46,241,647	93.82%	93.10%
Nov-24	23,278	42,489,691	24,004	45,068,742	96.98%	94.28%
Dec-24	21,381	55,493,338	21,999	57,983,477	97.19%	95.71%
YTD	195,035	382,110,252	202,856	411,705,477	96.1%	92.8%

The NHS invoice position continues to be challenging and shows that 81.1% (number) and 96.9% (value) of invoices were paid within 30 days to Month 9 2024-25.

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

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

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

3. Key Risks / Matters for Escalation

3.1 No matters for escalation

4. Assessment

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



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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable
	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	



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

5. Recommendation

The Committee is asked to:

- 5.1 **NOTE** the position on procurement matters for the period 01.12.2024 to 31.01.2025;

NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 9 of 2024/25;



Agenda Item

5.1

Audit, Risk & Assurance Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	13 February 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	November / December 2024	RISKS REVIEWED
Operational Management Board	November / December 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	Via email 10 January 2025	MANAGEMENT SIGN OFF RECEIVED
Quality, Safety & Experience Committee	21 January 2025	ASSIGNED RISKS REVEIWD
Health, Safety & Fire Sub Committee	24 January 2025	ASSIGNED RISKS REVEIWD
Operational Delivery Committee	28 January 2025	ASSIGNED RISKS REVEIWD

Acronyms / Glossary of Terms	



1. Situation /Background

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

2. Specific Matters for Consideration

Risk Review

- 2.1 Care Groups and Central leads are continuing to review and update their assigned risks considering 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 3 January 2025. 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.
- 2.6 The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of risks and therefore as noted in Appendix 1 there are three risks that have not been reviewed this period, however, the Care Group Senior Management Team have confirmed that they will endeavour to ensure a review is captured in the next iteration.
- 2.7 The risks on the Organisational Risk Register have been reassigned to align with the new Committee Structure implemented in January 2025.

Training

- 2.8 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.



- 2.9 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
- 2.10 To date **765** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2. In addition to this number training has also been provided to the Joint Commissioning Committee Senior Leadership Team during this period and their feedback is captured in the evaluations at 2.1.4.
- 2.11 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.
- 2.12 101 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.78 out of a maximum score of 5.
- 2.13 100% of the 101 attendees providing formal feedback found that:
- The session provided the right amount of information.
 - They gained more confidence and knowledge in risk management having attended.
 - They would recommend this training to a colleague.
- 2.14 99% of the 101 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.
- 2.15 Some of the recent comments from the session in June, received through evaluation, have been included below:
- *Easy to follow and enough information to have a clear understanding of the risk escalation process and how to appropriately document risks.*
 - *I am new to Risk. I found the session very interesting and informative. The presenter was a great speaker and gave good explanations and examples to follow.*
 - *"I'm new to NHS so this session was invaluable*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Nil as reported to the Organisational Risk Register in January 2025.

3.2 CHANGES TO RISKS

Risk Score Increased

Nil as reported to the Organisational Risk Register in January 2025.

Risk Score Decreased

Medical Directorate

- Datix Risk 4080 - Failure to recruit sufficient medical and dental staff. Risk score reduced from a 15 to a 12 in December 2024. The rationale for de-escalation from the Organisational Risk Register is that the risk is being managed through the Care Group Structure and scrutinised through the Medical Workforce Productivity Programme (MWPP) via relevant workforce and medical leaders. Core spend has increased. Agency usage has reduced but this has been offset against bank spend. The overall position remains above the previous 12 months and the risk will continue to be monitored through MWPP.

Finance Directorate

- Datix Risk ID 5764 - Failure to achieve the planned break-even position in 2024/25. Risk score reduced from a 20 to a 16 as a result of this financial support received as the Health Board was able to maintain a forecast break-even position at M8. The net risks to the forecast breakeven position have also reduced to £3.4m (M7: £11.7m).

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

There were no risks escalated to the Organisational Risk Register that were closed this period.

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

Consequence	5			3337 3993	4664 5276 5932	
	4			5820	4337 4809 4417 5374 4671 4908 4907 4885	5646 5579 5658 5761 5691 5961 5764
	3					4491 4071 4103 3826 5590 5462 5821 4632 5417 5765
	2					4672 4691 5040
	1					
	CxL	1	2	3	4	5
Likelihood						



3.5 EMERGING RISKS

Pathology Risk - Diagnostics, Therapies, Pharmacy and Specialties (DTPS) & Digital & Data

Risk assessments are underway in terms of the sustainability of pathology services and the delivery of a digital cellular pathology solution for the Health Board. Once the assessments are complete, they will be considered for escalation to the Organisational Risk Register as appropriate. Update as at January 2025 from the Service Director of the DTPS Care Group is that risk is being considered ahead of the next meeting of the Operational Management Board with the Chief Operating Officer. If once considered it is approved for escalation it will feature on a future Organisational Risk Register report.

4. Assessment

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



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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Date 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
5932	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Assistant Director of Planning - (Capital and Estates), Strategic and Operational Planning	Sustaining Our Future	Environmental / Estate / Infrastructure	Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.	IF: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof area at the POWH. Then: there is a risk of collapse of the roof coverings which could result in the roof coverings falling through the roof void into occupied clinic/consultation clinical areas and externally from the edges of Phase 1. This risk increases in adverse weather with additional loading on the roof. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations being considered under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport Workforce Digital Facilities Patient Safety Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update January 2025: Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor has been appointed. Welsh Government funding £10.246m was approved Friday 8th November. Contractor started the roof replacement programme on Monday 11th November. Phase 1 has prioritised Maternity and Special Care Baby Unit, on target to hand over to the clinical service on Monday 13th January. Contractors and any staff that need to be in any of the first floor areas must wear hard hats and hi-vis vests. Full programme including Theatre TEN works and fire compartmentation above vacated wards and depths due to be completed mid August 2025.	Operational Delivery Committee Quality, Safety & Experience Committee Health, Safety & Fire Sub Committee	20	C5xL4	10 (C5xL2)	↔	23.09.2024	06.01.2025	28.02.2025
5765	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to reduce the £18.4m recurrent deficit at the start of 2025 down to the planned £2.1m recurrent surplus at the end of 24/25	IF: The Health Board is not able to plan and deliver expenditure not 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. • Robust 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.	H8 update: The forecast underlying deficit at the end of 2024/25 is £8.3m (H7: £8.3m). Prior to H7, the monthly forecasts were positive with the planned recurrent surplus at the start of the year of £12.1m. It is important to note that the £3.4m net risk to the In Year break even forecast noted above also applies to the forecast £8.3m underlying deficit. The forecast recurrent deficit also excludes any ongoing costs of the POW critical incident, which will represent an additional non recurrent cost pressure in 25/26. Our latest estimate is that these costs will be circa £10.0m. The main action is to develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25.	Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	30.04.2024	17.12.2024	31.01.2025
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety	Failure to meet the demand for patient care at all points of the patient journey	IF: The Health Board is unable to meet the demand for patient care 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: • Robust monitoring arrangements and meetings in place with Care Groups and directorates. • Specialty specific plans are in place to ensure patients requiring clinical review are assessed. • All patients identified will be clinically reviewed which will include an assessment of the patient's condition. • 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 RIT reported lists. • All unreported lists that are to remain unreported (as they do not form part of the RIT 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 LHM 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 23/24 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 LUG 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.	Elective/ Planned Care - • Critical incident declared at Princess of Wales on 9th October 2024 due to the roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity. • There has been continuous planning on clinical pathways and diversion of emergency intakes, which again has impacted on the capacity and resilience across the full CTM/HLB system. • There has been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTM/HLB acute and community. • There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. • The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. • The large-scale capital programme at Prince Charles Hospital will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. • The current Fire enforcement notice at Princess of Wales hospital will be completed as part of the critical incident response and reduce the number of operating theatres until early summer 2025. Plans are ongoing for the temporary location of the theatres. • Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of A&E and W&I activity attributed to standardisation of pay. • Regional working continues and the positive and negative impact of this will be continuously reviewed. • There has been continuous planning on clinical pathways and diversion of emergency intakes that again has impacted on the capacity and resilience across the full CTM/HLB system. • There has been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTM/HLB acute and community. • There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. • Planning continues on recovery phase following critical incident with the impact not yet quantified. • There has been some improvement against trajectories for emergency demand. Specifically in total reduction of out ambulance hours. • There remains a high number of clinically optimised patients in care capacity that is impacting on patient flow. • The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. • Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of A&E and W&I activity attributed to standardisation of pay. The conversion from locum to substantive and establishing COVID un-commissioned capacity remains a priority.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4 x L3)	↔	13.7.2023	29.08.2024	31.12.2024
5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM LHM).	IF: CTM is unable to secure a new contract with an alternative commissioned provider. Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the Health Boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM LHM Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GPs have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update November 2024 - Work ongoing to work through short term contract offer with aim to finalise and gain approval. This service would deliver assessment and first line treatment for urgent cases. Meeting with a provider 6th November. Also to be discussed at next primary care commissioning meeting so updated contracts can go out to GPs Update January 2025 - December 24 Update - Work continues to source alternative service offer. Key updates include - the provider is ready to start triaging the first batch of 40 m/s Jan/Feb. Draft agreement been produced. Referral process established with referral management team. Still need to confirm how urgent referrals sent by provider that convert to follow up.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	4 (C4xL1)	↔	08.07.2024	24.12.2024	31.01.2025
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	IF: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM. Then: available 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. • Task 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 aligned to challenges • Quarterly briefing to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Strategy 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 November 2024 Risk reviewed by SHL - stroke services options appraisal has been submitted to Executive Leadership Group. The Stroke consultants within CTM cover Stroke services on two acute sites (POWH and PCH). They also provide a 1-6, seven-day stroke on-call advice service. However, due to vacancies and maternity leave within the consultant workforce the ratio for the on-call ratio is currently 1:3 to mitigate gaps. There are currently 4.0 WTE stroke consultants and 4.8 WTE CNS in post across CTM, broken down as follows: • PCH - 2.0 R&E consultants with 1.0 WTE vacancy • PCH - 2 WTE Clinical Nurse Specialist • POWH - 2.0 WTE consultants with an additional 0.6 WTE agency locum Consultant • POWH - 2.8 WTE Clinical Nurse Specialist The Stroke consultants at POWH also have a GIM on call commitment on a 1:21 ratio, comprising of weekday evening and full weekend day cover resident cover with non-resident overnight cover. The service becomes increasingly more fragile from September 2024 when one consultant at PCH will be commencing maternity leave for a 12-month period, from July they will also be coming off the on-call rota. This will leave just 3 substantive consultants undertaking a 1:6 rota with a 50% less workforce, as well as leaving just one consultant at PCH from September which will significantly impact being able to deliver a safe and sustainable stroke service at PCH. In order to try and mitigate this, a locum Consultant started at PCH on Tuesday 27th August to cover maternity leave, with a second fixed term locum due to start at the end of October, this will allow adequate time for the care group to work through more sustainable options Update January 2025 - The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of this risk, however, they will endeavour to ensure a review is captured in the next iteration. In terms of the urgent, temporary change to Stroke Services, stroke patients from Prince Charles Hospital were successfully transferred to the Royal Glamorgan Hospital (RGH) on the 8 January 2025, along with all the stroke specialist clinicians. This ward is now located to the stroke ward that was relocated to RGH from Princess of Wales Hospital and both wards have access to a shared rehabilitation space. Work is ongoing with internal and external stakeholders to monitor the impact of the move and explore any further opportunities to	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4 x L3)	↔	11.05.2021	05.11.2024	31.12.2024
5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety	Radiopharmaceutical Business Interruption	IF: CTM/HLB Radiology Department are unable to procure radiopharmaceuticals 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 Map Trace or alternative for SNUB - Breast Services	Update November 2024 - 07/11/24 Further shortage of Technetium HDP until 11/11/24 impacting Isotope provision, particularly bone scans. The Reactor in Poland restarted 31/10/24. Confirmation received that the usual levels of supply will be reinstated by 11/11/24. No change to risk score. Update January 2025 - 16.12.24 update - ongoing nationally - No change to risk score.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	4 (C4xL1)	↔	23.10.2023	16.12.2024	20.01.2025
5276	Director of Digital	Central Support Function - Digital and Data	Pathology Directorate Manager	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 November 2024: UAT has been extended and resulting in a 2 month delay to go live, however the end date of December 2025 is non-negotiable. Activity to understand the consequences of the delay such as dependencies on other projects such as ePRA are being investigated. Update January 2025: Progressing with User Acceptance Testing 2 in January, everything currently still on target for December 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	20.12.2024	28.02.2025
4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer pathway, and overall, enhanced monitoring with Velindre Cancer Centre. 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 HDTs, 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 recommending 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 rigorous monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update July 2024 - risk ongoing, mitigation continues to be - ongoing increased scrutiny of pathways, focused work with urology, Gynaecological, enhanced monitoring with Velindre Cancer Centre. Update November 2024 - Performance is improving, however, CTM are still not meeting the set Trajectory so the risk remains. Update January 2025 - Whilst not achieving SCP target there is a sustained improvement in cancer performance and backlog position.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	24.12.2024	31.01.2025

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
	Item 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 (Correspondence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	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 ODTIC DU reviews nationally. Clinical staffing situation stabilised and absence reduced (new consultant, nurse injector, ODTIC, 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 (5,500 cases) with harm review planing to assess all potential harms. Additional services to be provided in Community settings through ODTIC (January 2023 start date) Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enacted. Regular updates re follow up appointments not booked being monitored by Management Board / Q&R (patient safety issues) and Finance, Performance and Workforce Committee (Performance Issues). Reviewing UWB 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: WIL clinics, outsourcing of Cataract patients, development of an ODTIC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (DMS), 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 WIG 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 injective/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. CTHMT 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 for the NHS. The glaucoma service is currently at score of 23 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 NHS. Cataracts and eye casualty are ongoing pressure areas but are not urgent clinically thus the risks outlined below. Major risks in ophthalmology at present 1) Glaucoma - glaucoma cases irreversible vision loss due to damage to the optic nerve. a. high volume of long waiting patients. Many not seen for several years. Increasing list 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 later 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 hour consultant, Community glaucoma scheme and RSCDH 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. High volume of new referrals. b. Few dedicated medical retina appointments in April 2019. c. Inappropriate discharge by outsourcing company in April 2019. d. ~3000 patients discharged under care of outsourcing company in April 2019. e. 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. f. Sample of 350 records reviewed in 2021 - 50% were appropriate discharge, 22% not appropriate, 23% uncertain. g. DMC: Real time validation of waiting lists ensures appropriate signposting according to service speciality, alongside implementation of partial booking. Referral rates continue at approx. 100/mth with service capacity of 40/mth. h. A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3. Update January 2025 - update from 28.10.24: Risk reviewed, no change to score. Given there is unlikely to be additional funding available to support the business case for expansion of current service, discussions are underway with planning, DTFS and public health colleagues as to the best way to proceed. The non finance dependent mitigating actions remain in place: patients are offered the lowest intervention required in line with the Healthy Weight Healthy Wales pathways; signposting to 'waiting well' support; maximising digital opportunities for efficiencies within pathway and maintaining communication with patients to manage expectations; implementation of group interventions to maximise service capacity. CTHMT UWB is one of a number of Health Boards across Wales facing these challenges and national collaboration via the Executive Directors of Allied Health Professions and Health Science peer group has been strengthened to enable collective action and sharing of best practice.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	24.12.2024	31.01.2025
10	5462	Executive Director of Public Health Executive Director of Therapies & Health Sciences Care Group	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 - with the All Wales Weight Management Programme. IF: there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention 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 WISK, CVD and some cancers.	People are offered the lowest intervention required in line with the Healthy 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 all long term conditions. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways. 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 WISK, CVD and some cancers.	Update August 2024 - Current mitigations remain in place: Pathway redesign and Demand and Capacity (DMC) oversight. Pathway redesign: 74% of level 3 patients identified as suitable for group education, this group delivery model is in progress, which has resulted in an 80% increase in annual capacity compared to the original service model of 1 : 1 MDT treatment. Despite this efficiency demand exceeds capacity. DMC: Real time validation of waiting lists ensures appropriate signposting according to service speciality, alongside implementation of partial booking. Referral rates continue at approx. 100/mth with service capacity of 40/mth. A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3. Update January 2025 - update from 28.10.24: Risk reviewed, no change to score. Given there is unlikely to be additional funding available to support the business case for expansion of current service, discussions are underway with planning, DTFS and public health colleagues as to the best way to proceed. The non finance dependent mitigating actions remain in place: patients are offered the lowest intervention required in line with the Healthy Weight Healthy Wales pathways; signposting to 'waiting well' support; maximising digital opportunities for efficiencies within pathway and maintaining communication with patients to manage expectations; implementation of group interventions to maximise service capacity. CTHMT UWB is one of a number of Health Boards across Wales facing these challenges and national collaboration via the Executive Directors of Allied Health Professions and Health Science peer group has been strengthened to enable collective action and sharing of best practice.	Quality, Safety & Experience Committee Operational Delivery Committee Strategic Development Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	01.01.2025	28.02.2025
31	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 Due to business sensitivities the detail of this risk will be captured in closed session.	People are offered the lowest intervention required in line with the Healthy 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 all long term conditions. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways. 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 WISK, CVD and some cancers.	Update August 2024 - Current mitigations remain in place: Pathway redesign and Demand and Capacity (DMC) oversight. Pathway redesign: 74% of level 3 patients identified as suitable for group education, this group delivery model is in progress, which has resulted in an 80% increase in annual capacity compared to the original service model of 1 : 1 MDT treatment. Despite this efficiency demand exceeds capacity. DMC: Real time validation of waiting lists ensures appropriate signposting according to service speciality, alongside implementation of partial booking. Referral rates continue at approx. 100/mth with service capacity of 40/mth. A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3. Update January 2025 - update from 28.10.24: Risk reviewed, no change to score. Given there is unlikely to be additional funding available to support the business case for expansion of current service, discussions are underway with planning, DTFS and public health colleagues as to the best way to proceed. The non finance dependent mitigating actions remain in place: patients are offered the lowest intervention required in line with the Healthy Weight Healthy Wales pathways; signposting to 'waiting well' support; maximising digital opportunities for efficiencies within pathway and maintaining communication with patients to manage expectations; implementation of group interventions to maximise service capacity. CTHMT UWB is one of a number of Health Boards across Wales facing these challenges and national collaboration via the Executive Directors of Allied Health Professions and Health Science peer group has been strengthened to enable collective action and sharing of best practice.	Operational Delivery Committee	20	C5 x L4	15 (C5xL3)	↔	26.05.2021	20.12.2025	28.02.2025
12	3826 Linked to 4039 and 4841 in England Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care	Improving Care	Patient / Staff /Public Safety	Emergency Department (ED) Overcrowding Impact on the safety - Physical and/or Psychological harm	Emergency Department (ED) Overcrowding 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, long waiting times, hour breaches currently in excess of 400 per month. There are also long numbers of patients spending more 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 resort 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. IF: Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to a Community Dental Service team for paediatric GA. Then: the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in: 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 48 hrs form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Increased number of nursing staff being rostered over and above establishment. Additional reporting 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 Y5 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 hot call (including weekends) with a senior identified leader from the Health Board representing CTH and taking daily through the plans to reduce offload delays across the 3 DGH sites. - Twice weekly meetings with K&C 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 group with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports to Management Board.	Update November 2024 The USC SMT reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an SOP relating to fit2see. We continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Quality statement baseline assessment has been completed, part of this work, will result in the development of an overcrowding score which should help reduce the risk of harm with overcrowding in the emergency department. 1. Currents developing a standardised approach to our huddle capture and reporting. 2. Proof of concept has been completed with engagement from operational and clinical stakeholders. 3. Move development of software project. 4. This will support a consistent approach to recording and reporting escalation levels across all our acute sites. 5. USC Dashboard which provides daily and ongoing trend data for performance metrics 1 Emergency Care 6. Developing data intelligence Emergency department acuity levels, including risk stratification and also clinical frailty score for all attendances in each of our Emergency Departments. 7. CTH IMTP describes development of a predictive data model to enhance current systems (we already have predicted attendance) The 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. Update January 2025 - The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of this risk, however, they will endeavour to ensure a review is captured in the next iteration.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	05.11.2024	31.12.2024
31	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 a Community Dental Service team for paediatric GA. Then: the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in: 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 48 hrs 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 January 2025 30/12/2024 Update - A monthly list has now been secured for Peads in Prince Charles Hospital (released by Max Fax) and approximately 6 patients can be seen at present. This is used to prioritise Cat 1/urgent treatment that comes in during the month as well as rebooking patients who had a cancelled GA as a result of the issues in Princess Of Wales Hospital. On average over a 12-month period, 6 patients are booked in and 6 patients are not in. The number of patients waiting for GA as a result of only have one list per month, the number of patients waiting for GA will increase significantly. Currently, there are 707 children waiting for GA assessment/treatment under GA with a longest wait of approximately 183 weeks. The service is significantly reduced access to theatre hours, private theatre alternative providers is being explored. A QIA will need to be completed where appropriate when considering alternative providers.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	9 (C3xL3)	↔	20.04.2023	30.12.2024	21.02.2025
16	5961	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Estates Directorate	Sustaining Our Future	Environmental / Estate / Infrastructure	Remedial roof works to resolve the water ingress at POWH. Then: water ingress will continue to be a problem. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTH.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations to vacate flat floor wards & depths of Phase 1 being managed under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. Decant plan agreed 15th Oct. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport, Workforce, Digital, Facilities, Patient Safety, Communication. In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update January 2025 Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 8th October 2024. Contractor has been appointed. Welsh Government funding £26.524m was approved Friday 8th November. Contractor started the roof replacement programme on Monday 11th November. Phase 1 has prioritised Maternity and Special Care Baby Unit, on target to hand over to the clinical service on Monday 13th January. Contractors and any staff that need to be in any of the first floor areas must wear hard hats and hi-vis vests. Full programme including Theatre F&N works and fire compartmentation above vacated wards and depths due to be completed mid August 2025.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	8 (C4xL2)	↗	21.10.2024	06.01.2025	28.02.2025	
35	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. 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 recovery 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	•Contract: 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 R&R rating of £10.0m Green, £12.1m Amber and £0.9m Red. • R&R Update: The HB VTO position is now a £9.6m deficit (M7: £3.2m). This includes a £9.6m shortfall in savings delivery offset by other favourable variances of £(9.2)m. The significant improvement reported in HB was due to £7.5m of additional financial support received from H&G. As a result of this support, the Health Board has managed to maintain a forecast break-even position at HB. The net risk to the forecast breakeven position have also reduced to £3.6m (M7: £11.7m). • The following actions are in place to maintain a forecast break-even position for 24/25: •Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline delivery of £24.26m as well as schemes in place for 24/25. •Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improving going forward. •Develop the Value & Efficiency Programme with a focus on 'nabbing schemes' to support savings identification and delivery.	Operational Delivery Committee	16	C4xL4	12 (C4xL3)	↓	30.04.2024	17.12.2024	28.02.2025		
36	4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care Sustaining our Future	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	Update as at January 2025 Project Initiation Document drafted to capture the activity needed to support the review of the Non Clinical Written Control Documents process. This will include but is not exhaustive of the following areas: Explore available options to automate the process including a filing portal and automatic prompting. Explore if the process for the policy on policies for Non Clinical written control documents could be simplified. Review the policy library linked to the SharePoint site Produce a baseline position as to the status of all non clinical written control documents Timeframe - December 2025. Risk escalated as likelihood of increased due to the capacity constraints impacting the teams ability to undertake the mitigating actions required.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↗	26.10.2021	12.12.2024	28.02.2025	
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A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Date 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 Committee	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety	CCTV System Failure in Prince Charles Hospital	IF: Major CCTV security management platform (SMP) headend and camera outage at PCH. Unable to live view live data images at the security control centre. NVR recording function is not available to record data images. The outage is also linked with the PCH site refurbishment scheme. The Capital Major Projects team advise that the new (SMP) headend server is not part of the PCH scheme as there is no funding for it. THEN: As a consequence this presents a site security with very limited site surveillance available to identify site incidents and provide evidence of criminal activity and crime. Resulting in: The ground floor, first floor and external site areas require the roll out of (124) new CCTV cameras as part of the PCH refurbishment scheme and the existing old (SMP) headend server does not have the functionality and capacity to accept these additional cameras therefore the contractor TD are unable to roll out the new cameras on site until a new SMP is installed. Risks to the PCH site, patients and staff safety risk. Site risk of theft, property damage and personal injury/assault.	Incident meeting held by Facilities with Digital ICT, Estates, the system contractor and Capital Major Projects team who are managing the PCH site Major project scheme to review the faults and aim to resolve the issue.	Update October 2024 added in red to August update - The Estate CCTV system contractor attended site and identified the root cause of the system failure and restored the PCH security management system headend and power to the majority of existing site cameras. The outcome and recommendation from the system contractor, Capital Major Projects team and TD is that there is further CCTV system replacement and upgrade of hardware and software work to be undertaken. The existing Security Management Platform (SMP) which is the headend control system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced, the G/FF contractor will also be unable to fully install the (124) new site G/FF scheme CCTV cameras and a 'moderate' risk of future system failure remains until this work is completed. A specification and estimate of cost of a new (SMP) headend has been completed and funding has been approved. Waiting for a contractor to be allocated the work and an installation date to install the SMP system. Following a recent tender process a supplier has been awarded the contract and the work to install the security management platform headend is due to commence in November 2024. Security Systems Risk Assessments A rolling programme of security vulnerability risk assessments is being undertaken out at a number of sites that include the suitability, compliance and provision of current CCTV and control of access systems and where systems may require replacing and upgrading or where site system provision is inadequate. Where there is a requirement for replacement/upgrade or additional systems further work is then required with support from Estates and Digital Services to complete the system technical specifications before a statement of need is provided to the Operational Capital Group for replacement or new works and security hardware/software scheme funding. Update January 2025 - It is anticipated that the work to install the new Headend will not take place until January 2025. The review date for this risk has been amended to 31/01/25 so that the action to mitigate the risk can be updated as soon as work commences.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	C3xL4 12	↔	31.01.2024	16.12.2024	31.01.2025
5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety	Cross Health Board Data Sharing	IF: Digital services across Wales are unable to share 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 boundaries of Aneurin Bevan Health Board. As a health board we cannot raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTM/UBH 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. As of March 2024, the update from DHCW is that they working on delivering the open architecture to support sharing documents and diagnostic results. Update November 2024 - DHCW have confirmed they are anticipate the work will be undertaken in March next year to resolve this issue. CTM have reiterated the specific issues that need resolving. Risk remains the same until DHCW complete this work. Update January 2025 - No change to progress or risk score. Next review scheduled for 31.3.2025. CTM leads continue to follow up and raise at relevant stakeholder meetings.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	30.12.2024	31.03.2025	
5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff /Public Safety	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care	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 rates 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	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 October 2024 - The Planned Care - Care Group is currently undertaking a full gap analysis of the ITU service in line with the current dietetic position, but that this will be kept under review. Update January 2025 - Update from 21.11.24 - Risk reviewed following Princess of Wales Hospital critical incident, and remains unchanged at 16. Awaiting planned care group workforce gap analysis.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	19.12.2023	01.01.2025	28.02.2025
5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	The impact of 'Right Care Right Person' (RCRP) approach	IF: South Wales Police (SWP) implement Right Care Right Person Then: In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. Resulting in: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register.	Update January 2025 - Risk reviewed no change RCRP Health Board Regional position meetings with SBUNB and C&VUBH implemented Phases 3+4 implementation delayed until 10/03/25 - correspondence available from South Wales Police. RCRP is MHLd Care Group top investment priority in 2025/26 IMTP.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3xL4)	↔	08.12.2023	07.01.2025	31.03.2025
5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	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 PDPN (2-7yrs Metherly 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 October 2024: Meeting between DTFS, public health, planning, children and families care groups and growing well strategy leads on 17/10/24. Agreed model of care for CYP WMS and priority areas are level 1 and level 3 for business case. Agreed to develop a phased approach over 3 years. Next steps are wider engagement with care groups and refining the current business case to reflect decisions within the meeting. Business case to be developed for early Q4. Update January 2025 - The risk has had a change in risk handler and a detailed review is scheduled for the 8 January 2025. Further update will be provided in the next iteration once the new handler has had time to review the risk.	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	01.1.2025	28.02.2025
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 (Contaminability 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 Manager The team are having to apply an objective triage approach across the portfolio of redress, LFRs and Inquests to support the mitigation of this risk.	Update October 2024: Over the summer, all Redress cases have been reviewed by the senior staff member allocated overtime, with priorities identified for each case. The Legal Services team is currently depleted of staff, by 4 Claims Investigation Officers and 2 Legal Administrative Staff, which is due to sickness levels and members of staff leaving the organisation. This is having an effect on the workload of the Legal Services team. Staff members are being managed and supported appropriately through the Managing Attendance at Work Policy. The recruitment process of staff is also underway and the team are/have temporarily recruited agency staff to address the issues identified above, relating to management of legal cases. The agency staff recruited to be recruited are: • 2 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of February 2025; • 2 legal agency (solicitors) are being recruited, to cover the immediate gap in case management of Redress and Inquest cases. It is anticipated they will commence in November 2024 - for an initial period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety. It is proposed that both Datix ID 4907 & 4908 are amalgamated as one for the next ARC meeting as both the risks relate to Legal Services/Concerns and are of the same nature of risk. Update January 2025 - A full and robust review of both risks 4907 & 4908 will be undertaken in readiness for the next iteration of the risk register. No change to current risk score of 16.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	09.01.2025	28.02.2025
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 is 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, LFRs and Inquests to support the mitigation of this risk.	Update October 2024: The Legal Services team is currently depleted of staff, by 4 Claims Investigation Officers and 2 Legal Administrative Staff, which is due to sickness levels and members of staff leaving the organisation. This is having an effect on the workload of the Legal Services team. Staff members are being managed and supported appropriately through the Managing Attendance at Work Policy. The recruitment process of staff is also underway and the team are/have temporarily recruited agency staff to address the issues identified above, relating to management of legal cases. The agency staff recruited to be recruited are: • 2 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of February 2025; • 2 legal agency (solicitors) are being recruited, to cover the immediate gap in the management of legal cases. It is anticipated they will commence in November 2024 - for an initial period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety. It is proposed that both Datix ID 4907 & 4908 are amalgamated as one for the next ARC meeting as both the risks relate to Legal Services/Concerns and are of the same nature of risk. Update January 2025 - A full and robust review of both risks 4907 & 4908 will be undertaken in readiness for the next iteration of the risk register. No change to current risk score of 16.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	09.01.2025	28.02.2025
5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment /Estates/ 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 D&P by March 2024 • Board and Committee cover papers also now include environmental impact against S&S. • Sustainability Manager commenced.	Update January 2025: Mitigating action continues to undertake work to assess the environmental impact of projects and programmes that are not classed as "sustainability" projects/programmes. Timeframe is 30th April 2025. Currently score remains unchanged.	Strategic Development Committee	16	C4xL4	8 (C4xL2)	↔	21.2.2023	23.12.2024	28.02.2024
4337	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Digital Systems	Creating Health	Operational: Business Objectives Environmental / Estates Impact Projects	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. SBUS 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 operational 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 ABIB Clinical Workstation or Local Authority system. Numerous delays in NHS Wales progressing open architectural approach which results in CTM UBH 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 November 2024: A workshop is planned (15/11/2024) to look at the implications of the critical incident at POW related to the roll out of the WPAIS and clinical systems plan. Update January 2025: WPAIS integration is still on track 16th May 2025. The number of active patients to be transferred across has been rescope after discussions with DHWC and SBU.	Operational Delivery Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	26.12.2024	28.02.2025
4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety	Non Compliance with Mandatory Violence and Aggression Training	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 trainers 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 August 2024 - The proposal paper was submitted to the Mental Health Care Group Health and Safety meeting with a recommendation which was not accepted. Personal Safety Advisor discussed that the option was not feasible at the latest Mental Health Care Group Health and Safety meeting July 16th. The Health and Safety Committee has requested a further options paper. Further meetings with the Mental Health Care Group underway to discuss training options. Options discussed employing dedicated team or buying in training both options involve a significant financial commitment - Further meeting arranged for September 2nd. In the meantime PMVA training will be delivered up until December 24 Update January 2025 - This risk has now been transferred to the Mental Health Directorate and not longer sits within the Corporate H&S Team. From 1st April 2025 Mental Health will be contracting with an external provider to deliver this training.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	23.12.2024	30.03.2025	
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Date 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
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 a. Statutory Duty / Legislation	Following several serious incidents following patients absconding from clinical areas, the HSE have issued an Improvement Notice on Bridgend Integrated Locality Group (see Documents) In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. If: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update August 2024 - Report received by Operational Capital Group and recommendations for work will be made to Executive Capital Management Group in September 24. Update November 2024 - following assessment recommended priority POW supported by ECMG Oct. Pre-dated POW Critical Incident so review meeting in W/C 40. Now to check this is still feasible and right. No change to risk score. Update January 2025 - The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of this risk, however, they will endeavour to ensure a review is captured in the next iteration.	Health Safety & Fire Sub Committee	16	C4 x L4	8 (C4xL2)	↔	30.09.2020	01.11.2024	31.01.2025
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	Due to business sensitivities the detail of this risk will be captured in closed session.			Operational Delivery Committee	16	C4 x L4	9 (C3xL3)	↔	03.05.2021	20.12.2024	28.02.2025
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	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 FRB 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 2025: Following the identification of risks with the hospital roof in Princess Of Wales Hospital, the first floor of the Hospital has had to be vacated to allow the remedial roofing works to take place. As a result, this has emptied the Theatre template and will therefore make the current FEN invalid. Discussions with South Wales Fire & Rescue Service have led to them withdrawing the Fire Enforcement Works in this area due to the area now being unoccupied and the ongoing programme of work to satisfy the issues in the FRB. The Fire Service will continue to monitor the Health Board's progress with these works to ensure the Main Theatres are fully fire safety compliant prior to the Health Board taking back occupancy of this area.	Quality, Safety & Experience Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	06.01.2025	31.03.2025
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 Disputed 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 anonymised CT oncology server, WCP & E-forms etc. Technical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NDR /CDR & Sharing arrangements) Coding transformation programme - Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days of maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using anonymised 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 November 2024: Day forward continues to maintain 68 hour targets. Destruction has started to take place in Williamstown Hub for the CT notes all be it on a small scale, work ongoing to review speed and scale within available resource. No change to risk score. Update January 2025: The Critical Incident (CI) at PoW has impacted the Medical Records service. However, we continue to make progress with the reallocation of notes due to the pressures in our Bridgend sites to Williamstown Hub and this has resulted in us reducing the usage of storage containers by 1 in the last month.	Operational Delivery Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	20.12.2024	28.02.2025
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 registry 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 of the GDPR, safeguarding and information.	A Nystdin 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 fulfilment 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 CardIS) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying resources 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 tenuous 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. Until still awaiting availability of access to key HB data such as radiology and tests results.	Update November 2024 - Ethical Healthcare report has been received and is being reviewed. Update on modular EPR to Board is planned for November. Update January 2025 - Since the Autumn work has continued on planning the next steps for EPR. We will be submitting the next phases into our IMTP submission to Board to be approved at the end of March.	Operational Delivery Committee	15	C3xL5	9 (C3xL3)	↔	07.02.2022	08.01.2025	31.03.2025
3337 (Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer	Central Support Function: Digital & Data	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	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 CTHUMB staff who currently use WCCES via local authority over to CTHUMB WCCES platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLSD 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 October 2024 - risk reviewed, no change A business case has been put together with another Health Board to bring a single patient record system into the Care Group. The business case has been approved and Welsh Government have agreed funding. A programme board will oversee the implementation. Update January 2025 - Risk reviewed, no change, see uploaded Decembers newsletter for progress which is available upon request from Dates.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	07.01.2025	31.03.2025
4691 (Linked to RTE Risks 4803, 4799, 3273 and 3015.	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 recommending 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 October 2024 - Risk Reviewed no change. Risk will be transferred to new MHLSD Service Director when the post holder commences in late November. Update January 2025 - Risk Reviewed no change at this stage.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	07.01.2025	31.03.2025
5820	Executive Director of Public Health	Public Health - Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety	Impact on the safety – Physical and/or Psychological harm	If as a result of the reduced allocation of Health Protection resources the Health Protection Team has insufficient resources to deliver a safe and sustainable service. Then there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIP. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. Resulting in avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update January 2025 - This risk is due for review on 31st Jan 2025. Following the Health Board allocation letters, there has been an increase to the Health Protection (HP) funding allocation from Welsh Government, however, the impact of this will need to be evaluated against the current gap and the HP strategic plan.	Quality, Safety & Experience Committee Strategic Development Committee	12	C4xL3	8 (C4xL2)	↔	01.07.2024	03.01.2025	28.02.2025	
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Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
4080	Executive Medical Director Executive Director of People	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 January 2025 - Risk de-escalated. The risk is being managed through the Care Group Structure and scrutinised through the Medical Workforce Productivity Programme (MWPP) via relevant workforce and medical leaders. Core spend has increased. Agency usage has reduced but this has been offset against bank spend. The overall position remains above the previous 12 months and the risk will continue to be monitored through MWPP.Consequence risk lowered as contingencies are in place through agency agreements if low staffing situation does become unmanageable.	Quality, Safety & Experience Committee Operational Delivery Committee	12 Risk descreased from a 15 to a 12	8	Update January 2025 - Risk de-escalated. The risk is being managed through the Care Group Structure and scrutinised through the Medical Workforce Productivity Programme (MWPP) via relevant workforce and medical leaders. Core spend has increased. Agency usage has reduced but this has been offset against bank spend. The overall position remains above the previous 12 months and the risk will continue to be monitored through MWPP.

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	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
1											
2	No risks proposed for closure from the Organisational Risk Register this period.										



Agenda Item

5.2

Audit, Risk & Assurance Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	13/02/2025
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

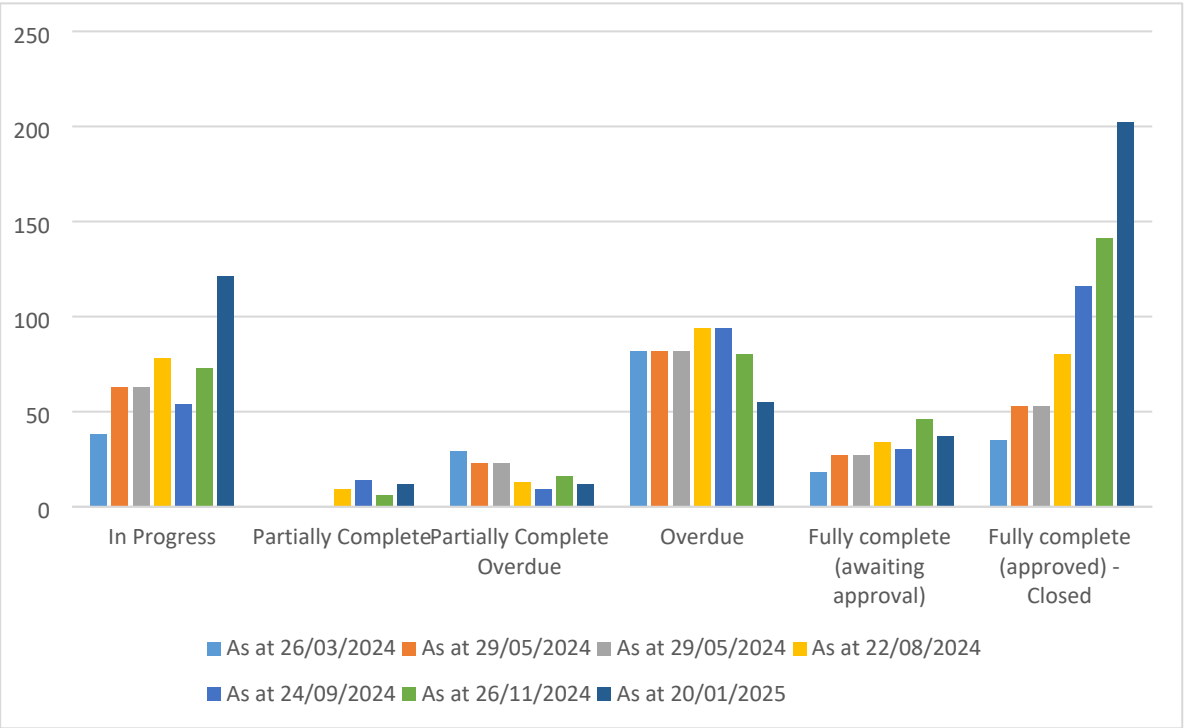
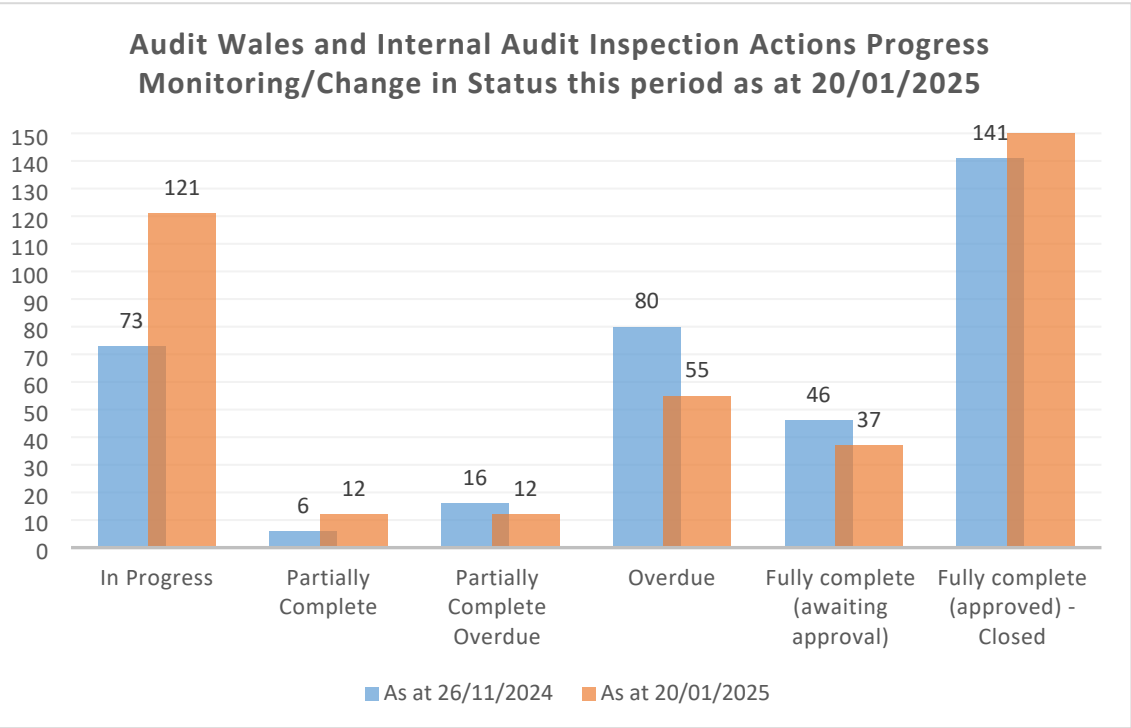
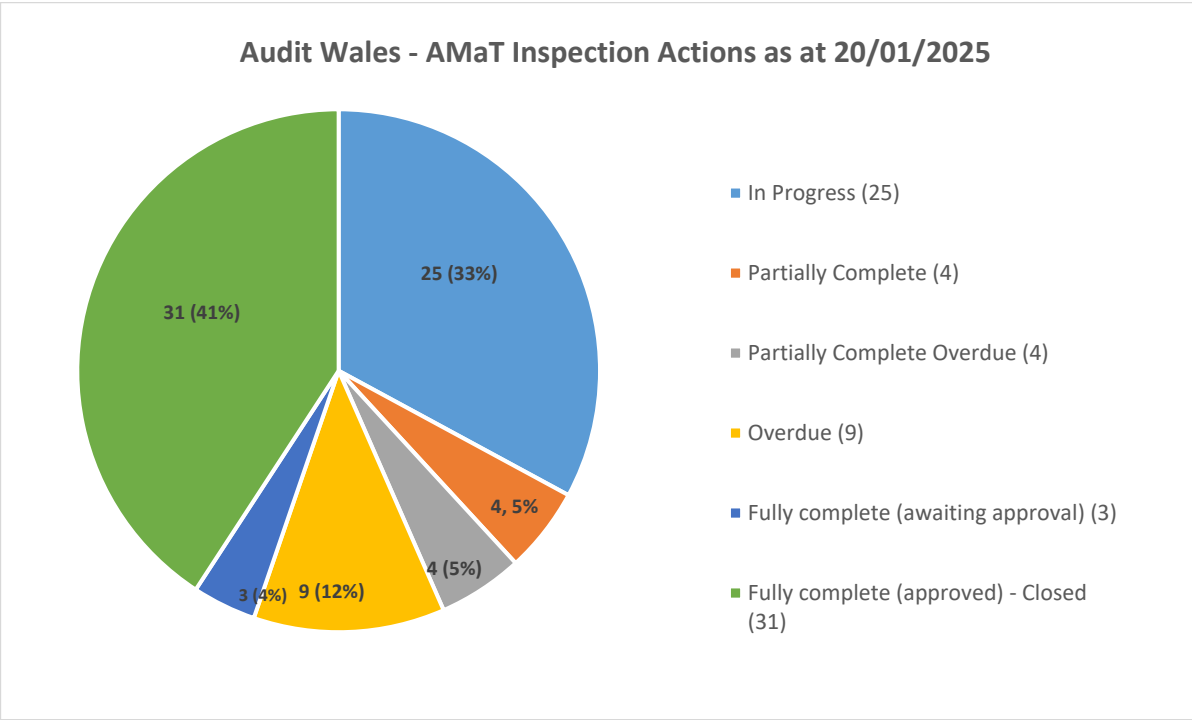
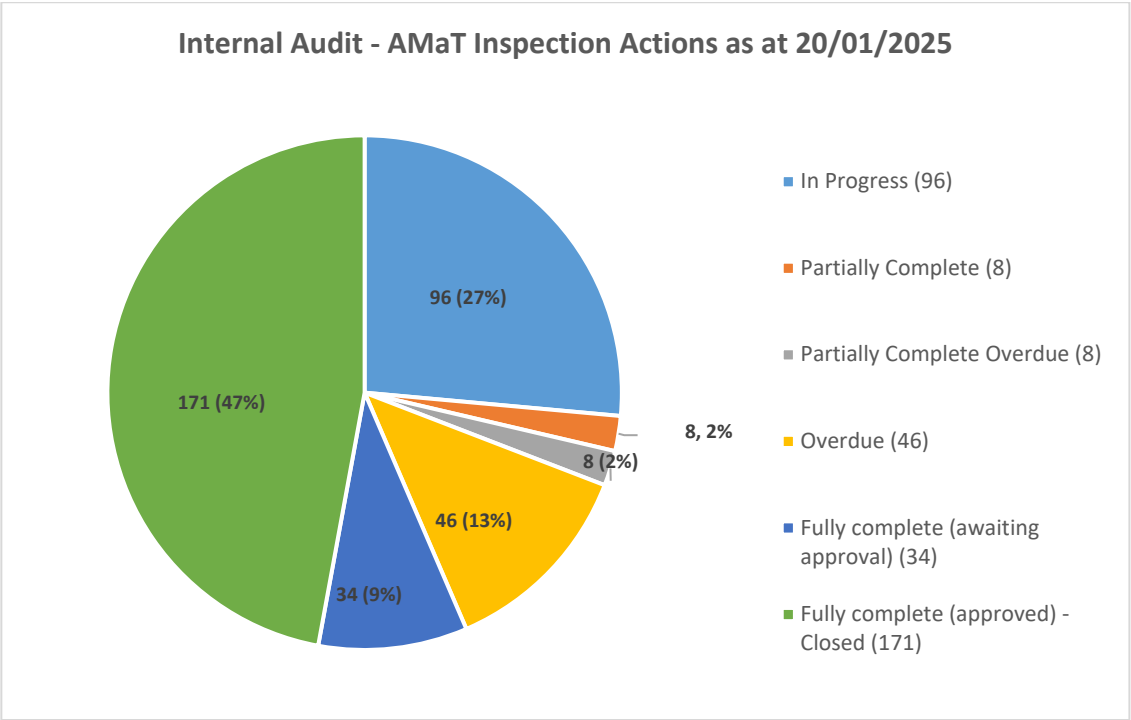
Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	3 rd February 2025	Reviewed and Management Sign Off Received.

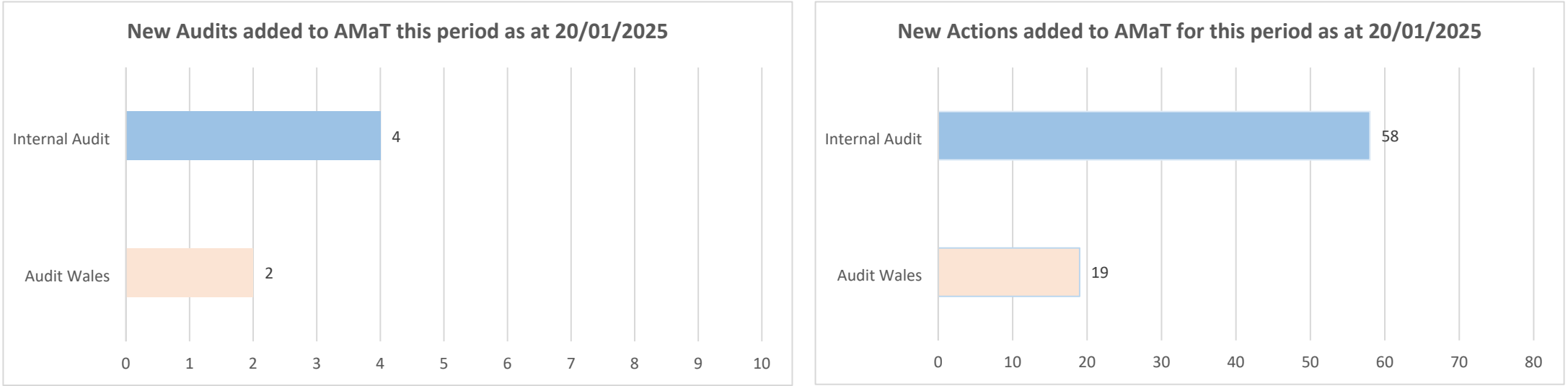
Acronyms / Glossary of Terms	
AMaT	Audit Management and Tracking
HIW	Healthcare Inspectorate Wales

Tracker Dashboard

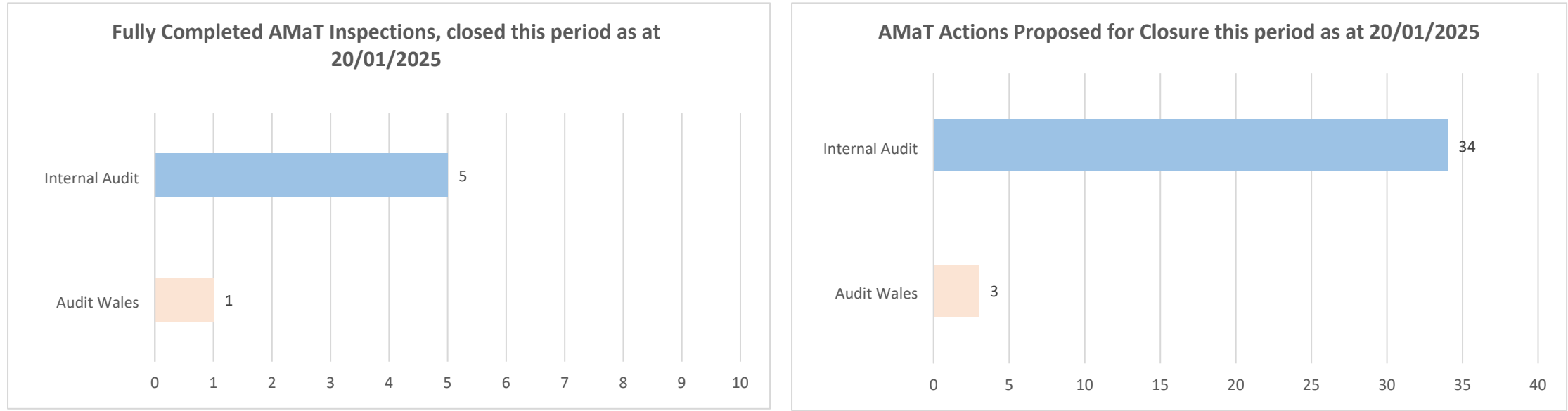
Status: Inspection Actions:



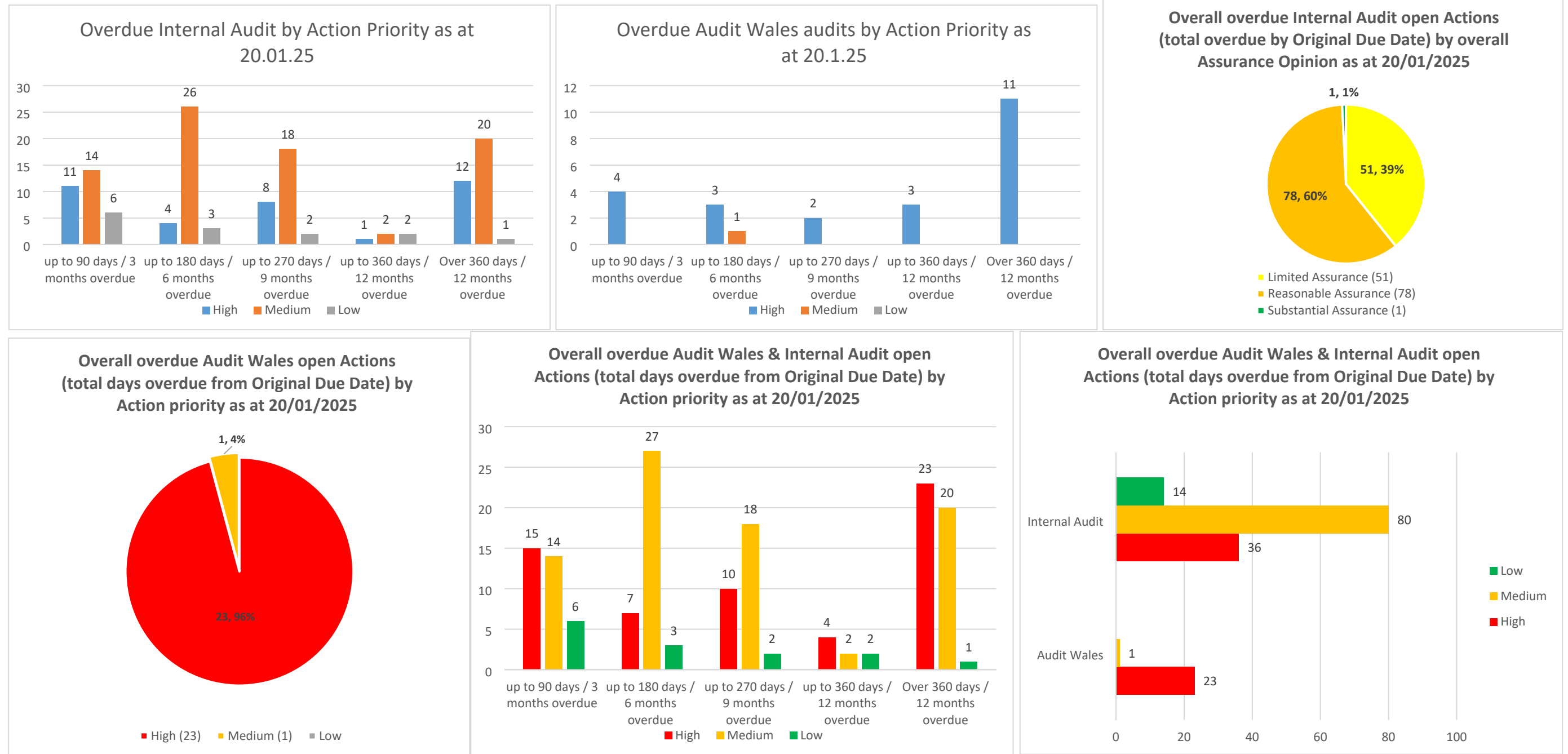
New Inspections/Actions added to AMaT



Closed Inspections:



Performance Dashboard



1. Background

- 1.1 The main purpose of this report is to present an update to the Audit & Risk Committee on reported progress of audit report recommendations in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module.
- 1.2 The scope of this report relates to both internal and external audit review recommendations. Information from HIW included for information only as this was received at the Quality, Safety & Experience Committee on the 21 January 2025.

2. Specific Matters for Consideration

- 2.1 In response to previous feedback from the committee, the overdue dashboard remains present in this report to provide the Committee with continued oversight in terms of overdue actions and their correlation to a limited assurance or high priority status action. Please note that this data has been populated as overdue from the original due date which differs from calculations within AMaT which takes into account the revised dates.
- 2.2 As indicated in graph 4 of the 'Performance Dashboard' (page 4), there has been a decrease in the number of overdue actions since the last report in December 2024. In terms of overdue actions from an Internal Audit perspective there has been a reduction of **9 Medium Priority** and **3 High Priority** actions. Additionally, in the case of Audit Wales overdue actions there has been a reduction of **1 Medium priority** and **5 High Priority**.
- 2.3 In relation to those actions which have exceeded a 12 months overdue status, graph 3 of the 'Performance Dashboard' (page 4) indicates that there are **20 Medium Priority** and **23 High Priority** recommendations, compared to 30 Medium Priority and 33 High Priority reported in the report received at the December Committee meeting showing a reduction in outstanding actions overdue by greater than 12 months.
- 2.4 It is evident from the dashboard data that improvements are being made to re-evaluate and address these overdue actions to ensure that any achievable open, overdue actions are prioritised and completed. However, it is important to note that there is a need for continued and sustained momentum in the evaluation and addressing these high priority actions.
- 2.5 As previously outlined, the focussed programme of work continues with the Executive Team to review all overdue actions within their remit. The Director of Corporate Governance/Board Secretary is continuing to liaise with Executive Directors in terms of the need to review overdue recommendations.

- 2.6 Work continues to cleanse the tracker and identify any recommendations which may have now become irrelevant or obsolete so that they may be closed ensuring the focus is on current, existing and ongoing governance and assurance priorities of CTM. Ongoing discussions with Executive colleagues and Internal Audit are continually progressing as well as regular meetings with the Business Managers for each Care Group in order to track the progress of ongoing Audit Recommendations.
- 2.7 Work on the cleansing of data has concentrated on the area of the Chief Operating Officer owing to the volume of recommendations in that area. Members of the Committee will note that 11 Internal Audit and 1 Audit Wales recommendations from that area are proposed for closure at this meeting. My work on data cleansing has also progressed and I will be recommending that a number of recommendations are closed or marked as being superseded. I plan to meet with colleagues in the Chief Operating Officer Office and Internal Audit to outline my findings and will report on the outcomes of this to the May Committee meeting. My attention will then turn to other Directorate areas with a view to achieving full coverage by the autumn of 2025
- 2.8 Progress on this work continue to be reported to this Committee following appropriate Executive approval at Executive Leadership Group before closure on the system. As at January 2025, there are **37 actions** proposed for **closure** this period.
- 2.9 The current position on the status of recommendation actions can be viewed in *Appendix 1*, with the most recent updates provided in red. Whilst this has been reduced as a result of the transition to AMaT, there is still the requirement for a hybrid approach including the manual manipulation of data to produce the required reports and system developments and requests continue to be made with the AMaT developers. This does mean that strict deadlines for updates must be adhered to. The team continue to work closely with the system development team to prioritise adjustments and developments to the system allowing a more governance focussed approach.
- 2.10 The Quality Assurance and Compliance team continue to support Care Groups in the transition to providing updates directly onto the system. This continues to be a "work in progress" whilst Care Groups adjust to following the prescribed process. The system development gaps in the AMaT system continues to be a necessitate a prescribed process that must be strictly adhered to in the independent updating of AMaT to ensure the team are able to provide a robust level of assurance of the governance process supporting the production of the Audit Tracker report.
- 2.11 As mentioned above, the engagement on CTM's development requests with the software developers continues and the current development plans are available upon request.

2.11 Tracker Updates

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

- **4 New** Internal Audit Review has been added to the Audit Recommendations Tracker including **58** new actions.
- **5** Internal Audit Inspections have been completed and **34** re are proposed for **CLOSURE**.
- **51** Overdue with Limited Assurance.

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

- **2 New** External Audit Review has been added to the Audit Recommendations Tracker which includes 19 new recommendations.
- **1** Audit Wales recommendation has been completed and **3** Recommendations are proposed for **CLOSURE**.
- **23** overdue High Priority Open actions.

Health Inspectorate Wales (HIW) - Reports from Healthcare Inspectorate Wales will be included in brief for noting and observation. The HIW tracker is included at Appendix 2, however, the Committee should note that this was received by the Quality & Safety Committee at its meeting on the 21st January 2025:

- **0 New** agreed Improvement Plans added resulting in **0 New** actions.
- A significant amount of work has been undertaken during recent months cleansing the HIW data and this has resulted in:

425 Inspection actions **Fully Complete-Closed** and a further **35** actions were fully complete and awaiting approval. The Head of Quality Assurance and Compliance continues to work closely with Inspection leads in providing assurance of the completion of actions which is reflected in the high number of closures seen in this period

3. Key Risks / Matters for Escalation

- 3.1 The audit tracker will continue to be updated with a targeted focus on actions where the implementation date has passed with reference to the targeted programme of work and the performance dashboard indicating the areas of concern.

4. Assessment



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

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



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

5. RECOMMENDATION

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

AMaT Inspection Code	Title	Date of Inspection	Assurance Rating	Recommendations	Actions
Audit Wales/2021/144	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	01/08/2021	Not Applicable	7	7
Audit Wales/2021/7	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	01/08/2021	Not Applicable	2	2
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	Not Applicable	5	5
Audit Wales/2023/149	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	01/10/2023	Not Applicable	6	6
Audit Wales/2023/150	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	01/11/2023	Not Applicable	9	9
Audit Wales/2023/18	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	01/02/2023	Not Applicable	8	8
Audit Wales/2023/23	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	01/03/2023	Not Applicable	3	3
Audit Wales/2024/168	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	01/02/2024	Not Applicable	6	6
Audit Wales/2024/196	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	01/07/2024	Not Applicable	1	2
Audit Wales/2024/205	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	01/08/2024	Not Applicable	7	7
Audit Wales/2024/212	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	30/11/2024	Not Applicable	6	11
Audit Wales/2024/213	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	31/10/2024	Not Applicable	8	8
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	Reasonable	2	2
Internal Audit/2020/74	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU 1920-45b)	24/01/2020	Reasonable	1	1
Internal Audit/2021/76	Sunnyside Health & Wellbeing Centre_Final Internal Audit Report August 2021 (Review reference: CTMUHB_1920_03)	06/08/2021	Reasonable	15	15
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	Reasonable	1	1
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	Limited	13	13
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	24/10/2022	Reasonable	5	5
Internal Audit/2022/95	Follow-up: Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-31)	15/06/2022	Reasonable	1	1
Internal Audit/2022/97	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	10/10/2022	Reasonable	1	1
Internal Audit/2023/100	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	31/05/2023	Reasonable	3	3
Internal Audit/2023/107	Decontamination_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	08/08/2023	Reasonable	5	5
Internal Audit/2023/113	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	08/08/2023	Reasonable	8	8
Internal Audit/2023/117	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	28/07/2023	Reasonable	2	2
Internal Audit/2023/124	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	31/05/2023	Reasonable	4	4
Internal Audit/2023/146	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	11/10/2023	Limited	8	8
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	09/10/2023	Reasonable	5	5
Internal Audit/2023/37	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17)	06/06/2023	Limited	5	5
Internal Audit/2023/54	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	06/02/2023	Limited	7	7
Internal Audit/2024/162	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	06/02/2024	Limited	15	15
Internal Audit/2024/163	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	08/02/2024	Reasonable	11	12
Internal Audit/2024/169	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	11/04/2024	Reasonable	17	18
Internal Audit/2024/170	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	12/04/2024	Limited	7	7

AMaT Inspection Code	Title	Date of Inspection	Assurance Rating	Recommendations	Actions
Internal Audit/2024/171	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	09/04/2024	Limited	9	9
Internal Audit/2024/172	Follow-up: Digital Operating Model Final Internal Audit Report_April 2024 (Review reference: CTM-2324-24)	02/04/2024	Reasonable	2	2
Internal Audit/2024/187	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	06/06/2024	Reasonable	4	7
Internal Audit/2024/188	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	11/06/2024	Reasonable	5	9
Internal Audit/2024/189	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	07/06/2024	Reasonable	6	6
Internal Audit/2024/190	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	03/06/2024	Reasonable	9	9
Internal Audit/2024/192	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	04/06/2024	Reasonable	15	27
Internal Audit/2024/199	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	04/10/2024	Reasonable	7	8
Internal Audit/2024/200	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	16/09/2024	Reasonable	7	8
Internal Audit/2024/201	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHB-2324-23)	16/10/2024	Reasonable	2	5
Internal Audit/2024/202	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference -CTM-2324-25)	02/10/2024	Reasonable	4	4
Internal Audit/2024/203	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	27/09/2024	Limited	9	9
Internal Audit/2024/204	Follow-up: Facilities Governance Arrangements Final Internal Audit Report - October 2024 (Review Reference - CTMUHB 2425-27)	07/10/2024	Substantial	2	2
Internal Audit/2024/211	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09)	10/12/2024	Limited	21	36
Internal Audit/2024/214	Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19)	12/12/2024	Reasonable	4	4
Internal Audit/2024/215	Charitable Funds 2024/25 (Review Reference CTM-2425-20)	09/12/2024	Reasonable	4	4

Audit Recommendations Tracker
AMaT Actions - Status Key

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

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2021/144	01/08/2021	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 123A2017)	Audit Wales/HIW Quality Governance Follow Up Review R3.5 Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: a- Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety b- Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates c- Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety	Audit Wales/2021/144/MD3/1	Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive Executive Director of Therapies & Health Science	01.10.2021	31.10.2024	High	Partially complete (Overdue)	January 2025 - An Executive Director led quality and patient safety Huddle takes place each week. Within the Huddle quality metrics capture a greater breadth of HB services and functions, including detailed discussion of quality and patient safety information: patient safety incidents, complaints and concerns and patient experience. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2021/7	01/08/2021	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2020-21 (Document reference: 2535A2021-22)	Matter arising 2 - 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.	Audit Wales/2021/7/MD2/1	There is a context to the DoTHS delay, for example, which is that the situation was novel, and required Welsh Government banding for a new joint role, which took some time.	People Executive Director for People	31.08.2021	31.05.2024	High	Fully complete (Awaiting approval)	January 2025 Update - The All Wales Flexible Pension Policy was published by the Welsh Partnership Forum in October 2024 and formally adopted by the People and Culture Committee on the 5 December 2025. The policy has been published on the CTM Policy SharePoint page and is being used by managers and staff. All actions associated with this risk have now been completed. It is recommended that the risk is closed. A copy of the new All Wales Flexible Pensions Policy has been uploaded as evidence. November 2024 Update - An update against this recommendation has not been provided on this occasion.
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.	Audit Wales/2022/12/MD3/1	Agreed. Within the new governance structure there will be an integrated resources group which will be tasked to develop the risk management framework.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.01.2025	High	In progress	January 2025 update - work continues on the ICCS as set out below - which includes shared resources to manage shared risks across the region. November 2024 Update - Bridgend, Merthyr Tydfil and Rhondda Cynon Taf County Borough Councils and Cwm Taf Morgannwg University Health Board (CTMUHB) have agreed to work together, with other Regional Partnership Board partners, to create an integrated community care system for older people and people living with frailty which is capable of meeting changing and increasing community need. The planned Integrated Community Care System (ICCS) where multidisciplinary teams will work on cluster footprints across the region. The ICCS will be based on two new community pathways – Urgent Community Response and Population Health Management, where the Urgent Response Pathway may be accessed primarily through a Navigation Hub. A new management model – comprising integrated management roles and shared resources, is seen as necessary to deliver integrated services effectively.
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.	Audit Wales/2022/12/MD6/1	Agreed. The development of the RIF delivery plan is only one funding stream and TLPB recognises that we will need to align core budgets, for example around children with complex needs. This will be addressed through the planning cycle in advance of 2023/24.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.01.2025	High	In progress	January 2025 Update - the MOU set out below is currently being taken through the Boards of statutory partners for sign off. November 2024 Update - "MOU has been drafted under the provisions of Part 9 of the Social Services and Wellbeing (Wales) Act 2014. • The MOU sets out the ambition of partners to develop a single Regional Partnership Agreement, which will be in place from April 2025 and reviewed annually, for delivery of services within the new community pathways set out in the ICCS. It has been agreed that a Section 33 Agreement is the appropriate vehicle for achieving this. The new RPA will supersede existing legally binding partnership agreements.
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"	Audit Wales/2022/12/MD7/1	Agreed. Regional workforce development arrangements exist through SCWDP Board workforce development group and work is underway to strengthen links with RPB and Health.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	31.03.2023	31.01.2025	High	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - Ongoing discussions to expand and strengthen the Social Care Workforce development group to better align with regional integrated pathways developments.
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).	Audit Wales/2023/149/MD6/1	The Health Board has developed a working version of the Performance Framework, however it does require updating to reflect the new organisational structure and the latest Welsh Government performance framework. This activity will be undertaken before 31st December 2023 and presented to the first meeting of the Planning, Performance & Finance Committee in 2024 (currently scheduled for the 27 February 2024), for approval.	Performance Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	01.02.2024	01.02.2024	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - The performance structure for the IMTP is set out in the reports provided to board. The formal framework document is under review.
Audit Wales/2023/150	01/11/2023	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUHB 2022-23_November 2023 (Document reference: 3727A2023)	Audit of Accounts Addendum 2022/2023 R3 The Health Board should ensure that its primary-care working papers are clearly cross referenced to the relevant figures within the financial statements. The Health Board should also ensure that, where spreadsheets are the underlying evidence base, all cell values have an appropriate audit trail (typically formula based) and that manually entered figures are used sparingly, when they are the only valid option.	Audit Wales/2023/150/MD3/1	There were changes to the staff preparing the primary care working papers at the end of the financial year, therefore some working papers provided were incorrect at the draft stage. However there was an improvement in the timeliness of providing working papers on the Audit system compared to previous years. The audit team were subsequently able to meet with the team who prepare the primary care figures and agree the figures for the final accounts. The financial accounting team will liaise with the finance officers completing the working papers for primary care to ensure the latest working papers are provided with clear links to information included in the annual accounts.	Finance Executive Director of Finance	01.04.2024	01.04.2024	High	Partially complete (Overdue)	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - Financial Accounts are liaising with the accounting officers responsible for Primary Care to agree mapping of codes to allow full reconciliation to returns. This will be implemented in readiness for the close down of the 2024/25 accounts.
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.	Audit Wales/2023/18/MD3/1	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable the Board to align measures to strategic priorities etc, the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.	Performance Executive Director of Strategy & Transformation (Performance Framework) Chief Operating Officer (Operational Performance) Director of Digital (Performance Information)	30.09.2023	31.12.2023	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 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 R7 Structured Assessment 2022 R7: Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions - NOT COMPLETED	Audit Wales/2023/18/MD7/1	a) The Health Board will undertake a review of the Chief Executives upper financial limit. This will form part of the review of the Health Board's Standing Financial Instructions being led by the Head of Corporate Finance. b) Capital approvals are managed through the Executive Capital Management Group (ECMG) which meets monthly and approves all new schemes and adjustments to approved capital schemes. ECMG is Chaired by the Director of Finance and the Director of Strategy and Transformation and Chief Operating Officer are also members. Since the removal of the Capital Programme Board the reporting for the capital programme and all business cases are reported through Planning, Performance and Finance Board Committee prior to being reported at the Board. It is proposed that quarterly capital reporting is reinstated through Planning, Performance & Finance (PPF) Committee and to the Board to cover updates on the capital programme and major projects. Business case over £1M will be brought through the PPF and Board Agenda prior to approval to Welsh Government dependent on project progression and Board Agendas. c) A review of all the outdated Financial Control Procedures is underway.	Finance Executive Director of Finance	31.12.2023	31.12.2024	High	Partially complete (Overdue)	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - A number of FCPs have been reviewed and approved by Audit & Risk Committee, including recently Medical Variable Pay and Charitable Funds. All other outstanding FCPs are currently updated and out for review with applicable officers. These will require formal review by finance and other relevant staff before being taken to December's Audit & Risk Committee. We anticipate the majority will be updated by end of year, but there may be a small number that require further review.
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.	Audit Wales/2023/23/MD2/1	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	01.05.2023	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - Running 'Perfect Month', Reduced LOS for Elective to 1.03 days, Running 4 cases on all day list. Condensed trauma take. Will review before changing permanently. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - An update against this recommendation has not been provided on this occasion. May 2024 Update - An update against this recommendation has not been provided on this occasion. March 2024 Update - An update against this recommendation has not been provided on this occasion. February 2024 - An update has not been provided against this recommendation on this occasion. October 2023 Update - Work continues in this area as part of the Planned Care Programme and other projects. In particular, the Prehabilitation Service has just been launched and monitoring of the GIRFT work is continuing. The UHB has paused work on the Orthopaedic Reconfiguration paused and is being reviewed alongside the launch of the CTMUHB Clinical Strategy and alignment to the emerging UHB strategy. Further updates will be available in forthcoming meetings.
Audit Wales/2023/23	01/03/2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	Audit Wales/2023/23/MD3/1	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 specialists, Nurse led, Consultant led and A&Ps. • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr Cynon and there are clear pathways in place for patients to transition from primary care into secondary care. The clinicians working within the primary care settings are working at advanced practice level.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - Based on these recommendations and feedback from local stakeholders we have integrated the CMATS service into core services to give greater sustainability and clear pathways for both referrers and patients - with all orthopaedic referrals now being triaged electronically (since October 2022 for old CTM) by a multidisciplinary team which has resulted in reduced time to triage, increased redirection to AHPs (principle of only do what you can only do) and increase in advance and guidance utilised alongside the launch of health pathways. Please note the MCAS service remains under an SLA with SBUH thus the picture for Bridgend is different. Clinicians working within the primary care settings are still working at advanced practice level until 31st March 2025 as per current funding arrangement. Each cluster is currently deciding whether they'd like to continue with their FCP provision into the new financial year. September 2024 Update - An update against this recommendation has not been provided on this occasion.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2023/23	01/03/2023	Orthopaedic Services in Wales – Tackling the Waiting List Backlog Report of the Auditor General for Wales_March 2023	Review of Orthopaedic Services R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	Audit Wales/2023/23/MD4/1	The Health Board will undertake the following in order to ensure the recommendations are achieved: • Within POWH, PREMS and PROMs data is currently being captured electronically for all arthroplasty patients and utilising the MyMobility applications AI system, patients with anticipated poorer outcomes are having enhanced Therapies input digitally. There is at present no system for PROMs or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Within POWH, all Arthroplasty patients are enrolled on the MyMobility application to provide prehab for all patients awaiting surgery to try and minimise the harm caused by delays and ensure patients are medically optimised. There is at present no system for PROMs or PREMS within the "old CT" part of the UHB, with PCH having some help from Clinical Audit. Changes would require a commitment to roll out MyMobility HB wide. • Single Clinical Director Leadership required to establish performance structure and review of current services. • Weekly performance reviews that monitor waiting list volumes and actions being taken to address and recover the position • Action plan development with single CD for performance and governance structure across CTMUHB.	Planned Care Chief Operating Officer	01.04.2024	01.04.2024	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - CTMUHB is making significant progress in embedding VBHC principles in healthcare delivery. Collection and use of PROMs is key to delivering value based care to inform decision making. Significant progress has been made to secure a new digital PROMs platform which was launched July 2024. Need to establish a baseline status of PROM collection across the Health Board. This will inform on further discussion on Care group priority areas and implementation plans.
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.	Audit Wales/2024/168/MD1/1	Work has begun on the development of the CTM SWP, approach underpinned by the KPMG action plan, next steps are:- • Using workforce data and wider information to develop high level workforce plans by staff group to enable the development of short, medium and long-term goals, with action plans, aligned to CTM 2030, in partnership with key stakeholders. Build into the plans:- • Agreed priorities aligned to the Acute Clinical Services Plan • To agree SWP actions for Llantrisant Health Park • Identify opportunities from regional working and other programmes e.g. Accelerated Cluster Working, Six Goals, HEIW workforce Plans	People Executive Director for People	01.03.2025	01.03.2025	High	In progress	January 2025 Update - some scenario plans are being developed for the nursing workforce and potentially for some areas for the ACSP. Progress continues but this action is dependant on a number of other factors such as service modelling, which may delay completion at the target date. More will be known at the end of January 2025. November 2024 Update - Short term workforce plans are developed in CGs with Heads of People. Medium and longer term plans are aligned to Regional working, ACSP and LHP. The latter are in progress but not fully developed to establish the medium and long term plans. The workforce shape and supply group is looking at the supply pipelines and where there are gaps. Service plans aligned to the IMTP are in development and will help to shape the workforce demand for the different staff groups, and any potential risks/gaps. Additionally, these will inform the education commissioning, internal education and supervision requirements. The IMTP Education Commissioning first draft to be submitted in Jan 2025. The next meeting of the Workforce Shape and Supply is in December 2024 focussing on the recruitment, retention, education and development of new roles.
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.	Audit Wales/2024/168/MD2/1	• 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	31.03.2025	High	Partially complete	January 2025 update: delays with some of the data has meant that the timelines have slipped. Expected completion of the data testing is early February 2025. Request to change the completion date to 31 March 2025. November 2024 Update - Alignment of finance and workforce data is being finalised for discussions to test the feeds in December 2024.
Audit Wales/2024/168	01.02.2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	The Health Board should 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.	Audit Wales/2024/168/MD3/1	• 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	31.03.2025	High	In progress	January 2025 Update - The assessment has been paused for POW, business continuity and Christmas. This will also align to the new Leadership training so completion dates have slipped. Request to change the completion date to 31 March 2025. Materials and tools are in development. November 2024 Update - This action has been slightly delayed due to work needed to support the POW critical incident but will be a priority over the next 2 months.
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.	Audit Wales/2024/168/MD4/1	• 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	30.04.2025	High	Partially complete	January 2025 Update - The assessment has started and is linked to the BAF. Priorities, actions, targets and trajectories to be agreed and reporting arrangements. A request to extend the action to 30 April 2025. November 2024 Update - The assessment is in development using the work of the BAF and risk register to inform the workforce risks. This is taking longer due to a number of challenges around data and capacity but is hoped to be in draft by February 2025.
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.	Audit Wales/2024/168/MD5/1	• Assessment of progress and impact of recommendations to be on the agenda for PCC June 2024. • Regular progress updates to the relevant Board Committee.	People Executive Director for People	01.06.2024	01.06.2024	High	Partially complete (Overdue)	January 2025 Update - This action was completed at PCC in June and regular updates provided. This is complete but needs to be an agenda item for the SDC / relevant committee for quarterly updates. November 2024 Update - Workforce Planning updates have taken place at PCC and updates will be provided to the new replacement Group and relevant Committees. This is on target.
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.	Audit Wales/2024/168/MD6/1	• 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	31.03.2025	Medium	Partially complete	January 2025 Update - The horizon scan draft is nearly completed. New information has been shared by HEIW which will mean the horizon scan will need updating. Request to change the completion date to 31 March 2025. November 2024 Update - The horizon scan is in draft and is anticipated to be finalised in January 2025.
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	Audit Wales/2024/196/MD1/1	As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	31.03.2023	31.01.2025	High	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	R4. Enhancing Quality and Safety Committee oversight - Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	Audit Wales/2024/196/MD1/2	Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24.	Patient Care and Safety Executive Director of Nursing/Deputy Chief Executive	31.05.2023	31.01.2025	High	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 1 - While we accepted the use of the additional narrative for the 2023-24 remuneration report, from 2024-25 the Health Board should report the gross total remuneration within the relevant tabulated figures.	Audit Wales/2024/205/MD1/1	Adjusted figures will be used for the 2024/25 accounts.	Finance Executive Director of Finance	30.04.2025	30.04.2025	High	In progress	January 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April. November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 2 - The Health Board should ensure that all its pension calculations reflect the Greenbury guidance (which provides templated calculation examples).	Audit Wales/2024/205/MD2/1	This will be actioned in full in the 2024/25 accounts.	Finance Executive Director of Finance	30.04.2025	30.04.2025	High	In progress	January 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April. November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 3 - The Health Board should review its procedure for preparing the operating leases note at the financial year-end, and make improvements where required. As part of the review, the Health Board should ensure that management review and sign-off are part of the process.	Audit Wales/2024/205/MD3/1	Due to illness there was an interim arrangement for completing note, the procedure will be improved for future accounts.	Finance Executive Director of Finance	30.04.2025	30.04.2025	High	In progress	January 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April. November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 4 - The Joint Commissioning Committee should put in place a robust process to ensure that: • all the necessary declarations of Interests (DoIs) from its senior officers and members are received soon after the financial year-end; • the DoIs are evaluated by officers to establish where an individual has control and / significant influence over a declared organisation; • thereafter and where necessary, officers undertake the relevant checks to the financial ledger to identify all relevant income, expenditure, payables and receivables to be disclosed; and • that all the above is clearly documented for the purpose of officers preparing the accounts and to enable our audit.	Audit Wales/2024/205/MD4/1	As part of the ongoing governance review for the new organisation, revision work on the DOI process for 2024 - 2025 financial year has already commenced. The new template, in the agreed format, is being used to ensure that there is clear documentation. This will ensure that the assessment of control or significant interest is complete and that the process will be robust. This will be a joint exercise between finance and governance colleagues to ensure a more comprehensive assessment and to make the financial ledger checks more integrated in the process. As part of the review of governance processes for the new organisation, both new lay members and existing members are being circularised mid year to ensure that all information requirements will be familiar in time for the year end exercise and that it will be fully complete. Regarding the end of year exercise, forms will be given to JCC members following the last JCC meeting of the financial year at the end of March, after one week members and their PA's will be followed up and again after one further week, which will continue in that manner until all forms have been returned.	Finance Executive Director of Finance	17.10.2024	17.10.2024	High	Overdue	January 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April. November 2024 Update - No update as this will be implemented on completion of 2024/25 accounts in April.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 5 - The Health Board should perform regular (e.g. monthly or quarterly) formal checks of the Prolease users who have access; and remove any users who no longer need access. The Health Board should also review the audit log to determine whether any inappropriate actions have been taken by unknown MRI users, and to promptly investigate any such actions.	Audit Wales/2024/205/MD5/1	There is an All Wales group using Prolease, so this is not fully in control of the Health Board. The group are in discussion with the supplier to establish a report which would show there is no inappropriate access. This work is ongoing.	Finance Executive Director of Finance	31.10.2024	31.10.2024	High	Fully complete (Awaiting approval)	January 2025 Update - This is now complete and reports are being run regularly and being saved. November 2024 Update - This is an All Wales system and the health board do not have control of system. Public Health Wales are in discussions with supplier to provide report to show access is not being compromised.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 6 - The Health Board should review its current data admin accounts and remove any access from staff who do not need it. This action should include the removal of any duplicate accounts. Also, the Health Board should regularly review (i.e. monthly) its privileged access accounts so that access is maintained only for the appropriate personnel.	Audit Wales/2024/205/MD6/1	All privileged network access accounts are presently being subject to review by the corporate End User Computer Team. Progress on this task will be tracked at the fortnightly EUC NISCyber review meeting and assured at the Monthly Cyber Security and Availability board. As the reviews identifies issues any accounts, changes will be enforced. An automated process for this cycle is being explored.	Finance Executive Director of Finance	29.11.2024	29.11.2024	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - No update yet, implementation end of this month.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 7 - The Health Board should migrate its RAM financial server system to up-to-date and fully supported infrastructure.	Audit Wales/2024/205/MD7/1	Plans have been made by the server team to migrate nearly all 2012 SQL servers onto supported operating infrastructure and operating systems. The date for the migration is pending awaiting confirmation from Finance system admin and the supplier.	Finance Executive Director of Finance	29.11.2024	29.11.2024	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - No update yet, implementation end of this month.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R1 - 2024 New Recommendation - The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer-term by improving the coverage of primary care matters in its routine Annual Report.	Audit Wales/2024/212/MD1/1	A Primary Care Dashboard will be finalised by end of January 2025.	Primary Care & Community Care Group Chief Operating Officer	31.01.2025	31.01.2025	High	In progress	January 2025 Update - The Dashboard is in progress and the first draft of the Dashboard is due to be considered in the February Operational Management Board (January Board cancelled due to exceptional circumstances)
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R1 - 2024 New Recommendation - The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer-term by improving the coverage of primary care matters in its routine Annual Report.	Audit Wales/2024/212/MD1/2	The requirement to expand the coverage of primary care matters in CTMUHB Annual Report for 2024-2025 and beyond has been captured in the forward planning for the Annual Report development.	Primary Care & Community Care Group Chief Operating Officer	30.09.2025	30.09.2025	High	Partially complete	January / February 2025 Update - This requirement has been added to the Annual Report submission requests for 2024-2025. The Annual Report will not be finalised until the end of June 2025 so this action will remain open until the Annual Report is published.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R2 - 2024 New Recommendations - The Health Board should clarify which committee within the new committee structure being introduced in January 2025 will be responsible for providing assurance to the Board on the organisation's arrangements for primary and community care services after the Population Health and Partnerships Committee is disbanded at the end of December 2024.	Audit Wales/2024/212/MD2/1	If the primary care matter relates to informing the Board in terms of strategic decision making with a focus of 18 months and beyond then it will be considered at the Strategic Development Committee. If the primary care matter relates to in year performance and delivery activity then it will be considered at the Operational Delivery Committee. The Primary Care & Community Service Director in conjunction with the Deputy Chief Operating Officer for Primary Care, Community and MhLD and Chief Operating Officer will notify the Corporate Governance Team of any items for agenda planning for these Committees. Corporate Governance Team to reference the requirement to consider in agenda planning meetings. Board Development programmes will also be utilised to share progress and improve visibility.	Primary Care & Community Care Group Chief Operating Officer	28.02.2025	28.02.2025	High	Fully complete (Awaiting approval)	Action completed at time of finalising management response in December 2024. Will move to "Fully Complete" Awaiting approval in February 2025. Complete - as clarity provided in management response and will form business as usual in terms of the management of business through Board Committees. The Strategic Development Committee which met on the 16 January 2025, received a spotlight item on transforming primary care and community services.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R2 - 2018 Open Recommendation - While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a) calculate a baseline position for its current investment and resource use in primary and community care, and b) review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	Audit Wales/2024/212/MD3/1	R2a - A baseline position can be obtained based on the current budget and resource allocation for the Primary Care and Community Care Group.	Primary Care & Community Care Group Chief Operating Officer	31.01.2025	31.01.2025	High	In progress	January 2025 Update - The current baseline of investment and resources is available through the Budget position. The 2025/28 IMTP plan is in the process of being finalised and as part of this work a baseline of spend and activity and resultant shift in activity and resources required to delivery the objectives. This is anticipated to be completed February/March for the IMTP submission to WG.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R2 - 2018 Open Recommendation - While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a) calculate a baseline position for its current investment and resource use in primary and community care, and b) review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	Audit Wales/2024/212/MD3/2	R2b - This review and report will form part of the Primary Care and Community Transformation Plan and will be aligned to the Acute Clinical Services Plan (ACSP). The aim is to facilitate both the shift in services but also the resource from secondary care into Primary Care and Community Services.	Primary Care & Community Care Group Chief Operating Officer	31.03.2025	31.03.2025	High	In progress	January 2025 Update - The 2025/28 IMTP plan is in the process of being finalised and as part of this work a baseline of spend and activity and resultant shift in activity and resources required to delivery the objectives. This is anticipated to be completed February/March for the IMTP submission to WG.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R3 - 2018 Open Recommendation - The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry, and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	Audit Wales/2024/212/MD4/1	R3 - The Health Board has a Primary Care Academy in place and workforce planning will be an essential remit for this. This will be an objective for 2025/26 onwards.	Primary Care & Community Care Group Chief Operating Officer	31.07.2025	31.07.2025	High	In progress	January 2025 Update - This will be a key objective of Academy. The target date for the completion of the initial baseline will be end of Quarter 1 of 2025.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	Audit Wales/2024/212/MD5/1	R4a - An evaluation template has been introduced for clusters to use to demonstrate outcomes and support continued investment implemented.	Primary Care & Community Care Group Chief Operating Officer	31.03.2025	31.03.2025	High	In progress	January 2025 Update. Framework for evaluations of cluster initiatives has been produced and is in the process of being shared with clusters. The governance structure for clusters has been reviewed and clarification on the reporting and approval process shared with clusters and at Joint Partnership Boards. All cluster initiatives will be reviewed internally by the Primary Care team and will be approved by the Joint Partnership Boards, to be implemented in February 2025.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	Audit Wales/2024/212/MD5/2	R4b - The clusters structure now sit under the GMS Directorate and all evaluations will report into one management and governance structure. Quarterly, these will be reported into the Primary Care and Transformation Board to inform wider strategic developments. The collaborative and cluster meetings are all in place and taken the opportunity to share learning of schemes.	Primary Care & Community Care Group Chief Operating Officer	31.03.2026	31.03.2026	High	In progress	January 2025 Update - a) & b) Cluster structure and reporting has been revised and brought under Primary Care GMS Directorate from a governance perspective. Meetings with Cluster Leads has been reinstated in order to enable clusters to listen and share learning from evaluations of current initiatives and to share new ones planned. Public Health representation is key member of the collaborative team assessing and discussing effectiveness. d)The primary care communications officer role has not been continued but instead has been incorporated into the corporate communications team. Relying on one post/person brought limitations but the corporate team is able to provide more capacity to provide a breadth of cover for sharing new ways of working.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	Audit Wales/2024/212/MD5/3	R4c - There is an active plan with the Health Board's Communications Team to promote the new ways of working and roles within the primary care model for Wales. Practices also work with the public to promote and discuss their cluster initiatives with their patient participation groups (PPG) as well as advertise services and offer feedback through their websites.	Primary Care & Community Care Group Chief Operating Officer	31.12.2024	31.12.2024	High	Overdue	January 2025 Update - Evidence can be provided where the corporate team has shared with the public new ways of working and new initiatives. Also evidence can be provided where GP practices have also worked with their PPG and shared on their own social media sites details of new initiatives and new roles.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R4 - 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	Audit Wales/2024/212/MD5/4	R4d - The Primary Care Communications Officer role is no longer in place and a decision has been taken to take a more holistic approach across the Primary Care to take opportunities of differing priorities during the year.	Primary Care & Community Care Group Chief Operating Officer	31.03.2025	31.03.2025	High	In progress	January 2025 Update - a) & b) Cluster structure and reporting has been revised and brought under Primary Care GMS Directorate from a governance perspective. Cluster Leads has been reinstated in order to enable clusters to listen and share learning from evaluations of current initiatives and to share new ones planned. Public Health representation is key member of the collaborative team assessing and discussing effectiveness. d)The primary care communications officer role has not been continued but instead has been incorporated into the corporate communications team. Relying on one post/person brought limitations but the corporate team is able to provide more capacity to provide a breadth of cover for sharing new ways of working.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R5 - 2018 Open Recommendation - We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. The Health Board should: a) review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	Audit Wales/2024/212/MD6/1	R5a - Each IPB will have a role to review and develop the clusters maturity and to report into Primary Care and Community Transformation Board.	Primary Care & Community Care Group Chief Operating Officer	31.03.2025	31.03.2025	High	In progress	January 2025 Update - A plan to address this recommendation is in the process of being drafted and will be shared at the next IPBs in Q4 of 2024/45.
Audit Wales/2024/213	31.10.2024	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	R1 - The Health Board should assess operational savings delivery potential and risks within each Care Group and Clinical Service Group on an ongoing basis.	Audit Wales/2024/213/MD1/1	The IMTP process for 2025/28 will utilise an assessment of operational savings delivery potential to inform savings targets for each Care Group	Finance Executive Director of Finance	31.03.2025	31.01.2025	High	In progress	January 2025 Update - The IMTP Steering Group has developed the savings requirements based on assessment of organisational requirements and capabilities. The IMTP and the delivery of improvement is supported by at Productivity Improvement and Transformation (PIT) programme which seeks to ensure efficiency and effectiveness. This programme supplies key data to inform appraisal of operational capabilities and potential for further improvement. The process of developing financial plans is tested against service plans and workforce plans to ensure plans are aligned and deliverable and the process is iterative to ensure that all interfaces between care groups and corporate divisions are considered.
Audit Wales/2024/213	31.10.2024	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	R2 - The Health Board should ensure that its service transformation plans more explicitly set out how they will help the organisation achieve financial sustainability in terms of the savings that will be generated and the timescale for achieving them	Audit Wales/2024/213/MD2/1	R2 - The IMTP process for 2025/28 includes an intention to ensure that at least the first stage of the ACSP public engagement is undertaken, in order to arrive at a set of options for further public consideration. In parallel, there are a range of emergency services changes that are being evaluated for performance, quality and financial sustainability opportunities. This will contribute to the development of a three-year plan, including a realistic assessment of impact on cost savings.	Finance Executive Director of Strategy and Transformation	31.03.2025	31.03.2025	High	In progress	January 2025 Update - The IMTP for 2025-2028 is in development and modelling of the impact of changes on service delivery performance and cost will be undertaken as part of the development process.
Audit Wales/2024/213	31.10.2024	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	R3 - The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R3.1 Extending its use of data and intelligence across a wider range of services. R3.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data.	Audit Wales/2024/213/MD3/1	Plan to make improvements in how we use data and intelligence to underpin savings identification and selection to be incorporated into our IMTP planning process	Finance Director of Digital Executive Director of Strategy and Transformation	31.03.2025	31.03.2025	High	In progress	January 2025 Update - Work ongoing to assess and identify the capabilities required within the data team to meet this objective
Audit Wales/2024/213	31.10.2024	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	R4 - Where "invest to save" opportunities are identified and taken forward through the Value and Sustainability Programme the Health Board should confirm that it is able to provide sufficient upfront funding to support them and able to demonstrate a clear return on investment.	Audit Wales/2024/213/MD7/1	R4 - Invest to Save opportunities will continue to be supported by clear cases setting out the proposed return on investment in year and recurrently. Any proposals where there is insufficient return in year to maintain cost neutrality will be managed as an investment proposal through our established IMTP processes	Finance Executive Director of Finance	31.03.2025	31.03.2025	High	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2024/213	31.10.2024	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	R5 - Plans for service transformation (5 years plus) need to be developed as the Care Groups continue to mature and increasingly focus on public health, prevention, community-based care and regional working	Audit Wales/2024/213/MD5/1	R5 - Plans for service transformation will continue to underpin our IMTP and strategy development. This will be reflected in our 2025-28 IMTP	Finance Executive Director of Strategy and Transformation Chief Operating Officer	31.03.2025	31.03.2025	High	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2024/213	31.10.2024	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	R7 - The Health Board should ensure that there is sufficient skills, capacity and capability across its corporate and operational teams to effectively deliver its longer-term service transformation.	Audit Wales/2024/213/MD8/1	R7 - We will consider the sufficiency of skills, capacity and capability in developing our IMTP and future strategy. Plan to be reflected in our 2025-28 IMTP	Finance Executive Director of Strategy and Transformation Chief Operating Officer Executive Director of People	31.03.2025	31.03.2025	High	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2024/213	31.10.2024	Review of Cost Savings Arrangements - CTMUHB 2023-24_October 2024 (Document reference: 4542A2024)	R8 - The Health Board should identify the key lessons from its approach to identifying and delivering savings during 2023-24 and apply the learning to its future approach.	Audit Wales/2024/213/MD9/1	R8 - We will consider the key lessons in developing our IMTP and future strategy. Lessons learned to be reflected in our 2025-28 IMTP	Finance Executive Director of Strategy and Transformation Chief Operating Officer Executive Director of People	31.03.2025	31.03.2025	High	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
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.	Internal Audit/2020/65/MD1/2	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Unscheduled Care Chief Operating Officer	01.04.2021	31.07.2024	High	Overdue	January 2025 Update - A new structure was established in 2023, moving away from the ILG model and replacing with a care group model. Now that the care group have been fully established, the Directorate manager has reviewed the recommendation with the view to adopt a process to ensure inventories are managed and reviewed across the sites. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion.
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."	Internal Audit/2020/65/MD2/1	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Unscheduled Care Chief Operating Officer	01.12.2020	30.04.2024	Medium	Overdue	January 2025 Update - Corporate services are conducting an internal review of the management of non clinical policies and procedures across the HB. The care group will feed into the review and take from that any learning or practices that can be adopted. A review of policies and procedures will form part of this review across 25/26, where the care group will have completed a full inventory of policies and procedures held by the care group, utilising this to support a process of review. ILG is no longer the structure and are now referred to as Unscheduled Care Group. November 2024 Update - An update against this recommendation has not been provided on this occasion.
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.	Internal Audit/2020/74/MD1/1	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM-5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Diagnostics, Therapies, Pharmacies and Specialities (Clinical Engineering) Care Group Chief Operating Officer	01.04.2020	31.01.2024	Medium	Partially complete (Overdue)	January 2025 Update (15/01/2025) - Supplier developed draft plan for final migration work and server switch over to be agreed with CE/ICT and ensure ICT available for any problems to be resolved when on site. A planned date at end of January/ beginning February to allow this to be sorted as handheld scanner apps will also be updated for new server when on site. This date will be sorted within next few days. December 2024 Update (20/12/2024) - Firewall issue sorted and Zone programming completed @ POW by Supplier for the antennas. System is usable on existing server but due to delay in resolving this problem, the migration /server switch over will have to be in January as any server changes are now on hold until new year. ICT will only allow corrective essential changes so close to Christmas break. Hopefully have the scheduled change over in January 2025. November 2024 Update - Due to issues with remote access, the completion of re-programming of zones was delayed, but is now in progress. There were also delays with issuing from manufacturer of licences for reader devices activation, now resolved. Supplier to schedule in with ICT a session to enable switch over to new environment. Linux server issue to be resolved by end December 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 18 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Internal Audit/2021/76/MD11/1	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Capital and Estates Executive Director of Finance	01.01.2022	30.06.2024	Medium	Overdue	January 2025 / December 2024 Update - Updated drawings provided as requested, with GP for final review. November 2024 Update - Lease not yet signed as required updated drawings, no issues anticipated but delayed while the final details are confirmed.
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.	Internal Audit/2021/76/MD13/1	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	29.02.2024	Medium	Overdue	January 2025 / December 2024 Update - No further update, as per November update next meeting in January 2025. November 2024 Update - Unable to complete at November 2024 meeting, will fall to next meeting in January 2025.
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.	Internal Audit/2021/76/MD14/1	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Capital and Estates Executive Director of Finance	01.01.2022	29.02.2024	Medium	Overdue	January 2025 / December 2024 Update - No further update, as per November update next meeting January 2025. November 2024 Update - Unable to complete at November 2024 meeting, will fall to next meeting in January 2025.
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.	Internal Audit/2022/161/MD1/1	The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed. As part of an internal review of CHC we have identified the need for a policy to outline the principles of CHC commissioning and the financial control procedure can be incorporated.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.05.2022	30.04.2024	Medium	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November Update - Nursing Team updated FCP on 17.10.24 and have emailed document to Finance Department on 12.11.24 for amendment / approval.
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.	Internal Audit/2022/43/MD4/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	In progress	January 2025 / December 2024 Update - Form of contract with J&N agreed, awaiting signing. November 2024 Update - part of direct consultant appointments with POWH Roof & Compliance Board, procurement method accepted by NWSSP-SES and W Gov. Contract for consultation in progress.
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.	Internal Audit/2022/43/MD8/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	Fully complete (Awaiting approval)	January 2025 / December 2024 Update - Costed risk register completed as part of Roof & Compliance Programme and reported to project board. November 2024 Update - will part of the Roof & Compliance Programme, has been requested by NWSSP-SES.
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.	Internal Audit/2022/43/MD9/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2025	Medium	Fully complete (Awaiting approval)	January 2025 / December 2024 Update - part of cost reporting for Roof & Compliance Programme. November 2024 Update - will part of the Roof & Compliance Programme, has been requested by NWSSP-SES.
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.	Internal Audit/2022/43/MD10/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.12.2023	Medium	Fully complete (Awaiting approval)	January 2025 / December 2024 Update - Part of reporting for Roof & Compliance programme. November 2024 Update - will part of the Roof & Compliance Programme, has been requested by NWSSP-SES.
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.	Internal Audit/2022/43/MD11/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.12.2023	Medium	Fully complete (Awaiting approval)	January 2025 / December 2024 Update - when applicable will form part of roof and compliance reporting. November 2024 Update - will be part of regular reporting to Programme Board, could be closed once the reporting is established, first meeting due early Dec 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 7.1 The Health Board should obtain advice from NWSSP- Specialist Estates Services in relation to a performance bond for construction works.	Internal Audit/2022/43/MD13/1	Agreed	Capital and Estates Executive Director of Strategy & Transformation	01.08.2022	31.01.2024	Low	Fully complete (Awaiting approval)	January 2025 / December 2024 - As per Nov update, now closed. November 2024 Update - Discussions with NWSSP-SES did not result in a recommendation in the contract, consequently it has not been included.
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.	Internal Audit/2022/67/MD2/1	The Service Group now sits in the Diagnostic and Therapies Care Group since September 2022 and the Care Group Director and Medical Director will work with the teams to advise of the workforce plan required for the IMTP/Annual Plan for 2023/24. On receipt of this advice the Service Group will work with the Workforce Business Partners to articulate the current workforce issues and medium and longer term plans.	Diagnostics, Therapies, Pharmacies & Specialities Chief Operating Officer	30.11.2022	31.12.2023	High	Partially complete (Overdue)	January 2025 Update - Still awaiting confirmation for approval at exec level for CT staffing. The workforce detailed in this paper underpins the Radiology workforce plans. Short term workforce planning meeting (07/01/25) - scoping of insourcing contract with procurement. November 2024 Update - Still awaiting confirmation for approval at exec level for CT staffing. The workforce detailed in this paper underpins the Radiology workforce plans.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
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.	Internal Audit/2022/95/MD1/1	The draft has been reviewed substantially and is now complete. The policy has been submitted to the Medical Workforce Sustainability Group (MWSG) for review. This will be set as an agenda item for the next meeting and then progress through the formal Health Board route to ratification.	People / Executive Medical Director, Executive Director for People	01.11.2022	30.04.2024	Medium	Partially complete (Overdue)	January 2025 Update - Policy to be reviewed at March 2025 LNC Committee meeting (11 March 2025). Request to change the due date to 30 April 2025. November 2024 Update - Final comments from the LNC are still awaited. A deadline has been suggested - agreeing the policy at the March 2025 LNC.
Internal Audit/2022/97	10/10/2022	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMU-2223-06)	Medical Records Management 1.1 The responsibilities of the Health Records departments across the Health Board should be standardised. Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation.	Internal Audit/2022/97/MD1/1	Accept There are challenges to standardising the operational procedures of the Health Records teams due to the variances between the digital systems used within the Princess of Wales and the rest of the Health Board. It should also be noted that some of the Health Records personnel within the Health Board are not under the direct responsibility and accountability of the Director of Digital. The Health Board has devised a programme of work to standardise the PAS in use across the Health Board. This programme is planned until the Autumn of 2024. Process will be aligned as practically possible prior to the completion of the programme.	Digital & Data Director of Digital	01.07.2024	01.09.2025	Medium	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - Significant disruption to the medical records processes due to the critical incident in POW and the commencement of the transfer of patients and notes to CT sites. The Dual PAS systems have historically not been configured to allow for this so a huge amount of work has been undertaken by our records teams to establish and implement new processes for the setting up and tracking on POW notes on CT PAS and vice versa. POW has not used CITO for digital patients prior to the CI but as patients from CT who are digital are now being transferred to POW a user guide for this site has now been created. Increased PAS patients registrations and new SOP's have been implemented and workload continues to increase in line with new operating models. PAS Merger work continues and meetings to explore expedited timelines have been scheduled.
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.	Internal Audit/2023/100/MD2/1	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 be included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team. A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required. 1.1b In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	31.12.2024	Medium	Partially complete (Overdue)	January 2025 Update - An audit tool for validation of open Inquest Data has been developed and run on a weekly basis. Claims and Redress dashboards are being developed to support the timely identification of discrepancies in data. Further audits of open and closed cases will commence in February 2024. Revised implementation date aligned to date of audits for assurance. November 2024 Update - An update against this recommendation has not been provided on this occasion.
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.	Internal Audit/2023/100/MD4/1	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2023	31.03.2025	Medium	Partially complete	January 2025 Update - Unfortunately, due to operational demands, and staff unavailability, the Redress Dashboard is yet to be completed. Anticipated time scale for completion is now 31 March 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion.
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.	Internal Audit/2023/107/MD4/1	3a Escalation to the Deputy Medical Director and escalated to the last IP&C Committee meeting (11/07/23). 3b Multi-stakeholder meeting to discuss the current arrangements with active service level agreements, Public Health Wales and CTM to inform the programme of work required to reach an appropriate substantive outcome. 3c Outcome report and appropriate plan from stakeholder engagement to be presented to IPC Committee meeting.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.10.2023	01.10.2023	Medium	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. October 2024 Update - No further update, there is no decontamination microbiologist lead for POW, the current arrangement only covers RGH and PCH, further discussion needed regarding local arrangements.
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.	Internal Audit/2023/107/MD5/1	5a Decontamination audit tools are currently being developed. Three audit tools will be taken to the next Decontamination Committee meeting for approval. Decontamination audit programme to commence. 5b Audit program to review decontamination facilities/arrangements across the Health Board to inform all appropriate future governance.	Patient Care & Safety Executive Director of Nursing/Deputy Chief Executive	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. October 2024 Update - Denal decontamination audit tool being developed.
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.	Internal Audit/2023/113/MD4/1	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	28.02.2025	Medium	Partially complete	January 2025 Update - The Training Strategy is being finalised and will be presented to the Executive Quality & Safety meeting on the 05.02.24 for sign off. There is some slippage in full completion of a training needs analysis as a result of the implementation of the OCP process. Revised implementation date now February 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion.
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.	Internal Audit/2023/117/MD2/1	A review of the Standard Operating Procedure will be undertaken to ensure it comprehensively covers the activities required.	Performance Executive Director of Strategy & Transformation Director of Digital	01.01.2024	30.06.2024	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2023/117	28/07/2023	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-15)	Performance Reporting Integrated Performance Report 1.1 The draft performance management framework should be reviewed to ensure: • There is alignment to the most up to date Welsh Government Performance Framework, ensuring all metrics and measures outlined are accurate and there is link the IMTP trajectories required by WG • Greater clarity is provided on how the framework will be applied in practice, including how reporting against metrics will take place. • Listed metrics can be clearly linked to source requirements e.g. WG quadruple aims, other national indicators, internal indicators. • The roles and responsibilities of all Health Board Committees is set out including how those roles relate to one another. • Reference is made to the revised operating model and therefore reporting structure within the Health Board. Following the completion of the review, the framework should be appropriately approved and made available to relevant staff.	Internal Audit/2023/117/MD3/1	The Health Board needs to formalise a Performance Framework. This review will consider the points listed above.	Performance Executive Director of Strategy & Transformation Director of Digital	01.01.2023	31.12.2024	Medium	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 update - The performance structure for the IMTP is set out in the reports provided to board. The formal framework document is under review.
Internal Audit/2023/124	31/05/2023	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-29)	Concerns Follow Up Review 3.1 3.1a Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes. 3.1b A training programme should be put in place to deliver the identified concerns training requirement. 3.1c A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward.	Internal Audit/2023/124/MD3/1	3.1a Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training 3.1b Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board. 3.1c Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	Patient Care & Safety / Executive Director of Nursing/Deputy Chief Executive	01.10.2023	31.10.2024	Medium	Partially complete (Overdue)	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 1.1 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.	Internal Audit/2023/146/MD1/1	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Planned Care Chief Operating Officer	01.09.2023	01.09.2023	High	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 1.2 A Standard Operation Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	Internal Audit/2023/146/MD2/1	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 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 WHSS 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.	Internal Audit/2023/146/MD3/1	Individual patient funding request panel to be re-established to receive INNU. Intervention requests necessary. Application and outcome to be documented and WPAS to be updated.	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	High	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.

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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.	Internal Audit/2023/146/MD4/1	With the establishment of the recording and monitoring mechanism. Monthly reports will be produced with trends and anomalies highlighted. Any matters that require addressing will be via the Care Group with the service performance meeting structures.	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	High	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 1.3 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.	Internal Audit/2023/146/MD5/1	Application of the above actions	Planned Care Chief Operating Officer	01.01.2024	01.01.2024	Medium	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 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.	Internal Audit/2023/146/MD6/1	Data work stream established to look at the recording of INNU's across CTMUHB. An agreed coding and monitoring mechanism to be agreed and implemented.	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Medium	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions Not Normally Undertaken 5.2 Consideration should be given to the need to periodically report compliance / non-compliance at a relevant level within the Health Board.	Internal Audit/2023/146/MD7/1	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Medium	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.
Internal Audit/2023/146	11/10/2023	Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 3.0 The importance of capturing accurate information on patient records should be reiterated to all staff, with the use of alternative names ceasing.	Internal Audit/2023/146/MD8/1	Review and update of waiting list 'holding names' to be undertaken	Planned Care Chief Operating Officer	01.03.2024	01.03.2024	Low	Overdue	January 2025 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance. November 2024 Update - INNU is an area that is being picked up at a national level. CTM are waiting for the outcome of this to inform local policies, procedures and guidance.
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.	Internal Audit/2023/148/MD1/1	Continue to prioritise and review aged assets with a view to replacement, balanced with limited funding sources. Manage and maintain the related risk within the Departmental risk register.	Digital & Data Director of Digital	30.06.2024	30.01.2025	Medium	In progress	January 2025 Update - We were successful in a recent bid to WG for slippage funding and have been allocated £1.9m in WG end of year slippage money. This will help in several key areas; however, we still struggle to meet our technical debt challenges without sustainable funding. November 2024 Update - Work continues to rollout newer Wireless Access points and PCs for the iGel replacement. Further funding is in place via the ePMA project to provide further upgrades to our Wireless Infrastructure. Digital have also submitted a slippage bid to WG valued at £4.4m which covers a range of infrastructure technology.
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.	Internal Audit/2023/148/MD2/1	The individual has now left. Management of the SolarWinds platform is now shared across the infrastructure team, although there is no lead and documentation produced is of limited value. Develop the skills and documentation within the team to maximise the use and value of the system for monitoring purposes. Recruit Additional staff in line with the Infrastructure Review resource plan."	Digital & Data Director of Digital	30.06.2024	30.03.2025	Medium	In progress	January 2025 Update - Unfortunately no progress has been made on the activity, we have recently lost a member of the team and we are in the process of recruiting additional staff to help with capacity. November 2024 Update - Significant disruption due Critical Incident (CI) at PoW and a shortage of resource has again impacted progress on this activity. Additional recruitment into the team is underway.
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.	Internal Audit/2023/148/MD4/1	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	31.07.2025	Low	In progress	January 2025 Update - We have been allocated funding for the Armis software in the recent Digital capital slippage bid and are currently in the process of procuring the software. Revised due date of July 2025 requested. November 2024 Update - A bid for the Armis software has been included in a recent Digital capital slippage bid to WG. We are waiting for feedback on that bid to see if funding for Armis can be included.
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.	Internal Audit/2023/37/MD1/1	A project team has been set up to develop the guidance required for development of SLAs. This includes Strategy and Transformation, Finance (Commissioning) leads and will include Procurement and Care Group representatives as the work progresses. This group will: • Develop guidance for the development of SLAs. • Provide templates for SLAs and service specifications. • Ensure all SLAs currently in place are recorded on the register of agreements and have Strategy, Commissioning and Care Group (service) leads. This guidance will be supported by a clear structure of governance supported by meetings with each Care Group to manage and monitor SLAs. Progress already made includes: • A checklist for the development and changes to SLAs has been drafted. • A revised SLA template is being tested for a current SLA development	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	High	Fully complete (Awaiting approval)	January 2025 / December 2024 Update - A checklist is in place for setting up and ceasing SLAs. Revised SLA documents are in place. The requirements for SLAs will be reconsidered when the new procurement regulations come into place from February 2025. November 2024 - The Head of Commissioning is facilitating the further review of the SLA checklist. The SLA template is fully revised and in use. The SLA cessation checklist remains in use. Commissioning meetings with care groups are used to facilitate the use of these documents.
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.	Internal Audit/2023/37/MD4/1	The guidance to be developed, as described in the response to action one will include clarity on processes for signing and storing of agreements.	Commissioning Executive Director of Strategy & Transformation	01.09.2023	30.06.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update - Guidance is in place for teams on setting up agreements. An audit review has identified further recommendations to strengthen this area and a management plan is in place. This action is now recommended for closure. November 24 - Update as per September. The Head of Commissioning is now in post and undertaking further review of guidance. All new agreements will have lead officers allocated.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs _Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 2.1 2.1a The process for using non-direct engaged medical locums should be reviewed to ensure suitable controls, scrutiny, challenge and authorisation is in place going forward. 2.1b The FCP and SOP should be updated to reflect the correct process to be followed, and staff should be made aware of the correct processes and the additional cost implications of using non-direct engaged staff.	Internal Audit/2023/54/MD1/1	2.1a The process around non-direct engagement booking will be fully reviewed. Any identified shortcomings, along with the recommendations of this audit, will be rectified and added to the SOP and FCP. 2.1b Staff will be provided with the new FCP and SOP. They will also be provided with training on how to apply these to this particular part of the audit. The training will be recorded centrally, to ensure every area using the system is up to date with their responsibilities relating to it. Part of this training will be conveying the importance of direct engagement (DE) bookings and the financial benefit to the Health Board.	Medical Directorate and People Executive Medical Director Executive Director for People	01.06.2023	01.06.2023	High	Fully complete (Awaiting approval)	January 2025 Update - These actions are now being captured and monitored in the actions for the 2024 audit recommendations and this action can be closed. November 2024 Update - The FCP and SOP are currently being revised and will be available on the Intranet. A provisional timetable for training will be discussed and agreed. Re-opened October 2024 - Follow Up Report Medical Variable Pay - Agency Costs received by the Audit & Risk Committee on the 17th October. Internal Audit Colleagues consider this item not to be fully complete and therefore it has been re-opened as partially implemented with the residual aspect in relation to updating the Financial Control Procedure. To close this action please indicate which section of the new FCP addresses these points.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs _Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 2.2 The Health Board should resume previous work undertaken with Retinue to encourage agency locums to switch to being directly engaged.	Internal Audit/2023/54/MD2/1	2.2. All current agency workers being used by the organisation will be reviewed for their DE status. Any that are not being engaged through DE will be approached to switch. Retinue will be required to offer up DE candidates in the first instance if available, as well as encourage non-DE agency workers seeking to work in Cwm Taf Morgannwg to switch to DE. This will become a constant process of analysis and identification of non-DE workers in the Health Board, which will allow the organisation to target and reduce DE use.	Medical Directorate and People Executive Medical Director Executive Director for People	01.06.2023	01.06.2023	High	Fully complete (Awaiting approval)	January 2025 Update - This action is complete. November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Re-opened October 2024 - Internal Audit Report Follow Up Medical Variable Pay - Agency Costs - September 2024 - this inspection stated that Internal Audit did not consider this action to be fully completed. It was concluded that this matter arising should be marked as partially implemented, with the residual aspect in relation to updating the FCP. To close this action please indicate which section of the new FCP addresses these points.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs _Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 5.1 Following the implementation of any actions arising from the Medical Productivity Board, the future reporting and monitoring requirements, in relation to medical variable pay, should be agreed and the FCP updated accordingly.	Internal Audit/2023/54/MD3/1	5.1 Finance currently provide comprehensive reports to the Care Groups detailing medical spend. This reporting will continue to happen and any additional requirements recommended by the Medical Productivity Board (MPB) will be added to this financial dataset. The FCP will be updated to reflect the recommendations from the MPB as soon as they are communicated.	Medical Directorate and People Executive Medical Director Executive Director for People	01.06.2023	31.03.2025	High	Partially complete	January 2025 Update - These actions are now being captured and monitored in the actions for the 2024. Request to change the date of completion to 31/3/2025. November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Reopened October 2024 following the Internal Audit on MVP Agency Costs September 2024 where Internal Audit considered this action to be only partially completed and added the following commentary: "Whilst it has been confirmed that the relevant financial information is being appropriately disseminated, there remains an outstanding requirement to incorporate details of financial monitoring procedures into the revised FCP. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points.
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs _Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	Medical Variable Pay 6.1 6.1a The process for seeking CSG Manager approval to use agency staff to cover roster gaps should be reviewed to ensure that agency use is appropriate. 6.1b The FCP and SOP should be updated to reflect the correct process to be followed.	Internal Audit/2023/54/MD6/1	6.1a A process for authorisation will be clearly defined and communicated via the new FCP and SOP. How to undertake this process and ensure authorisation is gained, will be incorporated into the training provided to all areas using agency staff. 6.1b The recommendations and subsequent processes developed will be included in the FCP and SOP.	Medical Directorate and People Executive Medical Director Executive Director for People	01.08.2023	01.08.2023	High	Fully complete (Awaiting approval)	January 2025 Update - This has been captured and incorporated into the 2024 audit actions. We recommend this closed and picked up in the 2024 FCP/SOP updates. November 2024 Update - Discussions are taking place regarding further training for staff to ensure correct reasons are entered into the system. A meeting is scheduled to take place on 25/11/2024 to discuss this action. Reopened October 2024 - Internal Audit Report MVP Agency Costs September 2024 advised that Internal Audit considered this action to only be partially completed. The following commentary was concluded in their findings: "The FCP and SOP are yet to be updated to include information on the process for authorisation for the use of agency staff. However, as the process is now undertaken via the Retinue system, we confirmed appropriate manager approval of bookings from our review data relating to bookings for the period October 2023 to March 2024. Conclusion: Whilst the FCP and SOP have not been updated, we were able to evidence booking approvals via the Retinue system. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2023/54	06.02.2023	Medical Variable Pay – Agency Costs. Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-12)	4.1 It should be ensured that suitable processes are in place and adhered to for engaging agency staff on a longer-term basis, or for extending any placements thus making them longer term. Prior to authorising longer-term placements, it should be confirmed that recent efforts to recruit into the post have been made and that plans for future recruitment attempts are in place, to prevent ongoing reliance on the agency locum. Where there is a need to extend existing placements, it should be ensured that a review of the current post holder and any alternative agency staff is carried out to ensure the Health Board is achieving value for money and the best fit person is used.	Internal Audit/2023/54/MD7/1	4.1 - The recommendations of this action will be included in the FCP and SOP. Setting out a clear process for extending agency workers placements, that ensure the recommended considerations are taken and recorded, before offering an extension. Training will be provided to all areas on how and when this process is to be used, to ensure the Health Board gets the correct balance between value for money and the correct person for the role.	Medical Directorate and People Executive Medical Director Executive Director for People	31.08.2023	31.03.2025	High	Partially complete	January 2025 Update - This action will be addressed in review of the FCP/SOP along with the new 2024 audit recommendations. We request that the date is changed to 31 March 2025. November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Likely to be rules and plans for looking at data and improvements. Re-opened October 2024 - This action has been entered on AMaT as the Internal Audit MVP Agency Costs for September 2024 concluded that this item was only partially completed. Internal Audit commented: "The FCP and SOP have not been updated to provide clarity on extending agency worker placements. However, our review of booking data identified that longer-term placements, which represent a minority of engagements, were subject to regular re-approval via the Retinue system. We saw evidence that management have worked to substantively recruit longer term agency staff in some cases. Details of individual longer-term placements are reported to the Audit & Risk committee, and reasons are provided to explain their necessity. Whilst the FCP and SOP have not been updated, work has been carried out by the Health Board to reduce the numbers of longer-term placements. We consider this matter arising partially implemented, with the residual aspect in relation to updating the FCP reported under Matter Arising 1." To close this action please indicate which section of the new FCP addresses these points.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	1.1a A standardised approach to the application of the 4-hour performance clinical exception guidance should be established by the Health Board. 1.1bA comprehensive SOP should be created for use across all sites setting out a standardised approach to the application of the WG guidance on calculating the 4-hour performance target and the use of breach exemptions. The SOP should include details on capturing and recording data in relation to the 4-hour performance target, especially definitions for recording of times, when breach exception codes can be used, the responsibility for inputting data and the validation process. Managers across all sites need to be involved in the process of creating SOP.	Internal Audit/2024/162/MD1/1	Develop standardised approach to application of 4 hour clinical exception to include a pan CTM SOP for application of WG guidance.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	January 2025 Update - 4 Hour Action Card The 4 hour action card has been reviewed and updated following engagement with management, lead clinicians and senior nurses. The drafts have been sent to the site teams for sign off. Following successful testing on the 12th December, a standardised SOP will now be drafted and training provided by the operational and WPAS teams on both the PCH and RGH sites - Action by end Jan 25. November 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.	Internal Audit/2024/162/MD2/1	Develop a standardised set of codes to be used across all sites.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - Since April 2024 the WPAS team has worked closely with the 3 EDs across the sites to review and standardise all of the codes and drop down options available in WPAS in preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. Meeting held on 12th December to review the breach reason and WG breach codes to confirm if the data pull in line with the 4 hours breach reason is accurate. November 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.	Internal Audit/2024/162/MD3/1	Communicate through safety briefings the importance of fully completing CAS Cards and review implementation of summary table across all sites.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	January 2025 update - ED lead nurses have confirmed that they undertake a triage audit of the cas cards. Care Group Manager has requested that they all move to a quarterly audit which should also include a review of the receptionist section of the card - Agreed 6th December and PCH audit template circulated - Action care group manager to confirm roll out. November 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.	Internal Audit/2024/162/MD4/1	Develop standardised CAS card for all sites in conjunction with Clinical Director and Lead Nurse.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - Standardised CAS cards completed and can be provided as evidence. Start date to be confirmed. November 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.	Internal Audit/2024/162/MD5/1	Ensure standardised approach to training across all ED's, monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	January 2025 Update- review and standardisation for breach exemption codes and reasons is in progress as part of the automated validation tool. Following successful testing on the POW site an SOP will be developed and training will be undertaken on both the PCH and RGH sites. November 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.	Internal Audit/2024/162/MD6/1	Ensure standardised approach to training across all ED', monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	January 2025 Update - Monthly emails have commenced to ED reception team to ensure it is reiterated to staff the importance of accurate and complete data capture- band 7 operational managers. CAS card available. Plans to recruit patient flow co-coordinator to support real time data capture on WPAS. November 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.	Internal Audit/2024/162/MD7/1	- Undertake review of treatment complete time and implement consistent definition on all sites. - Ensure breach exemption codes applied consistently, develop SOP and monitor through Directorate Performance Meetings.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - The new sample card will ensure accurate data capture moving forward with a standardise approach and understanding of the data requirement / meaning being in place across CTM - Action by End Jan 25. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 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.	Internal Audit/2024/162/MD8/1	Implement a standardised approach to capturing any changes to records, monitor through Directorate Performance reviews	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - Following implementation of the standardised patient tracking and breach recording, monthly audit meetings will be arranged and will feed into existing Directorate Performance review meetings - Action end January 25. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	5.2Further work should be undertaken to ensure that those cases adjusted as part of the retrospective validation process are being correctly captured and reported. Consideration should be given to maintaining a record of the WPAS entries that have been adjusted in order to allow spot checks to be performed to confirm the adjustment was correctly captured on the system.	Internal Audit/2024/162/MD9/1	Undertake regular "snapshot" audits to ensure validation is correctly captured and monitor through Directorate Performance reviews.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	High	Overdue	January 2025 Update - PFC should review overnight cards to check that the record has been appropriately updated and roll back when appropriate - Include in SOP DNW would be an example of this. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 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.	Internal Audit/2024/162/MD10/1	Review validation approaches across all ED's and implement a standardised approach to reporting.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - Plans to produce a spreadsheet and share with Senior Nurses on all 3 sites to ensure that any adjustments made to the original entry on WPAS is captured and used to identify staff training requirements. Look at original findings to know what criteria needs to be added into the database. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 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.	Internal Audit/2024/162/MD11/1	Undertake review of outstanding cases at POW and determine if validation is required	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Low	Overdue	January 2025 Update - Discussions have been held to support this action and review, agreed in the meeting on the 3rd Dec that given that WG or CTM will have a requirement to use past breach data, the HB should consider not working through the backlog but ensure monthly compliance going forward. Discussed in the pan CTM ED Senior Team meeting on the 4th December where it was agreed by the Senior Team that they also support the request not to validate the backlog. RM to write to the Care Group to request permission to sign this off formally - Action RM end Dec 24 November 2024 Update - An update against this recommendation has not been provided on this occasion. September 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.	Internal Audit/2024/162/MD12/1	Re-instate weekly SM meetings at POW.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - POW, RGH and PCH weekly ED Senior Team site based and pan CTM meetings in place. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 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.	Internal Audit/2024/162/MD13/1	Ensure agenda and action logs are retained.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - A dedicated pan CTM ED folder has been created that can be accessed by the ED teams across the sites to ensure all documentation and records are easily accessible. Site based, Digital Project Group, site based and pan CTM action plans have been developed with updates and further action discussed and updated in the weekly meeting. Agenda in place for pan CTM meetings. Clinical Advisory Group commenced 7th January 2025 to support implementation of WECD5. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 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.	Internal Audit/2024/162/MD14/1	Site specific slide deck in place, ensure used to underpin discussions.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - Weekly performance slide are sent out via the informatics team and are circulated to the teams across the sites. ED Performance has also been added to the agenda for site based and the pan CTM senior team meetings. Again the patient tracker function on WPAS will allow ED and the site to see at a glance where the barriers to flow. Once in place engagement sessions with site teams. The band 7 operational managers going forward, will play an active role in the daily review, escalation and reporting of ED waiting times, delays, reason for delay from December 2024. This information will provide the deep dive narrative around issues that impact on ED weekly performance. This will enable the ED team to engage with the wider Site Flow teams, WAST, Diagnostics, Speciality teams and Primary Care colleagues to work towards a collaborative approach to improve ED performance. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 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.	Internal Audit/2024/162/MD15/1	Develop a more detailed report to include analysis of breach codes.	Unscheduled Care Chief Operating Officer	01.06.2024	01.06.2024	Medium	Overdue	January 2025 Update - Meeting arranged early December to work through the Informatics team, Clinical Lead and Directorate to undertaken an analysis of the breach codes as part of the automated validation pilot. Following the roll out of patient tracking across the sites, this information will be available live on the ED Dashboard App that is currently in development - Action information to confirm completion date November 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.	Internal Audit/2024/163/MD1/1	Ensure the Service Catalogue is updated to reflect all of the critical systems in place and complete the additional fields including identifying if the system is locally managed or run by a supplier, and also identify where the system is hosted.	Digital & Data Director of Digital	01.07.2024	01.03.2025	Medium	In progress	January 2025 Update - A local review has been carried out of the server/hosting, networking and EUC components of our infrastructure. These were all reviewed against the CIS benchmarks and any follow up actions/risks are being logged. A view of national systems needs to be developed. November 2024 Update - The Critical Incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activates from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
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.	Internal Audit/2024/163/MD1/2	Further refine and review the Service Catalogue and extend it to include dependencies of local, national and cloud infrastructure. E.g. The majority of systems are accessed via CTM Managed end user devices so the review should ensure that these common components (such as Citrix, Wireless, LAN and WAN) are reviewed for their resilience and recover ability.	Digital & Data Director of Digital	01.07.2024	01.03.2025	Medium	In progress	January 2025 Update - A local review has been carried out of the server/hosting, networking and EUC components of our infrastructure. These were all reviewed against the CIS benchmarks and any follow up actions/risks are being logged. A view of national systems needs to be developed. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud.
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.	Internal Audit/2024/163/MD2/1	Creation of a Digital Service Management Function. Create a Digital Service Management function as part of current structural review of Digital Delivery. Appoint into the vacant Head of IT Service Management role. Then assess current maturity of ITIL aligned processes and procedures and prioritise development.	Digital & Data Director of Digital	01.10.2024	31.07.2025	Medium	In progress	January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25.
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.	Internal Audit/2024/163/MD3/1	Once a Digital Service Management function has been created (Action 2.1) develop a framework and approach to internal service relationship. This action is predicated on the development of our service catalogue (Action 1.1) as well as an approach to business relationship management (BRM) that will need to span the Digital Delivery, Digital Systems and Digital Intelligence, Compliance & Design.	Digital & Data Director of Digital	01.01.2025	31.07.2025	Medium	In progress	January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. Progress on this action reliant on Internal Audit/2024/163/MD4/1. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25.
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.	Internal Audit/2024/163/MD4/1	Once a Digital Service Management function has been created (Action 2.1) develop a single, central register of suppliers and contracts. This will need co-ordination with our Internal Business Admin team, Finance and Procurement.	Digital & Data Director of Digital	01.10.2024	31.07.2025	Medium	In progress	January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. However thinking has already started on the approach. We are also waiting for a new Head of Procurement to be appointed in the coming months. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25.
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.	Internal Audit/2024/163/MD5/1	Creation of a tiered framework categorising high, medium and low value/importance suppliers and contracts, and the appropriate level of governance and level of management given to each category.	Digital & Data Director of Digital	01.10.2024	31.07.2025	High	In progress	January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed - this reliant on progress of action Internal Audit/2024/163/MD4/1. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024.
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.	Internal Audit/2024/163/MD6/1	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	31.07.2025	High	In progress	January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. Progress on this action reliant on Internal Audit/2024/163/MD4/1. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. New revised date of 31/07/25. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024.
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.	Internal Audit/2024/163/MD7/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25.	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024.
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.	Internal Audit/2024/163/MD8/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud. September 2024 Update - We have now successfully appointed a new Head of Digital Service Management, we will be looking to transfer over responsibilities from mid-October 2024.
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.	Internal Audit/2024/163/MD9/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud.
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.	Internal Audit/2024/163/MD10/1	This action is dependent on the selection, procurement, and implementation of a new ITSM tool. There is an expectation that ServicePoint is being deprecated by DHCW with the next 12 months. A bid for a new ITSM tool will be placed in the IMTP for 24-25	Digital & Data Director of Digital	01.04.2025	01.04.2025	Low	In progress	January 2025 Update - Conversations have started with DHCW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud.
Internal Audit/2024/163	08.02.2024	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	6.1Management should ensure that a defined problem management process and procedure is finalised, published, and adopted.	Internal Audit/2024/163/MD11/1	Once a Digital Service Management function has been created (Action 2.1) complete process and procedures for Problem Management.	Digital & Data Director of Digital	01.01.2025	31.07.2025	Medium	In progress	January 2025 Update - We have a start date for the new Head of Datacentre and Cloud for the 3rd March 2025 - this should then free up the Head of Digital Service Management to progress Service Management activities - we will then look to undertake an ITIL Maturity assessment in the new FY once end of year activities have been completed. Due to delays, request to revise due date to July 2025. November 2024 Update - The Critical incident (CI) at PoW has disrupted this action. Whilst the Head of Digital Service Management is now in place, they are still covering a number of activities from their old role whilst we recruit and onboard a new Head of Datacentres and Cloud.
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.	Internal Audit/2024/169/MD16/1	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	30.09.2025	Low	Partially complete	January 2025 update - being reviewed by digital pharmacy team. No specific update but the due date will need to be reviewed. Suggest September 2025. November 2024 Update- Meeting took place October 2024 with Chief Pharmacist Medicines Governance. Options to be sent for final decision to CD accountable officer. To be closed.
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.	Internal Audit/2024/169/MD17/1	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	01.09.2025	Medium	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - A central electronic record is retained for staff trained since 2020, however consideration will be given to using ESR for this purpose. Request put to ESR team to add this on. This timeframe will need to be revised for completion 1/9/25
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 exception process to be followed for areas such as GP and internal referrals, the triage and triage process and timeframes for undertaking the various stages in the process. The draft SOP should be agreed at an appropriate level within the Health Board. Where there are variations in service delivery, such as the Nurse Led Rapid Access One Stop Colorectal Clinic based at PCH, then a separate SOP should be formalised for use.	Internal Audit/2024/170/MD1/1	A CTM Standardised LGI SOP to be developed, reviewed and agreed.	Planned Care Chief Operating Officer	30.06.2024	31.05.2025	High	In progress	January 2025 Update - Draft SOP to be ratified in the March Surgical Business Meeting. Revised due date of May 2025 from June 2024. November 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.	Internal Audit/2024/170/MD2/1	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	31.05.2025	Medium	In progress	January 2025 Update - T&F group set up to develop the SOP. Revised due date of May 2025 from June 2024. November 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 negotiate 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.	Internal Audit/2024/170/MD3/1	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	31.05.2025	Medium	In progress	January 2025 Update - Work is ongoing to merge WPAS within CTM and is expected to be completed in May 2025. Electronic vetting is now live for RGH site and work is in progress to align pathways to bring PCH into electronic vetting. Revised due date of May 2025 from June 2024. November 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.	Internal Audit/2024/170/MD4/1	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	31.05.2025	Medium	In progress	January 2025 Update - Referrals are vetted twice a day by colorectal consultants at the RGH site. Revised due date of May 2025 from September 2024. November 2024 Update - An update against this recommendation has not been provided on this occasion.

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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.	Internal Audit/2024/170/MD5/1	1. Understand go live date for E-Ref for LGI/Surgery. 2. link in with Records/Digital team.	Planned Care Chief Operating Officer	30.09.2024	31.05.2025	Medium	In progress	January 2025 Update - LGI/Surgery now have a full electronic gateway. Revised due date of May 2025 from September 2024. November 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'.	Internal Audit/2024/170/MD6/1	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	31.05.2025	High	In progress	January 2025 Update - Gastroenterology/Endoscopy team to use the afternoon of audit days to hold this meeting, similar to Surgical colleagues. Peer review of referrals to be a standing agenda point as part of this. Revised due date of May 2025 from June 2024. November 2024 Update - Gastroenterology/Endoscopy Team to use the afternoon of audit days to hold this meeting, similar to Surgical colleagues. Peer review of referrals to be a standing agenda point as part of this.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	5. There should be a consistent approach to reviewing and monitoring referral and demand activity across the Gastroenterology and Colorectal GI services. This could be supported further by the use of the Medical Records reports that outline delayed and unvetted referrals. Regular reporting at a Care Group level should take place to enable management to effectively review and understand the efficiency of referral throughput and assist with the planning of services. Consideration should be given to other ways in which the data currently collected can be used to identify potential issues in processes and inform decision making to improve service delivery.	Internal Audit/2024/170/MD7/1	1. Imbed new CTM leadership structure. 2. Continue to work with our informatics teams to build purpose dashboards that support D&C and monitoring of productivity and efficiencies.	Planned Care Chief Operating Officer	31.12.2024	31.05.2025	Medium	In progress	January 2025 Update - Dashboards are still being worked on, D&C conversations with colleagues ongoing in regards to drill down data. Productivity and efficiencies monitored via SIG KPI data for Gastroenterology. Revised due date of May 2025 from June 2024. November 2024 Update - Dashboards are still being worked on, D&C conversations with colleagues ongoing in regards to drill down data. Productivity and efficiencies monitored via SIG KPI data for Gastroenterology.
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.	Internal Audit/2024/171/MD1/1	This recommendation is accepted and the terms of reference for the Environmental Sustainability Group will be updated to reflect this.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.07.2024	31.07.2024	Medium	Partially complete (Overdue)	January 2025 Update - Terms of reference will be approved in ESG in January. November 2024 Update - Revised ToR has been given to ESG for approval.
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.	Internal Audit/2024/171/MD5/1	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.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	31.03.2025	High	In progress	January 2025 Update - Work is underway to gather data on the investment and fiscal requirements for the activities within the DAP. Information will be reported to ESB in the January meeting. It is anticipated that a fully costed plan will be available by the end of March 2025. November 2024 update - Work is in progress with some assessments of financial requirements complete or underway.
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.	Internal Audit/2024/171/MD6/1	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 'MTP' references decarbonisation as a key priority in the 'Green 2030' section of the document, there is an opportunity to make greater emphasis on it throughout. For example, when discussing the major transformation schemes.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2026	31.03.2026	High	In progress	January 2025 Update - Information is being gather as part of the long term investment requirements and will be reported to ESG in January. November 2024 update - Work is in progress with some assessments of financial requirements complete or underway.
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.	Internal Audit/2024/171/MD7/1	This recommendation is accepted by the Health Board. Work on this recommendation will commence following the recruitment of the Sustainability Manager as this will create additional capacity needed to better understand how this can be enacted systematically across the health board. Environmental Sustainability Group meetings: The terms of reference for the ESG state that they are responsible for monitoring progress in implementing the Health Board's DAP. We acknowledge that it would not be practical to review each initiative during these meetings. However, from our review of minutes for the group, it was not clear how the ESG is actively managing and overseeing the progress of implementation of the 30 initiatives it is responsible for that make up the DAP. The DAP is structured around the six Welsh Government workstreams. Highlight reports from three of the six workstreams should be presented at alternate ESG meetings. Whilst we could see regular updates from a number of departments, such as facilities, pharmacy and ICT, these did not clearly align to the workstreams. As such, we were unable to confirm if there was appropriate reporting on the workstreams. Board and Committee reporting Reporting progress against implementation of the DAP does not appear to be taking place bi-annually, as set out in the ESG terms of reference. Our fieldwork identified one instance of the DAP / monitoring return being submitted to the Population Health and Partnership Committee since returns began in quarter two of 2022/23. The report that we saw used the Welsh Government monitoring return format, so did not include narrative for the reader to gain an overarching view of the position of the Health Board against its targets. Whilst the cover report referred to 'varying degrees of success' and the risks to achievement of the target, there did not appear to be reporting against the Health Board's overall carbon reduction target of 16% by 2025.	Strategy, Planning and Transformation Executive Director of Strategy and Transformation	01.03.2025	31.03.2025	Medium	In progress	January 2025 update - Work has been delivered to include decarbonisation as part of processes. Governance has been updated at corporate level with strong links to decarbonisation. November 2024 update - In progress but more work required. Decarbonisation has been incorporated into the VBH application process.
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.	Internal Audit/2024/172/MD1/1	Accept. The implementation of ePrescribing and the development of a Patient Contact Transformation Programme provides the Health Board with a new way and ownership of delivery for digital and data programmes. It is anticipated (ahead of final confirmation), that both programmes will report into the Improving Care Board and then into Executive Management Board. Discussions are also ongoing with the Chair regarding a greater emphasis at our public board on the Digital Agenda.	Digital & Data Director of Digital	31.12.2024	31.12.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update - Monthly EMB in place that will approve plans and priorities. Committees now in place to provide assurance. This action can now be closed. November 2024 Update - The new committees are currently scheduled to begin in January 2025.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	1.1 Short, medium and long-term objectives should be developed that are specific to the leadership and management development programmes.	Internal Audit/2024/187/MD1/1	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.	People Executive Director for People	31.07.2024	31.07.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update - Short, medium and long term objectives agreed and embedded into Inspire Cohort 1 Launch day. These will be shared alongside the collation of personal objectives from participants. Communication of any over-arching leadership paper/ approach on hold. In its place, a robust leadership development update was provided at People and Culture Committee and will be taken to an upcoming Operational Management Board and other relevant committees in the coming months. A wider leadership approach/ paper can be developed with output from Inspire Cohort 1. November 2024 Update - Inspire cohort 1 participants confirmed and long term objectives communicated via launch communications from CDO. Overall leadership approach (i.e. long term objectives) also contained in Leadership Competency Framework and paper. Greater detail of short and medium term objectives to be shared with participants during Module 1 development day, to take place during January 2025.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported.	Internal Audit/2024/187/MD2/1	These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a). Actions: • Develop new programme dashboards with HEIW, using functionality in Gwella.	People Executive Director for People	30.11.2024	31.03.2025	Medium	Partially complete	January 2025 Update - All metrics designed and reporting functionality built into programmes. To supplement HEIW Gwella reporting dashboard, participant tracker developed to monitor programme engagement. Data to be reported following Module 1 March 2025. November 2024 Update - All metrics designed and reporting functionality built into programmes. Data to be reported following Module 1 in January 2025.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	1.2 Performance indicators such as the sign-up rate, conversion rate (the number that have registered that go on to start the programme) and the completion rate should be developed for the programmes, and these should be appropriately reported.	Internal Audit/2024/187/MD2/2	These performance indicators were developed for the programmes, although inaccuracies in the data are recognised (as per 2.1a). Actions: • Report dashboards and programme performance indicators to People and Culture committee.	People Executive Director for People	31.12.2024	31.03.2025	Medium	Partially complete	January 2025 Update - All metrics designed and reporting functionality built into programmes. To supplement HEIW Gwella reporting dashboard, participant tracker developed to monitor programme engagement. Data to be reported following Module 1 March 2025. November 2024 Update - All metrics designed and reporting functionality built into programmes. Data to be reported following Module 1 in January 2025.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure: • Data is accurate. • Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme. • Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme. 2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight.	Internal Audit/2024/187/MD3/1	2.1a • As per 1.2, develop new programme dashboards with HEIW, using functionality in Gwella. Ensure inclusion of evaluation data from 2.1b.	People Executive Director for People	30.11.2024	30.11.2024	High	Partially complete (Overdue)	January 2025 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme having not yet started. Following the launch, dashboards and evaluation reports will be compiled and shared. At an appropriate time and once the dataset is big enough, updates and accompanying reports will be shared with the relevant committee. November 2024 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme having not yet started. Following the launch, dashboards and evaluation reports will be compiled and shared. At an appropriate time and once the dataset is big enough, updates and accompanying reports will be shared with the relevant committee.
Internal Audit/2024/187	06.06.2024	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-01)	2.1a The content of the Leadership Management section of the L&D Monthly Analysis Report should be reviewed to ensure: • Data is accurate. • Information is comprehensive enough to enable readers to clearly understand the number of registrations, active learners and completions for each level of the programme. • Reporting covers all the evaluation criteria that have been set out plus and any future performance indicators that may be set for the programme. 2.1b The Leadership and Management Programmes Evaluation & Impact Report should be prepared on a more frequent basis and presented at the People & Culture Committee to allow greater oversight.	Internal Audit/2024/187/MD3/2	2.1b • In-line with the relaunch of Inspire, apply HEIW's Kirkpatrick Bronze evaluation framework. This will supersede and replace any previous evaluation methods/ reporting, and will be reported to Inspiring People Board and People and Culture Committee.	People Executive Director for People	30.09.2024	30.09.2024	High	Partially complete (Overdue)	January 2025 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme not having starting yet. Following the launch, dashboards and evaluation reports will be compiled and shared. At appropriate time and once dataset big enough, update and accompanying report will be shared with the relevant committee. November 2024 Update - New dashboards and an evaluation framework have been designed. These have not been shared due to the programme not having starting yet. Following the launch, dashboards and evaluation reports will be compiled and shared. At appropriate time and once dataset big enough, update and accompanying report will be shared with the relevant committee.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures). 1.1b Regular monitoring should be carried out to ensure compliance.	Internal Audit/2024/188/MD1/1	1.1a Staff have been reminded of the importance of completing Datix. The SOP will be updated to provide guidance to ensure accurate data is recorded. An audit is being developed with support from the BI team to easily identify and monitor accurate data recording.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	31.03.2025	Medium	In progress	January 2025 Update - Unfortunately, due to operational demands, and staff unavailability, the Redress Dashboard is yet to be completed. Anticipated time scale for completion is now 31 March 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	1.1a Management should remind staff of the importance of ensuring that complete and accurate data is input to Datix (see also MA 5 relating to Standard Operating Procedures). 1.1b Regular monitoring should be carried out to ensure compliance.	Internal Audit/2024/188/MD1/2	1.1b Regular monitoring is currently carried as part of the payment approval process. To support regular monitoring, a regular opened and closed cases audit is being developed with support from the BI team.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	31.03.2025	Medium	In progress	January 2025 Update - Unfortunately, due to operational demands, and staff unavailability, the Dashboard for regular monitoring of open and closed cases is yet to be completed. Anticipated time scale for completion is now 31 March 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	3.1 Management should continue to remind staff of the importance of working towards the timeframes specified by WRP and should continue to monitor to ensure compliance with this requirement.	Internal Audit/2024/188/MD3/1	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.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2025	Medium	In progress	January 2025 Update - work is ongoing to complete this action on 30/09/2025. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.	Internal Audit/2024/188/MD5/1	5.1a The relevant section of the Standard Operating Procedure (SOP) will be reviewed to ensure that it clearly outlines what constitutes final payment and the process that should be followed if an invoice is disputed. Training will be provided once the SOP has been updated. This action will need to be aligned with the all-Wales approach and completion will be dependent on this.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2024	Medium	Overdue	January 2025 Update - Following being updated, the SOP to be finalised and approved. Training undertaken in September 2024 for Claims Investigations Officers. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1d All SOPs should be finalised and made available to staff. 5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.	Internal Audit/2024/188/MD5/2	5.1b Management will attend or delegate staff to the WRP's Task and finish group to ensure the key stages are clearly defined. The SOP will be updated once the work has been finalised.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	31.08.2024	Medium	Overdue	January 2025 Update - Action remains open. Team to contact WRP Task & Finish Group. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1d All SOPs should be finalised and made available to staff. 5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.	Internal Audit/2024/188/MD5/3	5.1c The SOP will be reviewed and updated to ensure authorisation details align to the information contained in the CMRs. Staff will be informed of the updates at the Legal Services team meeting.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	30.09.2024	Medium	Overdue	January 2025 Update - Due to operational pressures and restructuring of staff - action continues on this recommendation. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/188	11.06.2024	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms.	Internal Audit/2024/188/MD5/4	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 DCQJ system.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	31.08.2024	Medium	Overdue	January 2025 Update - Action remains open. Team to contact WRP Task & Finish Group. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	1. Consideration should be given to enabling SRM in order to better facilitate DR to alternate sites.	Internal Audit/2024/189/MD1/1	A review into the use of VSRM will be carried out. Although an automated DR would be optimal, there are a number of scenarios where it would be preferred to have manual intervention into this type of response. This is in part due to some of the other work that would be required to ensure systems were accessible at the DR site such as network addressing.	Digital & Data Director of Digital	30.09.2024	03.03.2025	Low	In progress	January 2025 Update - Dell have confirmed that RecoverPoint still has a development roadmap, a process has begun to update all of the VMWare environments so that the new version of RecoverPoint can be used. November 2024 Update - Recoverpoint is a fit for purpose solution for VMWare replication and we have validated replicas. In order to have full automated site recovery, dependent networking capabilities need to be in place, such as stretched layer 2 networks. Discussions are developing with both Cisco and PSBA on this.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	2.1 The Health Board should consider increasing alternate site capacity to enable full service delivery.	Internal Audit/2024/189/MD2/1	Prior to increasing capacity, CTM should complete the system criticality mapping, and therefore have a structure and precedence for systems to be brought back (while noting that certain key infrastructure components need to be present as a foundation – such as DHCP, File, Print and Citrix). Capacity relates to storage in this matter, and by not restoring legacy archive data, the storage requirements may reduce.	Digital & Data Director of Digital	30.09.2024	03.03.2025	Medium	In progress	January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. November 2024 Update - The provision for Disaster recovery is currently being sent replicas of key systems. This will allow a Virtual Machine level recovery. Currently the space available is not a constraint. A review of the next servers (Tier2) to replicate is underway.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	3.1 Once the DR site has been provisioned the resilience position should be tested to ensure it operates as anticipated. Going forward resilience should be subject to regular testing, falling over between rooms and across sites to ensure it still operates.	Internal Audit/2024/189/MD3/1	A schedule for end-to-end failover testing will be produced and implemented. This should include a full prioritised recovery of systems and validation by system managers/end users. An ongoing log will be maintained.	Digital & Data Director of Digital	31.12.2024	31.03.2025	Medium	In progress	January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. November 2024 Update - A resource has been aligned to support Disaster Recovery planning. They will also coordinate the testing activities with the respective infrastructure and systems leads.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	4.1 The DR plan should be updated to reflect the new environment. The plan should consider the main types of failure such as IT, power, communications and cover the network infrastructure. • The DR plan should include processes to follow in order to restore services in the event of varying degrees of failure such as: • Failure of site provision of failover instructions, restore priorities; • Failure of rack provision of failover and restore instructions; • Failover of VM restore and restore from backup, and • Failure of system – VM restore / backup restore.	Internal Audit/2024/189/MD4/1	The UHB will establish a prioritised plan, incorporating step by step procedures for the restoration of services following a major incident, under 4 separate scenarios, incorporating the fault domain failures as relevant (site, rack, VM, system): - Cyber impacting affecting CTM network and services - Environment impact affecting CTM network and services (e.g. utility loss, flood or fire) - Loss of DHCW services - Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & Internet)	Digital & Data Director of Digital	30.09.2024	31.03.2025	Medium	In progress	January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. November 2024 Update - A resource has been aligned to support Disaster Recovery planning. They have commenced their work with a focus on the overarching DR plan aligned to server hosting.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	5.1 An assessment of the need for individual service DR plans should be undertaken. Following that detailed DR documentation should be in place, either within the Server DR document, or within individual DR documents for each service which sets out the architecture, and processes to follow in order to restore the service. The DR documentation should explicitly include information on the resilience tier and RTO/RPO and this should be communicated to service leads.	Internal Audit/2024/189/MD5/1	The criticality of systems will be prioritised based on criticality. The exercise to document DR plans for all critical systems as defined by NIS regulations will continue with progress overseen by the Cyber Security Assurance Board. The DR documentation will include information on the resilience tier and RTO/RPO and will be communicated to system managers.	Digital & Data Director of Digital	30.12.2024	31.03.2025	Medium	In progress	January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. November 2024 Update - A resource has been aligned to support Disaster Recovery planning and they will use the output from the System Criticality mapping to ensure that the prioritisation for recovery is set out and communicated agreed.
Internal Audit/2024/189	07.06.2024	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	6.1 The services to be restored to alternate sites should be formally defined and a prioritised order for recovery set out. This should be based on a formal assessment of service criticality and risk.	Internal Audit/2024/189/MD6/1	This links to the work being carried out for the NIS Regulations. This will be complete in line with MAs 2.5.	Digital & Data Director of Digital	30.12.2024	31.03.2025	High	In progress	January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities. Operational pressures have affected the timescales - new target date of 31st March 2025. November 2024 Update - A resource has been aligned to support Disaster Recovery planning and they will use the output from the System Criticality mapping to ensure that the prioritisation for recovery is set out and communicated agreed.
Internal Audit/2024/190	03.06.2024	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	4.4 Quality and Safety Corporate Directorate The terms of reference for the Quality and Safety Business Team Meeting should finalised as soon as possible, so as to formalise the responsibility in relation to risk register monitoring and the process for escalation or risks. It should be ensured that department risk register is routinely discussed at the Quality and Safety Business Team Meeting with onward reporting and escalation to the Quality and Safety Improvement Meeting where necessary. Minutes or action logs from each meeting should be retained to allow clarity on what was discussed and actions that need acting upon.	Internal Audit/2024/190/MD9/1	The terms of reference for the Quality and Safety Business Team Meeting to be finalised incorporating the monitoring of risk as a routine item. Minutes and decision log reflect action taken.	Patient Care & Safety Executive Director for Nursing/Deputy CEO Director of Governance	31.07.2024	30.04.2025	Medium	Partially complete	January 2025 Update - This action was not fulfilled in so much as the approval process of the ToR was not completed, this was due to a review of the meetings and the aims and objectives of the same with a revised way of working and meeting structure. This is still work in progress and we are planning to have a fully revised meeting structure in place to start the new financial year April 2025. Revised due date of 30th April 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	1.1b Up to date terms of reference for each committee and group should be in place and include information such as purpose and remit of the group, frequency of meetings, attendees and quoracy arrangements.	Internal Audit/2024/192/MD1/1	The Terms of Reference for the current established Care Group meetings have been drafted and will be reviewed and amended where required to reflect the audit findings, these will be taken to the relevant meetings for sign off. The Terms of Reference will be saved in the Care Group Teams channel and reviewed annually.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - Terms of Reference are ratified or going through ratification for all areas and maintained within the Business, Improvement, Strategy and Commissioning directorate.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	2.1 Consideration should be given to the format of capturing meeting information. Whilst slide decks are a useful platform for presenting information, an appropriate mechanism to capture attendees, key points discussed, decisions made and actions to take forward should be in place.	Internal Audit/2024/192/MD2/1	The Integrated Performance Meetings Terms of Reference will be updated to ensure that key actions and decisions are documented and included for future meetings.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - All key fora have action logs and minutes to confirm attendance, and actions are recorded. With new Service Director coming in, governance processes will be reviewed. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - The Terms of Reference have been reviewed and revised and will be taken to the next MR&LD People, Planning, Performance & Finance Meeting on 31.7.24 for final approval. These capture the need to document decisions and actions.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.1 For absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed. All periods of absence should be fully covered by self-certification forms or medical certificates.	Internal Audit/2024/192/MD7/1	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.1 For absence to be properly managed and pay not to be affected, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. Management should ensure that self-certification and return to work forms are fully completed. All periods of absence should be fully covered by self-certification forms or medical certificates.	Internal Audit/2024/192/MD7/2	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate Integrated Performance Meeting Quarterly.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - complete/continuous now - we have regular workforce meetings to review September 2024 Update - An update against this recommendation has not been provided on this occasion.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.2 Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Internal Audit/2024/192/MD8/1	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - complete/continuous now - we have regular workforce meetings to review September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AM&T Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.2 Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.	Internal Audit/2024/192/MD8/2	A sample audit of 5 staff files will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting Quarterly.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.3 Long-term absence should be managed in line with the policy in order to prevent absences being longer than necessary.	Internal Audit/2024/192/MD9/1	All Ward Managers and deputies will attend a refresher training session on managing Sickness and Absence in accordance with CTM policy.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Low	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - A list of all appropriate staff has been shared with People Services and a training date is pending.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	6.3 Long-term absence should be managed in line with the policy in order to prevent absences being longer than necessary.	Internal Audit/2024/192/MD9/2	A sample audit of 5 staff files for sickness absence documentation will be carried out by the Senior Nurse every 3 months and reported into the Directorate QSRE/Performance meeting.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Low	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - complete/continuous now - we have regular workforce meetings to review. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role.	Internal Audit/2024/192/MD11/2	The Ward Manager will ensure that time is protected for staff to complete training modules.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - training and compliance is reported through our workforce meetings and staff are provided opportunities for core training as well as additional training. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role.	Internal Audit/2024/192/MD11/3	A laptop will be made available which can be booked for the purpose of completing e-learning modules	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - training and compliance is reported through our workforce meetings and staff are provided opportunities for core training as well as additional training. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	9 It should be ensured that all staff are provided with the opportunity to undertake their mandatory training Staff. should be reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that training at higher levels is a Health Board expectation for that role.	Internal Audit/2024/192/MD11/5	Senior Nurses will review the ESR system and ensure that the correct core skills are allocated to each staff group.	Care Group Chief Operating Officer	31.07.2024	31.07.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update – Following the update as at November 2024, this action can be closed. November 2024 Update - training and compliance is reported through our workforce meetings and staff are provided opportunities for core training as well as additional training. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	10.1 Care should be taken to ensure data is accurately transferred from the worked roster to the Health Roster system on a weekly basis.	Internal Audit/2024/192/MD12/2	A spot check audit of 2 separate weeks of Health Roster will be undertaken by the Senior Nurse which will compare paper roster and the Health Roster system for accuracy. This will be reported at the Directorate QSRE meeting.	Care Group Chief Operating Officer	31.08.2024	31.08.2024	Medium	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion. September 2024 Update - An update against this recommendation has not been provided on this occasion. July 2024 Update - Work has commenced and this action is expected to be completed by the target date.
Internal Audit/2024/192	04.06.2024	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	11.1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period.	Internal Audit/2024/192/MD13/1	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.	Care Group Chief Operating Officer	30.06.2024	30.06.2024	High	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - we have experienced issues with the Allocate software and more training on the software is being sought.
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	1.1 The data and AI programme should be reviewed and if necessarily refreshed following the publication of the revised Ministerial Statement of Intent.	Internal Audit/2024/199/MD1/1	The UHB will seek to contribute to the refresh of the Ministerial Statement of Intent on data and AI and the strategic and tactical refresh of the accompanying work programme. We will ensure that the data strategy is refreshed at the appropriate time.	Director of Digital Digital & Data	31.12.2024	31.12.2024	Medium	Overdue	January 2025 Update - Work programme for data developed for consideration within the IMTP development process, aligns to organisational and national priorities. It will require additional investment, not necessarily directly into any one service or department, if design principles are agreed and adhered to. AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. We anticipate WG strategic direction on this. In the interim we are seeking to safely enable the use of AI within the UHB to support delivery of our CTM 2030 objectives. November 2024 Update - The UHB is presently contributing to the phase 4 NDR business case which is a key driver for delivery of the data programme for the next 3 years. This is pertinent as WG provides funding for the UHB's data function via the NDR programme and in agreeing to the NDR business case, the UHB will be required to contribute to delivery of these strategic objectives. If the case is agreed, the data programme will be revised accordingly. In regards to AI, there remains an intention to develop an AI strategy and to continue to benefit from the its use. An AI policy has been drafted for wider consideration and processes incorporating training materials have been established to enable staff to benefit from web based generative AI applications (e.g. chatgpt).
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	1.1 The data and AI programme should be reviewed and if necessarily refreshed following the publication of the revised Ministerial Statement of Intent.	Internal Audit/2024/199/MD1/2	It is the intention of the UHB to develop a strategic position and plan for AI over the course of the next 6 months.	Director of Digital Digital & Data	30.04.2025	30.04.2025	Medium	In progress	January 2025 Update - Work programme for data developed for consideration within the IMTP development process, aligns to organisational and national priorities. It will require additional investment, not necessarily directly into any one service or department, if design principles are agreed and adhered to. AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. We anticipate WG strategic direction on this. In the interim we are seeking to safely enable the use of AI within the UHB to support delivery of our CTM 2030 objectives. November 2024 Update - The UHB is presently contributing to the phase 4 NDR business case which is a key driver for delivery of the data programme for the next 3 years. This is pertinent as WG provides funding for the UHB's data function via the NDR programme and in agreeing to the NDR business case, the UHB will be required to contribute to delivery of these strategic objectives. If the case is agreed, the data programme will be revised accordingly. In regards to AI, there remains an intention to develop an AI strategy and to continue to benefit from the its use. An AI policy has been drafted for wider consideration and processes incorporating training materials have been established to enable staff to benefit from web based generative AI applications (e.g. chatgpt).
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	1.2 The Data and AI programme should be refreshed in the event that the Digital Strategy is updated. This should include an organisational wide perspective, noting that the Central Data / Information Team are the professional leads and the organisational aims to improve information use.	Internal Audit/2024/199/MD2/1	In a rapidly developing environment the UHB will endeavour to ensure that our strategic and tactical approach to digital, data and AI, the EHR, patient portal, and other areas align through regular consideration and refresh of our strategic, tactical and operational decision making.	Director of Digital Digital & Data	30.04.2025	30.04.2025	Medium	In progress	January 2025 Update - Work programme for data developed for consideration within the IMTP development process, aligns to organisational and national priorities. It will require additional investment, not necessarily directly into any one service or department, if design principles are agreed and adhered to. AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. We anticipate WG strategic direction on this. In the interim we are seeking to safely enable the use of AI within the UHB to support delivery of our CTM 2030 objectives. November 2024 Update - The UHB is presently contributing to the phase 4 NDR business case which is a key driver for delivery of the data programme for the next 3 years. This is pertinent as WG provides funding for the UHB's data function via the NDR programme and in agreeing to the NDR business case, the UHB will be required to contribute to delivery of these strategic objectives. If the case is agreed, the data programme will be revised accordingly. In regards to AI, there remains an intention to develop an AI strategy and to continue to benefit from the its use. An AI policy has been drafted for wider consideration and processes incorporating training materials have been established to enable staff to benefit from web based generative AI applications (e.g. chatgpt).
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	3.1 A Data Quality Policy, or statement of intent should be developed that makes clear what good quality data looks like and its characteristics along with clear expectations and responsibilities of staff.	Internal Audit/2024/199/MD4/1	The UHB will develop and implement a data quality policy, recognising that we anticipate the real improvements to be made when the data becomes available to the staff members who initially made the record and staff members who would use the records to meet the requirements. This availability is dependent upon the open architecture and NDR programmes moving into rapid delivery phases.	Director of Digital Digital & Data	31.01.2025	31.01.2025	Medium	In progress	January 2025 Update - Further review has identified that if the policy extends to not only to 'data' in the conventional sense, but also to the algorithms, tools, and workflows that led to that data there is a requirement to consider quality in development and adoption of AI materials. ABHB have kindly shared their approach in this area, which on review appears eminently sensible. The policy will thus be amended to incorporate this and then be subject to the scrutiny and assurance process for policy adoption. November 2024 Update - An outline data quality policy has been drafted, however the requirement to maintain services whilst re-roofing POW has resulted in the writing of the policy being postponed. However the requirement for good quality data has been highlighted and far more widely accepted by senior staff across the organisation as a result of the POW incident and it is anticipated that behaviours and attitude towards data quality will have been enhanced.
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	4.1 Consideration should be given to using the IAR process to fully identify data pools and expanding the information held within the IAR.	Internal Audit/2024/199/MD5/1	The UHB will establish a data catalogue in line with Welsh standards as part of a commissioned and funded element of the National Data Resource programme.	Director of Digital Digital & Data	31.03.2027	31.03.2027	Medium	In progress	January 2025 Update - No further update – NDR phase 4 BC not yet agreed by WG. November 2024 Update - This long term action continues to be pursued, with funding proposed to be set aside to fulfil this task as part of the phase 4 NDR business case.
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	5.1 A Data Governance Framework for the organisation should be defined that sets out the requirements and responsibilities for the identification, aggregation, recording and use of data. This should include requirements for the presentation of information products that comply with good practice.	Internal Audit/2024/199/MD6/1	A data governance framework complementary to the data quality policy, and incorporating the numerous mandated requirements placed on the UHB will be developed and implemented.	Director of Digital Digital & Data	31.01.2025	31.01.2025	Medium	In progress	January 2025 Update - As above – there is a requirement to incorporate a data governance framework that is applicable for the development and adoption of AI. This requires further work. November 2024 Update - An outline data governance framework complementary to the data quality policy has been drafted, however the requirement to maintain services whilst re-roofing POW has resulted in the writing of the policy being postponed. However the requirement for good quality data has been highlighted and far more widely accepted by senior staff across the organisation as a result of the POW incident and it is anticipated that behaviours and attitude towards data quality will have been enhanced.
Internal Audit/2024/199	04.10.2024	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07_	6.1 Training materials on data and its users should be provided, with targeted training provided to key staff tiers.	Internal Audit/2024/199/MD7/1	The organisation will explore core competency training that is presently available across NHS and public sector Wales with the intention of incorporating this into the personal development approach of the organisation.	Director of Digital Digital & Data	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - No update. November 2024 Update - Work to be progressed in the first quarter of 2025.
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	1.1 Management within Children & Families care group should review and update the terms of reference for their QPSE meetings.	Internal Audit/2024/200/MD1/1	We acknowledge the importance of having clear and up-to-date ToRs for our QPSE meetings. We agree that a review and update of these terms of reference is required, to ensure they align with current priorities and best practices of the Children's and Families Care Group. A thorough review of the existing QPSE meeting ToRs will be conducted. Any outdated elements or areas that require enhancement will be made to the ToRs. The ToRs will be reviewed on an annual basis.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	31.12.2024	Low	Overdue	January 2025 Update - Work has been undertaken within the Children & Families Care Group. These have now been standardised in the QSRE slides in alignment with USC & Planned care. The business intelligence team are now providing the data which means this is up to date. CYP presented an example of which during the December QSRE, these are also provided from the maternity HoMs as well. The terms of reference were updated accordingly in August 2024, the quarry was reviewed as it was identified that there were too many people in attendance. Finance representation has been reviewed and an invite dependent on the agenda items will be shared with the finance lead as a co-opted member of the group. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	1.2a - The quarry arrangements for the QPSE meetings should be reviewed and made clearer. A review of attendees at the Children & Families QPSE meetings should take place to make efficient use of time, whilst also adhering to any quarry requirements. 1.2b - Where the Head of Quality and Patient Safety is unable to attend care group QPSE meetings, a representative should attend on their behalf. The ToRs should be updated to provide clarity on the need for representatives to attend meetings, if key members are unable to attend. 1.2c - It should be determined if finance colleagues are required to be in attendance at QPSE meetings. If it is felt they are not required to attend, the ToRs should be updated. However, if it is determined that finance representation is a requirement, care group management should remind their finance representatives of this requirement.	Internal Audit/2024/200/MD2/1	We will conduct a thorough review of the existing ToRs and make the following updates: 1.2a - Clarify the quarry requirements, specifically defining how many representatives are needed from each service group/area for the meeting to be considered quorate. 1.2b - Update the list of required attendees and specify the need for deputies (especially in relation to the Head of Q&S and deputy) to attend in their absence. 1.2c - The QPSE Group will review whether finance colleagues are required to be in attendance at the QPSE meetings. If it is determined that finance representation is a requirement, the QPSE Chair will: • Remind finance representatives of the requirement to attend, • Emphasise the importance of their participation, • Ensure finance colleagues understand their role within the QPSE meetings.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.11.2024	28.02.2025	Medium	In progress	January 2025 Update - 1.2a The quarry arrangements for each of the QPSE meetings is to undergo a final review to ensure all QPSE meetings are quorate and make efficient use of time. 1.2b - Where the Head of Quality and Patient Safety is unable to attend care group QPSE meetings, a representative now attends on their behalf. Each of the QPSE ToRs are being reviewed to provide clarity on the need for representatives to attend meetings, if key members are unable to attend. 1.2c - Discussions are ongoing in relation to requirement for finance colleagues to attend QPSE meetings. Final completion of the 3 recommendations will be completed by 28 February 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	2.1 Management should ensure that care groups use the standard slide template provided by the framework. This includes incorporating sections for risk registers, key governance issues, and shared learning.	Internal Audit/2024/200/MD3/1	We acknowledge the importance of consistency and comprehensive reporting in our governance framework. The Corporate Quality & Safety team will review all Care Group QPSE slide templates and/or other methods of reporting, to ensure structures for reporting are consistent and in-line with the standard slide deck template within the Quality and Safety framework. The Corporate Quality & Safety Team will review compliance of the slide templates on a bi-annual basis.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.10.2024	31.10.2024	Medium	Overdue	January 2025 Update - The Corporate Quality & Safety team will review all Care Group QPSE slide templates and/or other methods of reporting, to ensure structures for reporting are consistent and in-line with the standard slide deck template within the Quality and Safety framework bi-annually: March and September each year. The Corporate Quality & Safety Team will review compliance of the slide templates on a bi-annual basis November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	2.2 Some CSGs included additional information in their slide deck presentations, such as data on Learning from Event Reports (LVERs), PDR & mandatory training compliance rates and other performance data. If care group management consider this additional information to be beneficial, then consideration should be given to standardising this practice across CSGs and care groups. The slide deck template could be updated to include these sections, ensuring departments present this information in a consistent way.	Internal Audit/2024/200/MD4/1	The Corporate Quality & Safety Team will conduct a review of the additional information currently being included by some CSGs. This review will assess the value and relevance of any additional information and whether, for consistency, this should be included within the standard slide-deck (or other method of structure for reporting).	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	28.02.2025	Low	In progress	January 2025 Update - Slide Decks have been reviewed and approval of final template will be agreed by 28 February 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	3.1 Management should ensure that all Care Groups have a documented assurance framework in place, setting out the assurance activities and structure of the CSGs and Care Group as a whole.	Internal Audit/2024/200/MD5/1	The Corporate Quality & Safety Team will: • conduct a detailed assessment of existing assurance frameworks within each Care Group to identify gaps and areas for improvement; • Develop a standardised assurance framework template that outlines key assurance activities and structures. This will include guidelines on documentation, reporting, and compliance requirements; • Establish a bi-annual monitoring and evaluation process to regularly review the effectiveness of the assurance frameworks. This will include periodic audits and feedback mechanisms to ensure continuous improvement.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	30.11.2024	28.02.2025	Medium	In progress	January 2025 Update - The Corporate Quality & Safety Teams are currently undertaking a review of existing assurance frameworks within each Care Group to identify gaps and areas for improvement. A standard assurance framework template is to be agreed by 28 February 2025 and will be monitored bi-annually: March and September each year. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	4.1 The annual quality work plans developed by the pathology departments should be updated to include SMART objectives. The approach used by pathology should then be shared wider within the care group and to other care groups as a template for the development of annual quality plans as required by the Quality framework. Progress in implemented the care group level plans should be monitored via the care group QPSE meetings.	Internal Audit/2024/200/MD6/1	The Pathology Department will update their Annual Quality Work Plan to include SMART objectives. Once the Pathology Department Annual Quality Work Plan has been updated, the revised plans will be shared at Care Group QPSE meetings.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	15.10.2024	15.10.2024	High	Overdue	January 2025 Update - Discussions continue with Pathology Department. Action Quality Work Plans to be agreed for other QPSEs thereafter. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	4.1 The annual quality work plans developed by the pathology departments should be updated to include SMART objectives. The approach used by pathology should then be shared wider within the care group and to other care groups as a template for the development of annual quality plans as required by the Quality framework. Progress in implemented the care group level plans should be monitored via the care group QPSE meetings.	Internal Audit/2024/200/MD6/2	Templates and guidelines will be distributed to each Care Group QPSE group, who will complete an Annual Quality Work Plan (using SMART objectives). Each Care Group will ensure their QPSE Annual Quality Work Plan aligns with the Health Board's Annual Quality Work Plan. Care Groups will: • Ensure the QPSE Annual Quality Work Plan aligns with the Health Board's overarching Work Plan. • Add quality work plan updates as a standing agenda item at QPSE meetings; • Provide quarterly progress reports on SMART objectives; • Establish a process to escalate any objectives that are off-track; • Conduct an annual review of completed objectives and any lessons learned. * Although we would normally undertake this work immediately, due to the nature of the action a realistic timescale will be 31 December 2024.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	31.12.2024	High	Overdue	January 2025 Update - Discussions continue with Pathology Department. Action Quality Work Plans to be agreed for other QPSEs thereafter. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/200	16.09.2024	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	5.1 Management should review the reporting timeliness for Children & Families to ensure that the data presented is as current as possible to enable more accurate and timely data for decision making.	Internal Audit/2024/200/MD7/1	The Children & Families Care Group will review of the current reporting processes to identify any delays in the reporting timeliness of data to ensure it is as current as possible.	Patient Care & Safety Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	28.02.2025	Low	In progress	January 2025 Update - this action is ongoing and it is anticipated to be complete at 28 February 2025. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: Information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/1	1.1a It was recognised through the medical workforce programme that greater control and assurance was required hence the need to revise the FCP and SOP. Scrutiny revealed longstanding inconsistencies throughout the Health Board therefore addressing these issues has taken longer than originally anticipated. The investment of time in completing this work is essential to meet our organisational workforce financial controls and assurance. The FCP is being revised in line with the new Care Group structure and the Scheme of Delegation and will be submitted to Audit Committee in October 2024.	People Executive Medical Director Executive Director for People	31.10.2024	31.10.2024	High	Fully complete (Awaiting approval)	January 2025 update: The FCP was updated and went to ARC in October 2024. Further comments picked up in the internal audit 2024 are being addressed but this action can be closed. November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action.
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/2	1.1a Contd. The FCP is being revised in line with the new Care Group structure and the Scheme of Delegation and will be submitted to Audit Committee in October 2024. Following this the action is to revise the SOP. (Linked to 1.1a).	People Executive Medical Director Executive Director for People	30.11.2024	30.11.2024	High	Fully complete (Awaiting approval)	January 2025 Update - The FCP was updated and went to ARC in October 2024. Further comments picked up in the internal audit 2024 are being addressed but this action can be closed. November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action. Rules and plans for action will be finalised.
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: Information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/3	1.1b - The revised SOP and FCP will be available on the intranet	People Executive Medical Director Executive Director for People	31.12.2024	31.12.2024	High	Fully complete (Awaiting approval)	January 2025 Update - The FCP was updated and went to ARC in October 2024. Further comments picked up in the internal audit 2024 are being addressed but this action can be closed. November 2024 Update - A meeting is scheduled to take place on 25/11/2024 to discuss this action.
Internal Audit/2024/201	16.09.2024	Follow-up: Medical Variable Pay – Agency Costs_September 2024 (Review Reference: CTMUHB-2324-23)	1.1a - The review of the Medical Variable Pay Financial Control Procedure and the Medical Agency Locums Standard Operating Procedure should be completed. Both documents should be updated to reflect the revised organisational structure and the processes and controls that staff should be adhering to when engaging medical agency staff. The review should include: Information on the agreed rate card values and the authorisation process should those values need to be exceeded. Clarity on when non-direct engagement is acceptable and the scrutiny and authorisation process that should be followed. The process for extending agency worker placements. The process for managers to approve the use agency workers to cover roster gaps. 1.1b - Updated copies of the updated FCP and SOP should be accessible to all staff, and staff should be made aware of their existence. 1.1c - Consideration should be given to providing training to relevant staff to raise awareness of the FCP and SOP and ensure staff are clear on the correct processes to be followed.	Internal Audit/2024/201/MD2/4	1.1c - The training provision timetable will be discussed and agreed at the Medical Workforce Productivity Framework Group.	People Executive Medical Director Executive Director for People	31.10.2024	31.10.2024	High	Fully complete (Awaiting approval)	January 2025 Update - The FCP was updated and went to ARC in October 2024. Further comments picked up in the internal audit 2024 are being addressed but this action can be closed. November 2024 Update - Discussed at Framework Group meeting on 19/11/2024. Further discussion to take place in meeting scheduled to take place on 25/11/2024, where plans and actions will be finalised.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference: CTM-2324-25)	1.1 The review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to Operational Management Board (OMB) and the Executive Leadership Group (ELG) for final approval.	Internal Audit/2024/202/MD1/1	1.1 To be added to the agenda for Operational Management Board (OMB) following the review and refresh of the Waiting List Management Standard Operating Procedure should be concluded and be presented to OMB and the Executive Leadership Group (ELG) for final approval.	Planned Care Chief Operating Officer	30.11.2024	30.11.2024	Low	Overdue	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection Action added October 2024.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference: CTM-2324-25)	2.1 Following completion of changes to the operating model and the merge to one WPAS system, the Health Board should perform a training needs assessment of staff responsible for booking appointments, including the application of the Waiting List Management SOP/RTT rules, specifically in relation to reasonable offers and the required audit trail within WPAS.	Internal Audit/2024/202/MD2/1	2.1 An additional training needs assessment and compliance sign off will take place post WPAS merge in May 2025.	Planned Care Chief Operating Officer	31.08.2025	31.08.2025	Medium	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference: CTM-2324-25)	3.1 Management should pursue their original management response of generating WPAS compliance reports as a mechanism to identify staff training requirements.	Internal Audit/2024/202/MD3/1	3.1 Following OCP phase 3, an additional audit of the 'all users with WPAS compliance' report to take place and training arranged for identified staff. Directorates will review and identify where they need training. Monthly Monitoring to enable staff training requirements.	Planned Care Chief Operating Officer	31.01.2025	31.01.2025	Low	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection added October 2024.
Internal Audit/2024/202	02.10.2024	Follow-Up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference: CTM-2324-25)	4.1 Post-restructure, a full review of the approach to data validation should be undertaken to ensure compliance with the Waiting List Management SOP and RTT rules. The outcome of this work should be used to identify trends in errors to allow training to be targeted on certain aspects of the process or to certain teams /specialties.	Internal Audit/2024/202/MD4/1	4.1 Planned Care to undertake a review of the validation process across CTMUHB. Outcome of review to be shared with the Improving Care Board.	Planned Care Chief Operating Officer	31.01.2025	31.01.2025	Medium	In progress	January 2025 Update - An update against this recommendation has not been provided on this occasion. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.1a To minimise the number of patients on the 'outpatients not booked' reports, following outpatient appointments, WPAS should be accurately updated in a timely manner. Each speciality should be clear who is responsible for performing this role and ensure relevant staff are aware of their responsibilities.	Internal Audit/2024/203/MD1/1	1.1a Directorates working with admin staff & records department to ensure they are taking back to source and to identify if any training requirements.	Planned Care Chief Operating Officer	31.01.2025	30.06.2025	High	In progress	January 2025 Update - Progress being made on actions, with delay as operational focus on Critical Incident. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.1b Each speciality should set out who is responsible for actioning 'outcomes not booked' reports. Staff should be made aware of their responsibilities.	Internal Audit/2024/203/MD2/1	1.1b Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team.	Planned Care Chief Operating Officer	31.10.2025	30.06.2025	High	In progress	January 2025 Update - Progress being made on actions, with delay as operational focus on Critical Incident. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New inspection action added October 2024.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.1c As reports are received each week, speciality managers should ensure they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data and those staff or department that are facility to rectify errors. Where necessary appropriate action should be taken including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for.	Internal Audit/2024/203/MD3/1	1.1c Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support.	Planned Care Chief Operating Officer	30.11.2024	30.06.2025	High	In progress	January 2025 Update - Progress being made on actions, with delay as operational focus on Critical Incident. Requires a CTMUHB focus on validation. A task and finish is being established for validation of pathways across all specialities. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	1.2 The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken.	Internal Audit/2024/203/MD4/1	1.2 Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams.	Planned Care Chief Operating Officer	30.11.2024	30.11.2024	Low	Overdue	January 2025 Update - Progress being made on actions, with delay as operational focus on Critical Incident. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.1a Each speciality should set out who is responsible for actioning 'closed pathway' reports when they are received each month. Staff should be made aware of their responsibilities	Internal Audit/2024/203/MD5/1	2.1a Directorate and Directorate Support Managers receive data and actions to be set at local Directorate performance meetings. To be rolled out across all Directorates. Updates are recorded and discussed at weekly Planned Care Weekly Performance Meeting – chaired by Director of Ops.	Planned Care Chief Operating Officer	30.11.2024	30.06.2025	High	In progress	January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.1b To minimise the number of patients incorrectly on closed pathways, as reports are received each month, speciality managers should ensure they analyse the data to identify those departments with high numbers of brought forward cases, and trends such as those staff or departments that are continually failing capture information correctly. Appropriate action should be taken, including the provision of additional training on the WPAS and holding staff to account if they are failing to perform tasks they are responsible for.	Internal Audit/2024/203/MD6/1	2.1b Distribution lists updated to reflect new Directorate structures, will need further updating once vacancies filled. Draft produced and to be sent to PAS team. Directorate ops teams continue to validate 'outcomes not booked', next steps to take back to source and work with admin, secretaries and medical records to ensure processes are followed. Any training needs will be highlight to WPAS team for support.	Planned Care Chief Operating Officer	31.10.2025	30.06.2025	High	In progress	January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Requires a CTMUHB focus on validation. A task and finish is being established for validation of pathways across all specialities. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.2a The wording used in the emails sent by the WPAS team could be further strengthened to ensure those receiving the reports are clear on the implications for patients if the reports are not acted upon and corrective action taken.	Internal Audit/2024/203/MD7/1	2.2a - Directorate Managers and Services Managers (new structure) will be included in reporting emails to ensure the correct message is disseminated to the ops teams.	Planned Care Chief Operating Officer	30.11.2024	30.06.2025	Low	In progress	January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	2.2b Consideration should be given to issuing separate 'closed pathways' reports to each speciality, as opposed to one generic report that has to be filtered.	Internal Audit/2024/203/MD8/1	2.2b - New updated distribution lists will ensure correct services and teams are receiving relevant report for their areas/specialities	Planned Care Chief Operating Officer	31.10.2025	30.06.2025	Low	In progress	January 2025 Update - All distribution and reporting tools updated. Focus in the weekly RTT meetings on validation. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/203	27.09.2024	Follow-up: Patient Pathways Final Internal Audit Report - September 2024 (Review Reference: CTM 23/24-31)	3. Those medical secretaries that do not yet have access to QL reporting tool should request access and if necessary, training, in order to be sure monitoring of patients awaiting diagnostic test results can be done in a consistent way across the Health Board, with no restrictions, such as those created by using 'watch lists'.	Internal Audit/2024/203/MD9/1	3. To be discussed and action set with new structure Directorate Managers and ops teams.	Planned Care Chief Operating Officer	30.11.2024	30.06.2025	Medium	In progress	January 2025 Update - Ongoing with development of 'watch lists' additional training supported by WPAS team for individuals and teams. However, audit and trends needs to be monitored. Revised due date is June 2025 from 31.10.2024. November 2024 Update - An update against this recommendation has not been provided on this occasion. New Inspection action added October 2024.
Internal Audit/2024/204	07.10.2024	Follow-up: Facilities Governance Arrangements Final Internal Audit Report - October 2024 (Review Reference - CTMUHB 24/25-27)	4. Management should liaise with the Procurement Department resume the regular receipt of the invoices on Hold reports. Once received it should be ensured that queries are reviewed and resolved as soon as possible	Internal Audit/2024/204/MD1/1	4. Liaison with the procurement department takes place during monthly SLT meetings and Facilities & Procurement Compliance meetings. We have raised the lack of receipt of invoice on hold reports with the procurement lead. This data will now be provided monthly to the Performance Governance lead who will disseminate the relevant parts of the report to the various facilities departments. The department leads will be present at the Facilities & Procurement Compliance meetings where there will be scrutiny of the reports and managers held to account on the actions they have taken to resolve the hold issues. The SLT meetings will have a higher-level overview of facilities as a whole, but focus on hotspot departments if required. The first SLT meeting where invoice on hold data will be presented is due to take place on 03/10/24. At the current time there are just over 1,000 invoices on hold that the facilities team are responsible for actioning. Nearly 200 of these relate to a specific supplier that we intentionally put on hold due to hygiene risks and concerns with quality of supply.	Facilities Chief Operating Officer	31.10.2024	31.10.2024	Medium	Fully complete (Awaiting approval)	January 2025 Update - As per November Update Procurement Compliance meeting took place on 19th November with Procurement and Facilities management team in attendance. This is now a bi-monthly meeting and the invoice on hold is a standard agenda item. The next meeting is scheduled for 26th January – The agenda for this meeting and any previous meetings will be made available from Facilities. November 2024 Update - Invoice on hold report has been added to the Facilities - Procurement Compliance Meeting which is held on a bi monthly basis to enable Facilities Senior Managers to review with support from Procurement team. It is recommended that this action is now marked as completed. New Inspection action added October 2024.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure. The SOP should incorporate all relevant information from recently issued guidance on WUJ usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as: • Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment. • Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system. • When WUJ / sessional shifts can be created, and the grade of staff they can be used for. • Definitions of the 'reason' codes and guidance of when they can be used.	Internal Audit/2024/211/MD1/1	The FCP will be updated to reflect the changes in the audit.	People Executive Medical Director Executive Director for People	31.01.2025	28.02.2025	High	In progress	January 2025 Update - The FCP has been updated to reflect the audit but will need to go to key stakeholders for approval. Request to extend the deadline to 28/2/25.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure. The SOP should incorporate all relevant information from recently issued guidance on WUJ usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as: • Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment. • Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system. • When WUJ / sessional shifts can be created, and the grade of staff they can be used for. • Definitions of the 'reason' codes and guidance of when they can be used.	Internal Audit/2024/211/MD1/2	The SOP will be finalised to include the points raised in the audit and will align to the FCP.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This action remains on target. The SOP is being updated to reflect the points in the FCP so that they align and support the process in practice.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure. The SOP should incorporate all relevant information from recently issued guidance on WUJ usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as: • Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment. • Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system. • When WUJ / sessional shifts can be created, and the grade of staff they can be used for. • Definitions of the 'reason' codes and guidance of when they can be used.	Internal Audit/2024/211/MD1/3	Controls will be reviewed with Retinue to align to the FCP and SOP.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This action remains on target. Working with Retinue to ensure processes are in place to support the actions which will be incorporated into the SOP.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedure. The SOP should incorporate all relevant information from recently issued guidance on WUJ usage and rate cards. Where appropriate it should include the flow charts developed by Retinue. Management should also ensure that the findings of this report are used to identifying other areas where clear processes need to be defined, such as: • Timeframe for entering shifts into Patchwork (e.g. within one week of the shift being worked) and timeframes for approval for payment. • Situations when the creation of shifts retrospectively is acceptable and how the Retinue out of hours service should be used to minimise the need for creating retrospective shift on the system. • When WUJ / sessional shifts can be created, and the grade of staff they can be used for. • Definitions of the 'reason' codes and guidance of when they can be used.	Internal Audit/2024/211/MD1/4	Reporting and monitoring of retrospective shifts, WUJs usage and reason codes will be discussed at MWPP: PEG	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	High	In progress	January 2025 Update - This action remains on target. Working with the COO's team on WUJ process and with Retinue to ensure processes in place to support the actions. These will be incorporated into the SOP and develop data outputs to report to MWPP:PEG.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	1.2 Once an SOP has been developed: • It should be made accessible to staff via the intranet pages and consideration given to having links to it within the Patchwork app. • Staff should be made aware of its existence. • Consideration given to running training events or overview sessions for key areas to be discussed and allow staff to raise queries.	Internal Audit/2024/211/MD2/1	Once the FCP and SOP are agreed, both will be made accessible to all and training will be organised.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - As the completion date for the SOP is being extended to 31/3/2025, this action will also need to be extended. Request to change the completion date 31 May 2025.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	2.1 Management should minimise the use of direct bookings within the Patchwork app and encourage managers and rota coordinators to book shifts via the worker application route. To do this: • Rota coordinators and managers should be reminded of the various booking approaches and the circumstances when each can or should be used. The importance of an open and transparent process should also be reiterated. Where necessary refresher training on use of the system should be provided. • Guidance documentation (a SOP) should contain information on the various booking approaches and the circumstances when each can or should be used.	Internal Audit/2024/211/MD3/1	A reminder on the appropriate booking approaches and when to be used will be shared with rota co-ordinators and managers.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	Medium	In progress	January 2025 Update - This action remains on target to agree booking processes with rota co-ordinators and managers, which will be incorporated into the SOP.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	2.1 Management should minimise the use of direct bookings within the Patchwork app and encourage managers and rota coordinators to book shifts via the worker application route. To do this: • Rota coordinators and managers should be reminded of the various booking approaches and the circumstances when each can or should be used. The importance of an open and transparent process should also be reiterated. Where necessary refresher training on use of the system should be provided. • Guidance documentation (a SOP) should contain information on the various booking approaches and the circumstances when each can or should be used.	Internal Audit/2024/211/MD3/2	The SOP will confirm the appropriate booking approaches and when they should be used.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	Medium	In progress	January 2025 Update - This is on target for completion. The SOP will include details of the booking processes and when they should be used.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	2.2 Management should implement regular monitoring of booking practices, generating reports to track the use of direct bookings versus the worker system application. Deviations from the established process should be flagged and addressed promptly.	Internal Audit/2024/211/MD4/1	Monitoring of booking practices will be undertaken monthly and reported to MWPP: PEG.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - This is on target. Data to support the rules around booking processes will be submitted on a monthly basis to MWPP:PEG.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	2.2 Management should implement regular monitoring of booking practices, generating reports to track the use of direct bookings versus the worker system application. Deviations from the established process should be flagged and addressed promptly.	Internal Audit/2024/211/MD4/2	Accountability for identifying and reporting deviations will be clarified to address promptly.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update -This is on target. Data to support the rules around booking processes will be submitted on a monthly basis to MWPP:PEG.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	3. The tiered rate escalation approval system within Patchwork should be reviewed to ensure: • Limits are set up that align to the revised FCP. • Authorisers are set up in groups that align to their approval level, with no authorisers being able to approve at both below 10% escalated rates and above escalated rates. Rate approvers should also not be the same staff who can authorise timesheets for payment. • Only current and relevant staff are set up with authorisation access. Periodic reviews of rate authorisers and their access should take place to ensure appropriateness.	Internal Audit/2024/211/MD5/1	The alignment of the process between People and Retinue has been addressed.	People Executive Medical Director Executive Director for People	31.12.2024	31.12.2024	High	Fully complete (Awaiting approval)	January 2025 Update - This action is complete as noted in the response to the Audit.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	3. The tiered rate escalation approval system within Patchwork should be reviewed to ensure: • Limits are set up that align to the revised FCP. • Authorisers are set up in groups that align to their approval level, with no authorisers being able to approve at both below 10% escalated rates and above escalated rates. Rate approvers should also not be the same staff who can authorise timesheets for payment. • Only current and relevant staff are set up with authorisation access. Periodic reviews of rate authorisers and their access should take place to ensure appropriateness.	Internal Audit/2024/211/MD5/2	A review of the authorisation process commenced before the audit and evidence sent to the auditor. The authorisation rate within Retinue has been corrected to 10% instead of 25%.	People Executive Medical Director Executive Director for People	31.12.2024	31.12.2024	High	Fully complete (Awaiting approval)	January 2025 Update - This action has been completed as noted in the response to the Audit.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	3. The tiered rate escalation approval system within Patchwork should be reviewed to ensure: • Limits are set up that align to the revised FCP. • Authorisers are set up in groups that align to their approval level, with no authorisers being able to approve at both below 10% escalated rates and above escalated rates. Rate approvers should also not be the same staff who can authorise timesheets for payment. • Only current and relevant staff are set up with authorisation access. Periodic reviews of rate authorisers and their access should take place to ensure appropriateness.	Internal Audit/2024/211/MD5/3	A review of authorisers will be undertaken and updated within the Retinue and Patchwork systems.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This is on target. Authorisers have been chased up to confirm we have an accurate and up to date list of approvers at the right level.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours. A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure: • Patient safety and staff wellbeing are not being compromised. • Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts. • Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system. Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length.	Internal Audit/2024/211/MD6/1	The SOP will confirm the approach to working long shifts and the appropriate reason codes	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This action remains on target and will be incorporated into the SOP.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours. A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure: • Patient safety and staff wellbeing are not being compromised. • Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts. • Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system. Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length.	Internal Audit/2024/211/MD6/2	A process to periodically review of long shifts by CG will be initiated.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This is on target to outline the approach to long shifts.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours. A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure: • Patient safety and staff wellbeing are not being compromised. • Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts. • Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system. Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length.	Internal Audit/2024/211/MD6/3	Control options will be discussed with Retinue (Patchwork) regarding long shifts to establish what is possible	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This is on target to confirm the use/approach to long shifts and when appropriate to use.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	4. Management should undertake monthly reviews of Patchwork data to identify shift bookings that are considered excessive, such as greater than 12 hours. A further analysis by care group and directorate would help to target areas where long shifts are being recorded. Appropriate action should be taken to ensure: • Patient safety and staff wellbeing are not being compromised. • Ensuring that higher equivalent hourly rates are not paid by paying for longer shifts. • Staff are reminded to properly code shifts to ensure correct rates are paid and accurate information is captured in the system. Where excessive shift lengths continue, the Health Board could liaise with Patchwork to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length.	Internal Audit/2024/211/MD6/4	Monitoring long shifts will be reported at MWPP: PEG	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	High	In progress	January 2025 Update - This action remains on target for the monitoring of long shifts and to develop the process to share with MWPP:PEG.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	5.1 Evaluate the existing reason codes to ensure they all remain relevant and accurately reflect the needs of the organisation. Simplifying and standardising the reasons could streamline the process and improve clarity in data reporting.	Internal Audit/2024/211/MD7/1	The mandated fixed codes will be reviewed and streamlined.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	Medium	In progress	January 2025 Update - This is on target. To review reason codes to streamline the list for use which will improve reporting.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	5.2 In order to ensure accurate data is captured and available for future analysis, management should include the reason codes, and a description of when they should be used, within the user guidance. Staff should be reminded of the importance of selecting the correct reason code for a shift. This will enhance the accuracy of data collection and reporting, aiding in more effective decision-making.	Internal Audit/2024/211/MD8/1	The SOP will include the reason codes and when they should be used.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	Medium	In progress	January 2025 Update - This is on target. The SOP will include the reason codes to be utilised.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	5.2 In order to ensure accurate data is captured and available for future analysis, management should include the reason codes, and a description of when they should be used, within the user guidance. Staff should be reminded of the importance of selecting the correct reason code for a shift. This will enhance the accuracy of data collection and reporting, aiding in more effective decision-making.	Internal Audit/2024/211/MD8/2	The reason codes used and volumes will be reported to MWPP: PEG.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - This is on target. The reason codes utilisation will be submitted on a monthly basis to MWPP:PEG.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	5.3 Management should produce and analyse periodic reports on the level of use of reason codes for hourly shifts. Particular attention should be paid to those departments that regularly book shifts using the 'establishment vacancies' code to determine what work has been taken to tackle vacancy issues.	Internal Audit/2024/211/MD9/1	Quarterly audits will be undertaken by CGs to review reason codes and the volumes of each.	People Executive Medical Director Executive Director for People	30.04.2025	30.04.2025	Medium	In progress	January 2025 Update - This is on target.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	6.1 Management should analyse and monitor retrospective shifts created by care groups to address the root cause of retrospective shifts in each area, especially those entered more than two days after being worked, or where an inappropriate reason code has been used.	Internal Audit/2024/211/MD10/1	The SOP will confirm the approval control process and appropriate use of retrospective shifts within the Retinue and Patchwork systems.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This is on target. The SOP will include the use of and approach to retrospective shifts and when it is appropriate.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	6.1 Management should analyse and monitor retrospective shifts created by care groups to address the root cause of retrospective shifts in each area, especially those entered more than two days after being worked, or where an inappropriate reason code has been used.	Internal Audit/2024/211/MD10/2	Monitoring and analysis of the use of retrospective shifts to be discussed with CGs.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This is on target. Monitoring of retrospective shifts with CGs is underway.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	6.2 To reduce the occurrence of retrospective shifts, clearer guidance should be in place for: • When retrospective shifts are acceptable, how higher rates should be authorised, the correct use of reason codes and the maximum timeframes for creating the shift in Patchwork after the shift has been worked. Consideration should be given to requiring additional approval where there are significant delays in creating the shift. • Using the Retinue out of hours service to book urgent or outside of normal working hours shifts that cannot be processed in advance by the manager or on duty executive.	Internal Audit/2024/211/MD11/1	This is covered in 6.1. Controls for retrospective approvals will be confirmed.	People Executive Medical Director Executive Director for People	31.01.2025	31.01.2025	Medium	In progress	January 2025 Update - Communication of the use of retrospective shifts to CGs is in progress and aimed to be concluded by 31/1/25.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	6.2 To reduce the occurrence of retrospective shifts, clearer guidance should be in place for: • When retrospective shifts are acceptable, how higher rates should be authorised, the correct use of reason codes and the maximum timeframes for creating the shift in Patchwork after the shift has been worked. Consideration should be given to requiring additional approval where there are significant delays in creating the shift. • Using the Retinue out of hours service to book urgent or outside of normal working hours shifts that cannot be processed in advance by the manager or on duty executive.	Internal Audit/2024/211/MD11/2	This is covered in 6.1. To be analysed and trends will be shared at MWPP: PEG	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - This is on target. Data to support discussions is in development.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	7.1 Management should ensure that breaks are not removed when the shift is created. Consideration should be given to implementing a validation step within Patchwork that requires reason codes to be captured if breaks are removed, in the same way they are required if a worker removes a break from a worked shift if they were unable to take the break.	Internal Audit/2024/211/MD12/1	The automatic break function was turned on 31st July 2024. Further work to be undertaken with Retinue / Patchwork to ensure that breaks are not removed when shifts are created. Ongoing monitoring will take place to ensure compliance with the SOP.	People Executive Medical Director Executive Director for People	31.01.2025	31.01.2025	Medium	Fully complete (Awaiting approval)	January 2025 Update - This action is completed.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	7.2 Management should circulate clear and updated guidelines regarding the automatic break function and break policy, especially emphasising the correct process for shifts longer than 6 hours.	Internal Audit/2024/211/MD13/1	The updated guidelines for the automatic break function and break policy to be circulated.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	Medium	Fully complete (Awaiting approval)	January 2025 Update - This is completed.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	7.3 Implement a monthly review of shifts where breaks were removed, focusing on shifts longer than six hours. This will help identify patterns of non-compliance and address issues proactively.	Internal Audit/2024/211/MD14/1	To work with Retinue to develop reporting for monitoring at MWPP: PEG.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - Work is underway with Retinue to develop reporting for monitoring at MWPP:PEG.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	8.1 Clear guidance should be available to staff emphasising the importance of timely and accurate timesheet submissions by the employee (and not the rota co-ordinator) and the consequences of non-compliance.Guidance should include instructions on how to submit electronic timesheets and the timeframe they should be submitted in. Where necessary, training on the use of the Patchwork app should be provided to shift workers.	Internal Audit/2024/211/MD15/1	A review of the timesheet process will be undertaken with Retinue and Patchwork to ensure the correct authorisation process is followed in accordance with the SOP.	People Executive Medical Director Executive Director for People	31.01.2025	31.01.2025	Medium	In progress	January 2025 Update - The timesheet process has been undertaken and is updated into the SOP. Expected to be completed by 31/1/25.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	9.1 Clear procedures should be in place in relation to WLIs and made available to staff that includes information on a standardised process for creating sessional shifts within the system i.e. consistency between either hourly rates or total costs and ensuring shift duration is accurately recorded. Consideration should be given to providing training for rota coordinators, managers, and relevant staff to ensure they are fully aware of the guidelines and understand the correct usage of sessional shifts.	Internal Audit/2024/211/MD16/1	The SOP will set out the approach for WLIs.	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This is on target to confirm the approach for WLIs in the SOP.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	9.1 Clear procedures should be in place in relation to WLIs and made available to staff that includes information on a standardised process for creating sessional shifts within the system i.e. consistency between either hourly rates or total costs and ensuring shift duration is accurately recorded. Consideration should be given to providing training for rota coordinators, managers, and relevant staff to ensure they are fully aware of the guidelines and understand the correct usage of sessional shifts.	Internal Audit/2024/211/MD16/2	Reporting and monitoring will be shared at MWPP: PEG.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	High	In progress	January 2025 Update - This is on target to prepare reports to share with MWPP-PEG
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	9.2 To aid consistency and monitoring of costs, management should determine if the free-text box for recording sessional shift costs is appropriate, or if a fix rate should be captured in the system. This will also allow appropriate escalation within the system, should anyone request rates above those agreed.	Internal Audit/2024/211/MD17/1	Free text option will be reviewed with Retinue and Patchwork systems in line with the FCP and SOP to ensure application of WLIs are applied correctly.	People Executive Medical Director Executive Director for People	31.01.2025	31.01.2025	High	In progress	January 2025 Update - This is on target. To remove the free text box to ensure appropriate escalation for WLIs. Discussions took place with Retinue in December 2024 to action.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	9.3 Management should liaise with Retinue to identify if a control can be built into the process that only allows the 'waiting list' reason code to be selected for WLI sessions. Where this is not possible, management should remind staff of the need for accurate coding and ongoing monitoring should take place to identify non-compliance.	Internal Audit/2024/211/MD18/1	To discuss with Retinue what controls can be built into the (Retinue and Patchwork) systems.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - This is on target. Discussions took place with Retinue in December 2024 for action.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	9.4 Management should remind staff that WLI sessions should only be used for consultants in line with the Welsh contract. Ongoing monitoring should take place to identify non-compliance.	Internal Audit/2024/211/MD19/1	Management will be reminded of the use of WLIs	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	Medium	In progress	January 2025 Update - This is on target, in conjunction with the COO's office and SWP Team.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	9.5 Monitoring of shifts coded as sessional should take place to ensure they reconcile back to COO agreed WLI activity.	Internal Audit/2024/211/MD20/1	Monitoring of shifts coded to ensure they reconcile back to COO agreed WLI activity.	People Executive Medical Director Executive Director for People	31.01.2025	31.01.2025	Medium	In progress	January 2025 update - monitoring of WLIs as coded as sessional is underway.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	10. Given the wealth of data that is available in the Patchwork app, the Health Board should liaise with Retinue to determine a suite of reports that can be routinely received and analysed to identify noncompliance with the FCP. The reports should be used to enhance the current monitoring at the PEG meeting, and to allow scrutiny in a wider range of matters.	Internal Audit/2024/211/MD21/1	A review of CG access to Retinue and Patchwork will be undertaken/	People Executive Medical Director Executive Director for People	28.02.2025	28.02.2025	High	In progress	January 2025 Update - This is on target. Work is underway to ensure the right access is available to CGs at the right levels.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-09)	10. Given the wealth of data that is available in the Patchwork app, the Health Board should liaise with Retinue to determine a suite of reports that can be routinely received and analysed to identify noncompliance with the FCP. The reports should be used to enhance the current monitoring at the PEG meeting, and to allow scrutiny in a wider range of matters.	Internal Audit/2024/211/MD21/2	A review of Retinue (Patchwork) reporting will be undertaken to support the FCP and SOP.	People Executive Medical Director Executive Director for People	31.03.2025	31.03.2025	High	In progress	January 2025 Update - This work is underway. Discussions took place with Retinue in December 2024, for action to determine what reports would support the UHB with data monitoring at PEG.
Internal Audit/2024/214	12.12.2024	Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19)	1. BMS The UHB has been proactive in looking to better understand the limitations of their existing BMS. An independent review was carried out in June 2022 by an independent firm of Consulting Engineers detailed several recommendations and areas for improvement (some outside the scope of any refit funding). These included: • Observations in respect of the ability of the UHB to react to alarms on the system at the Princess of Wales Hospital. • The report goes on to recommend that the UHB could address this and other legacy BMS oversight issues with the appointment of at "least 1 Whole Time Equivalent (WTE) Health Board wide BMS manager" along with "two off BMS Technicians to ensure that all equipment is correctly serviced". Noting the revenue implications of this especially in the current financial climate the report author suggests that if the "team were only able to achieve a conservative 3% reduction on every site in utilities, at the current predicted energy spend of £15M, this would represent a £450K annual saving. The findings of the report would benefit from a wider exposure within the UHB. In so doing ensuring that any decisions made may address not only those themes that can be addressed by refit monies, but also changes that can be made in the short-term utilising existing BMS architecture. This should highlight any limitations and agreed mitigating arrangements.	Internal Audit/2024/214/MD1/1	Findings of the report have been shared with the Environmental Steering Group Actions to employ additional BMS staff previously reported at the Green Group and the Environmental Steering Group and been included in the UHB's Decarbonisation Action Plan (DAP) and included in the Environmental Management Plan Objectives and Targets. The UHB is working towards a standardised BMS system across the UHB, as per the recommendations of the BMS study completed by CTM Estates. Veolia have included audits of the BMS system as part of the Refit High Level Assessment. Veolia are currently conducting a high-level assessment of BMS systems across the Estates, which will feed into an investment grade proposal for BMS repairs and upgrades as identified. Specialist contractors are employed across the Estate to maintain the standards of BMS systems operation and control. CTM Estates will share the findings of the BMS report again with the Environmental Steering Group and the Green Group.	Capital and Estates Executive Director of Finance	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - A detailed Building Management System (BMS) survey is currently being conducted by an external energy and utilities company, taking into consideration the CTM BMS strategy with a goal of meeting CTM's net zero targets. The employment of specialised staff will be reconsidered following the external companies findings and recommendations. Discussion underway with the external companies' BMS specialist to consider the opportunities for regular BMS audits to check for faulty and poorly setup systems, information gleaned from these audits could be addressed by contracting companies with specific instructions. The recommendations from the findings of the survey are awaited. In the meantime, CTMUHB continue to utilise contracted staff from specialised BMS installation and maintenance companies.
Internal Audit/2024/214	12.12.2024	Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19)	2. Site walk arounds During the site visits it was observed that there were several stand-alone fans in offices, resulting in energy inefficiencies. Conducting the twice-yearly site walk-arounds as recommended by HTM07-02 Enclave offer management first hand observation of where energy is being used and presenting an opportunity to raise the profile of energy awareness with Health Board colleagues. Alternatively, the rationale/ risks for derogating from the HTM should be reported and approved by an appropriate forum.	Internal Audit/2024/214/MD2/1	The UHB has all Wales benchmarking information from NWSSP for previous years and CTM properties perform well above benchmark in these reports. A CTMUHB Benchmarking exercise for properties above 500m2 is scheduled for Q4 of 2024-25 once the data has been provided to CTM by NWSSP-SES	Capital and Estates Executive Director of Finance	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - All Wales Estates and Facilities Performance Review data has recently been made available from the 2023-24 submissions for all NHS organisations across Wales. Emails have been sent to NWSSP-Specialist Estates Services for access to the data and access to the Microsoft BI benchmarking tool. A meeting to review the data and begin the benchmarking exercise is scheduled for 31st January 2025.
Internal Audit/2024/214	12.12.2024	Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19)	3. Benchmarking The UHB submitted energy data annually via the national NHS Wales Estates & Facilities Performance Management System (EFPMS) system – this requirement was recently changed to all sites over 500m². NWSSP: Specialist Estates Services (SES) advise that, whilst benchmarking dashboards haven't been published in recent years, raw EFPMS data has been shared with all NHS Wales organisations, which would facilitate internal data review and benchmarking against other Health Boards.	Internal Audit/2024/214/MD3/1	The UHB has all Wales benchmarking information from NWSSP for previous years and CTM properties perform well above benchmark in these reports. A CTMUHB Benchmarking exercise for properties above 500m2 is scheduled for Q4 of 2024-25 once the data has been provided to CTM by NWSSP-SES	Capital and Estates Executive Director of Finance	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - All Wales Estates and Facilities Performance Review data has recently been made available from the 2023-24 submissions for all NHS organisations across Wales. Emails have been sent to NWSSP-Specialist Estates Services for access to the data and access to the Microsoft BI benchmarking tool. A meeting to review the data and begin the benchmarking exercise is scheduled for 31st January 2025.
Internal Audit/2024/214	12.12.2024	Energy Management 2024/25 (Review Reference CTMUHB-SSU-2425-19)	4. Energy Risk Reporting It was recognised that risks pertinent to energy management measures were captured as part of the decarbonisation governance process. Additionally, there was narrative provided within the Health Board's risk register recognising energy related issues that were contributing to an assessed high-risk rating in respect of the UHB estate. However, several energy management related risks had been noted and discussed that may warrant formal assessment, including: 1. The new All-Wales energy contract, which continued to cause disruption to process and available data – potentially impacting billing; 2. Energy cost going forward, and 3. The Decarbonisation Strategy action to remove all Combined Heat and Power (CHP) units by 2030. Whilst this aims to reduce carbon emissions, electricity costs are significantly higher than gas, which is expected to increase the UHB's grid consumption and associated cost. All financial and non-financial risks should be recorded within the directorate risk register – to include proposed mitigating action.	Internal Audit/2024/214/MD4/1	Energy compliance risks are fed through to the Environmental Steering Group. Energy finance risks are fed through to the Finance Department and included in the Estates IMTP Intermediate Medium-Term Plan. 1. Risks associated with the All-Wales energy contract are reported through the Estates IMTP. 2. Energy cost risks "going forward" will continue to be recorded through the Estates IMTP. 3. Loss of CHP plant by 2030 will be recorded through the Estates long term financial plan. Risks associated with lifecycle and condition of energy related plant and equipment such as CHP and biomass boilers, is and will continue to be reported through the directorate risk register.	Capital and Estates Executive Director of Finance	31.03.2025	31.03.2025	Medium	In progress	January 2025 Update - Risk management form has been added to the Energy Compliance Group agenda for the feed back of energy related risks to the group. Risks when received will be formulated into an Energy Risk Register. Any risks that require escalation will be reported to the relevant group. i.e. ISO 14001 Environmental Management System group. Energy accruals and budgets are reviewed on a monthly basis and reported in the form of a spreadsheet from the Carbon and Energy Manager to the Head of Finance for Estates, which reports on energy related finance risks. NWSSP-Procurement provide utility cost forecasts for upcoming financial years, which are communicated directly to Directors of Finance across Wales via the Wales Energy Group (WEG), and to Energy and Finance leads via the Wales Operational Energy Group (WEOG).
Internal Audit/2024/215	09.12.2024	Charitable Funds 2024/25 (Review Reference CTM-2425-20)	1. Procedures and guidance Whilst the FCP has recently been updated some minor errors and discrepancies remain between the procedure and its appendices and the supplementary requisitioning and finance guidance documents. We note: • Section 2 - Creation of Charitable Funds - there is inconsistency regarding the approver details and the form Appendix A. • Section 9 - Investments & Administration Costs - sets out responsibilities regarding charitable funds investments, which refers to providing updates to the ARC regarding the investment portfolio including, consideration of ethical issues arising from the investments and the approval of changes to the investment policy. We believe this may be a legacy requirement prior to the establishment of the CFC. • Appendix B and C - Donation receipt form and Gift Aid form – both use the previous name of the Health Board. However, we note a revised form is used that is a combination of receipt acknowledgement and gift aid declaration, which negates the need for Appendix B and C. • There is ambiguity around the need for a Statement of Need (SON) for purchasing medical equipment. The FCP states a SON may need to be considered, whereas the Oracle requisition process document requires a SON. • The requisition process document has links to training information and forms, but the links no longer work. The document refers to the CEO authorising orders above £50k, whereas this is the responsibility of the CFC. • The Finance Guide contains an out of date (2018) list of funds. We also note that the supplementary guidance documents are held in different parts of the intranet, as opposed to having all guidance in one place. In addition, at the time of our fieldwork the FCP from 2016 was the version available on the intranet.	Internal Audit/2024/215/MD1/1	The FCP and supplementary guidance will be reviewed to ensure accuracy and consistency. All guidance will be available to staff via a single section of the intranet.	Finance Executive Director of Finance	28.02.2025	28.02.2025	Medium	In progress	January 2025 Update - The FCP and SoD has recently been updated and we are currently implementing the new hierarchy structure. Once this is in place we will review and update the FCP again to reflect the comments in the above recommendation.
Internal Audit/2024/215	09.12.2024	Charitable Funds 2024/25 (Review Reference CTM-2425-20)	2. Retrospective approval of expenditure We reviewed a sample of 20 orders from various funds and in two cases found that the expenditure had been retrospectively approved. It is unclear why approval of this expenditure and the checking of fund balances had not taken place in advance. The FCP has a form specifically for retrospective reimbursements and it had been used on both occasions. However, the FCP is not explicit in stating the circumstances when retrospective approval is acceptable.	Internal Audit/2024/215/MD2/1	The FCP and supplementary guidance will be reviewed and updated to explain that retrospective (reimbursement) orders should be an exception and provide greater clarity on when they may be acceptable.	Finance Executive Director of Finance	28.02.2025	28.02.2025	Medium	Fully complete (Awaiting approval)	January 2025 Update - As part of training for fund holders ensuring retrospective orders are not used will be raised as a priority.
Internal Audit/2024/215	09.12.2024	Charitable Funds 2024/25 (Review Reference CTM-2425-20)	3. Investment Policy / Strategy In accordance with the FCP, the Health Board should have an agreed investment policy to act as a guide for making investments, considering the level of returns expected, and the level of risk to be tolerated. The terms of reference of the CFC refer to the committee having oversight of investments in accordance with the investment strategy. We saw limited investment strategy information included in the charitable funds update reports presented at the CFC meetings. It is unclear if this information is considered to be the Health Board's policy / strategy, or if a more comprehensive document exists. Whilst there is some information included, for example the approach should reserves exceed the investment by a certain amount, key information about the type of funds to be used (e.g. ethical), the level of expected returns and the risk to be tolerated is not included. The paragraphs also state the strategy will be reviewed annually, with particular regard to risk and return, but we can not see where this has taken place. The information contained in these paragraphs again refers to the ARC's role in approving suitable investments, which we cannot evidence and believe is no longer not part of their remit.	Internal Audit/2024/215/MD3/1	A clearly defined investment policy / strategy will be developed and approved at the relevant committee. The policy / strategy will be reviewed and approved on an annual basis, with particular regard to risk and return. Monitoring of investment activity, to ensure it is in line with the agreed investment policy / strategy, will take place at the relevant committee.	Finance Executive Director of Finance	31.07.2025	31.07.2025	Medium	In progress	January 2025 Update - The investment policy is currently being reviewed and updated in line with discussions at the Charitable Fund Committee.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive / Inspection Lead	Original Due Date	Current (Revised) Due Date	Action Rating	Progress Status	Comments/Updates
Internal Audit/2024/215	09.12.2024	Charitable Funds 2024/25 (Review Reference CTM-2425-20)	4. Monitoring of Funds The CFC receive reports at each meeting that include information on low value funds (below £1,000) and funds with low, or no activity in the financial year (dormant). There are approximately 150 funds and the September 2024 CFC update report lists 100 funds with no expenditure in the year and 36 funds with balances below £1,000. The charitable fund update reports to CFC do not include information about high value funds where there is little or no activity and what is being done to encourage spend in line with the purpose of the funds. We note that the FCP does not include guidance on what constitutes a low or high value fund, or when a fund may be classified as dormant, and the subsequent actions required. We did not see monitoring of low value or low use funds outside of the six-monthly analysis that takes place to prepare reports to CFC. However, we understand that a review of low value and low usage funds has started but has been paused while work	Internal Audit/2024/215/MD4/1	We will define the criteria of 'low value' and of 'dormant' in order for there to be a consistent approach to monitoring. We will set out the actions to be taken if funds are classed as low value or dormant including the process for merging funds where needed. Once our review of fund management responsibilities has taken place, our comprehensive review of all funds will take place and going forward, we will consider if more frequent monitoring is required, for example quarterly instead of six-monthly. We will incorporate a review of high value funds especially those with low activity as part of our update reports to the CFC. As per the FCP, we will require fund managers to prepare spending plans for monitoring by the finance team and CFC.	Finance Executive Director of Finance	28.02.2025	28.02.2025	Medium	Fully complete (awaiting approval)	January 2025 Update - The hierarchy of approvals and fund holders has been updated to enhance the review and use of all funds based on Care Groups.

Inspection Code	Title	Date of Inspection	Care Group & DoN Lead	DoN Lead	Recommendations	Actions
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	14/08/2024	Primary Care and Community	Lucie Williams, Nurse Director	3	3
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	14/08/2024	Primary Care and Community	Lucie Williams, Nurse Director	5	5
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	Planned Care	Sharon O'Brien, Nurse Director	22	22
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	Primary Care and Community	Lucie Williams, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	20/04/2021	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	1	1
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	17	18
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	20/07/2021	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2022/129	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital)] (Ref: 3189)]	01/11/2022	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	6	10
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22/03/2022	Children & Families	Suzanne Hardacre, Director of Midwifery	7	7
Healthcare Inspectorate Wales (HIW)/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	17/10/2022	Unscheduled Care	Emma James, Nurse Director	1	2
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07/03/2023	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	39	180
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	Unscheduled Care	Emma James, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	Primary Care and Community	Lucie Williams, Nurse Director	7	7
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	Unscheduled Care	Emma James, Nurse Director	50	50
Healthcare Inspectorate Wales (HIW)/2023/156	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	25/09/2023	Children & Families	Suzanne Hardacre, Director of Midwifery	2	2
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13/11/2023	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	25	26
Healthcare Inspectorate Wales (HIW)/2023/158	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	20/11/2023	Mental Health & Learning Disabilities	Ana Llewelyn, Nurse Director	19	19
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	Unscheduled Care	Emma James, Nurse Director	31	36
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	09/01/2024	Children & Families	Suzanne Hardacre, Director of Midwifery	2	27
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	Children & Families	Suzanne Hardacre, Director of Midwifery	14	36

AMaT Actions - Status Key

In progress	Inspection action is in the process of being completed and has not yet reached the deadline.
Partially complete	Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.
Partially complete (Overdue)	Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.
Overdue	Inspection action deadline has been reached and no recommendations have been completed.
Fully complete (Awaiting approval)	Inspection actions have been fully completed and are waiting to be approved to be closed.
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.

HMV Inspection Code	Date of Inspection	Inspection Title	Recommendation	Actual Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/757	14/09/2024	HMP Parc Prison - DC [Case Reference: CA 0579/CM0000881]	Reception screening for any prisoner with known risks such as significant medical history or substance misuse is undertaken by a qualified nurse, to ensure that any concerns regarding health or risks are recognised and acted upon. Entries in the clinical record is made by a named member of staff and is done so contemporaneously where possible.	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/337/MO1/2	New admissions are now screened by a qualified nurse. A documentation audit to is to be completed and any issues identified to be reported on the Data management system.	Primary Care & Community	30.09.2024	30.09.2024	Partially complete (Downside)	December 2024 Update - Evidence to be approved at next QRCF meeting due 01.02.2025	
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/1297	14/09/2024	HMP Parc Prison - DC [Case Reference: CA 0579/CM0000881]	Incar prison transfers should not be made unless it is clear that a service exists to deliver the health needs of the patient at the appropriate destination, by confirmed age off between both prison health of health. When arriving at HMP Parc, currently there is no commissioned service for patients with confirmed or suspected ADRD to receive specialist input into care management. CHAMUS commissioners urgently seek to provide a clinical service to HMP Parc that would enable timely assessment and treatment optimisation for prisoners with ADRD.	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/337/MO1/2	A review of the current processes regarding the inter-prison transfers and the sharing of information between prison healthcare departments to be undertaken in partnership with G4S team. For patients who require ADRD assessments are currently reviewed by mental health services within secondary care. Whilst this is in line with the care provided within Community Services, the team are undertaking a review with Mental Health services to understand any further improvements that could be made to the service. Prison Healthcare Directorate representation included as part of the CMT Regional Neurodivergence Steering and Improvement Board to review current provision and identify work streams to improve services.	Primary Care & Community	31.12.2024	31.12.2024	In progress	December 2024 Update - Progress and evidence. Process to be embedded once agreed.	
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/757	14/09/2024	HMP Parc Prison - DC [Case Reference: CA 0579/CM0000881]	CHAMUS commissioners ensure that all contracted services providing any input into the health of the patient are required to maintain records in the main healthcare clinical record system.	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/337/MO1/1	Oral to be sent to all contracted services to remind them of the importance that when providing any input to the health of a patient that all records are maintained with the clinical system. The requirement to add relevant information in the main healthcare clinical record system (System One) to be included in all Future SLA and tender documentation. Healthcare Needs Assessment commissioned to provide baseline for service provision and resulting action plan to address identified recommendations.	Primary Care & Community	31.12.2024	31.12.2024	In progress	December 2024 Update - Progress and evidence. Email to be embedded. Specific part of contract to be embedded. Needs Assessment to be embedded and evidence.	
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126	14/09/2024	HMP Parc Prison - DC [Case Reference: RD 0517/CM0000882]	The Head of Healthcare should ensure that all prisoners, by the end of second routine screening, have a full set of baseline clinical observations to act as baseline for staff to monitor for changes from the patient normal values. Reception screening should always involve at least one registered health professional undertaking the assessment with the patient. They should arrange clinical audit of compliance against this standard.	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126/MO1/2	New admissions are now screened by a qualified nurse. Audit for 15 admissions to be undertaken to ensure that clinical observations have been undertaken. All staff have been informed that baseline observations must be recorded on admission screening. All staff will be trained with written guidance.	Primary Care & Community	30.09.2024	30.09.2024	Partially complete (Downside)	December 2024 Update - Auditing approval via QRCF Feb 2025.	
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126	14/09/2024	HMP Parc Prison - DC [Case Reference: RD 0517/CM0000882]	Patients with seizures (full loss of consciousness) without an established diagnosis of the cause of seizures should be treated as a clinical emergency by all healthcare staff, and should receive routine urgently by a registered medical practitioner. If none is available onsite, then the patient should be referred to hospital for emergency assessment.	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126/MO1/2	Emergency medicine training sessions to be devised and provided to ensure that all staff have adequate skills and knowledge to treat clinical emergencies and to identify those who require referral to hospital for an emergency assessment. All staff have been reminded that any patients reporting seizure activity in the absence of a diagnosis of epilepsy must be referred for an urgent GP appointment. All staff have been reminded that the GP must be informed of any patients with a diagnosis of epilepsy have any seizure activity. These patients will be reviewed by the practice nurse.	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Downside)	December 2024 Update - Auditing approval via QRCF Feb 2025.	
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126	14/09/2024	HMP Parc Prison - DC [Case Reference: RD 0517/CM0000882]	Healthcare staff should ensure that when reviewing clinical discharge summaries from hospital teams, the information on which they have based their assessment is accurate (for example, in this case, it was incorrect for the consultant neurologist to state this was a single episode of seizure) from the clinical record. These errors or omissions should be alerted to the relevant specialist, so that they can review the management plan for the patient.	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126/MO1/2	Admissions audit to be provided have access to the Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge summaries will be reviewed by a GP and Senior Nurse. The discharge summaries will be checked for accuracy and outstanding actions. Once checked and signed by Senior Nurse and GP they will be scanned onto records. Audits to be undertaken in relation to 10 discharges to ensure all summaries have been checked by the GP and Senior Nurse	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Downside)	December 2024 Update - Progress and evidence. Meeting with Digital Health Care Wales w/c 02/09/24. Audit and findings to be embedded.	
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126	14/09/2024	HMP Parc Prison - DC [Case Reference: RD 0517/CM0000882]	Where a hospital letter is requesting potential actions if a future event should occur (e.g. "refer back to my service should a further seizure occur") this should be flagged on the clinical record as an "Alert", so this potential action / request is visible to all staff.	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126/MO1/4	Admissions audit to have access to Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge letters will be checked by a Senior Nurse and a GP and any requests for actions to be taken if a future event should occur this will be flagged as an alert on medical records.	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Downside)	December 2024 Update - Progress and evidence. Register of staff with dates of action provided to be embedded. Audit in number 3 will evidence the findings. Auditing approval via QRCF Feb 2025 - evidence embedded.	
Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126	14/09/2024	HMP Parc Prison - DC [Case Reference: RD 0517/CM0000882]	Clinical teams in other services providing care to prisoners (e.g. psychiatry) should clearly document that they have considered the risk of their prescribing recommendations to general practitioners, where these recommendations increase the risk of worsening of other illness (e.g. increasing risk of seizure). Formal letters of referral and assessment need to be conducted between HMP Parc primary care and In-Reach Psychiatry teams, to ensure that all relevant information on the clinical history of the patient is available to both parties (e.g. to ensure that psychiatric colleagues are aware of risk of seizure, and that these colleagues make recommendations for prescribing that clearly document that risk has been considered in their assessment).	Healthcare Inspectorate Wales (HIW): Death in Care/Nor/2024/126/MO1/2	Recommendation shared and teams reminded of the importance for enhanced communication and documentation between clinical teams providing care to prisoners at HMP Parc. A task and finish group to be established to address the recommendation and to improve processes between clinical teams and to identify standardisation for referral and assessment to include patient's clinical history, prescribing recommendations, risk assessment and communication protocols.	Primary Care & Community	30.11.2024	30.11.2024	Partially complete (Downside)	December 2024 Update - Progress and evidence. Email to be embedded. Findings from the task and finish group to be embedded. Meeting approval via QRCF Feb 2025 - evidence embedded.	
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NHS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	Roll out of OpenEye has been delayed nationally. Primary Care have worked with the programme team to provide context details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HC CT programme and primary team to implement OpenEye, the national electronic patient record/referral system for eye care which will support clear and integrated working across care settings. A task and finish group has been established with the clear objective of implementing the system in glaucoma clinics in the NHS hospitals by the end of March 2023. The programme plan is to then implement or communicate (including a referral) between primary and secondary care as stage 2 and to roll out to the other sub-specialties in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WIC for the 15 months from Jan 2023 to March 2024.	Planned Care	01.04.2023	01.12.2023	Partially complete (Downside)	December 2024 Update - Stage 1 is complete, further stages on hold due to delayed national CHCW digital programme rollout. 2 referral system (BNC) has returned to tender stage of national procurement. Ongoing work with GPs based on identifying clinical consultant Ophthalmology (MO) to help drive this, need to identify 16/18 digital representation on CHCW national EPRES meetings and ensure feedback to Ophthalmology. 100% of HB primary care optometrists issued NHS email addresses (15% had) with new shared operational roles at RSO to receive urgent referrals (from primary care GP & optometrist) & A and E triaging (on August 2024 Update - August 2024 Update - this ongoing, due to delays in national EPRES programme. 2 referral software under national tender. CMT (working) to CHCW national setting groups to establish necessary minimum standards of GPs. Primary care optometry MGS/NHS email rollout progressing (84% live across HQ) which will support direct email referral into secondary care (and ERS in place). No recent local progression with EPRES rollout beyond glaucoma clinics (on OpenEye business project manager), await EPRES programme updates from CHCW.	Significant delays to national CHCW ERS programme rollout, still in tender stage with no publication of awarded contract as yet.
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	The CHCW National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. (Patient Referrals - Referral Process) All parties (Welsh Government, NHS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system directly to secondary care.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	Primary care has produced and shared patient information on CTM social media platforms to explain changes to patient referral and enhanced services now being delivered at primary (and/or) to home. Recent recruitment of additional Optometry Advisor (par) will support practices to improve communication and referral pathways for patients, and will support practices where poor quality referrals are flagged. HES updates on waiting times are shared with practices on SEMONK to support conversations with patients and manage expectation.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 16/11/2024 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals - Quality of Referrals) A. Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate care pathway in a timely and efficient manner, avoiding unnecessary visits.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	Primary Care (HBs have already established a number of referral refinement schemes within practices in CTM: • West GAD • Diabetes Referral • Diabetes Referral • Glaucoma (avoiding existing service in place	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 16/11/2024 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals - Quality of Referrals) B. Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	Practices are notified when new local referral pathways are introduced and updates circulated to practices. Optometry newsletter to be produced in primary care and circulated 4 times a year. Accelerated Cluster Development will allow cluster working for practice within clusters. CTM to hold this event par 25	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 16/11/2024 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	Quality of referrals being sent to rapid access pathway (Patient Referrals - Quality of Referrals) C. Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	> 90% of referrals come directly from optometrist with good communication between primary and secondary care. Optometry dept. working with DA-developed letter templates to communicate insufficient referral detail to primary care for glaucoma referrals which has improved referral detail.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 16/11/2024 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals - Communication Following referral) (Discharge patient - Quality of information) A. Health Boards should ensure feedback of diagnosis and a treatment plan is provided to referring optometrists following every referral made to the service, including whether a referral to a low vision service has been made.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	Optometrists are copied into all clinic correspondence for new patients where the referral has come from the optometrist in ROBEH - this will be done across all sites within CTM.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 16/11/2024 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed.	
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals - Communication Following referral) (Discharge patient - Quality of information) B. Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	Primary care are working with HES to identify when this is an issue within practices and provide support via OA to ensure appropriate information is shared in the referral. New recruitment OA to undertake referral audits to support this. Optometrists contact details are not always clear on the referral form, internal arrangements being made to monitor the quality and individuality feedback to the Optometrists via local advice.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 03.12.2024 Approved by Care Group at SLT Meeting 16/11/2024 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - meeting scheduled with Planned Care Group leads to seek confirmation as to when this action was completed. Dec 23 update this will be an ongoing process. Optometry Advisors will continue to work with both practices and HES to ensure the submission of high quality referrals. Implementation of the ECR system will also support/improve referral process.	
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals - Communication Following referral) (Discharge patient - Quality of information) C. Health Boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	The implementation of Open Eye will provide optometrists with access to patient information that will promote, improve and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024	31.12.2025	Partially complete (Downside)	Dec 2024 Update - completion delayed due to national CHCW digital eye care programme rollout delays. EPRES implemented in community glaucoma pathways, practices provided with detailed case notes/discharge summaries, allowing seamless transfer of care. New primary care optometry contract has defined new national datasets and discharge summary templates including minimum data standards on discharge to Optometry - to be implemented in CTM glaucoma, medical retina, and eye casualty pathways (by March 2025). National CHCW work ongoing to provide primary care optometrists with access to WGP (see published timeline). Due to national delays in EPRES implementation, a revised due date of 31.12.2025 is required. August 2024 Update - August 2024 Update - this is ongoing, due to delays in national EPRES programme.	National/CHCW Eye Care Digitisation programme embeds delaying local implementation of EPRES across both primary and secondary care.
Healthcare Inspectorate Wales (HIW)(2023/134)	30/01/2027	National review of Ophthalmology Services	QC reports concerns around lack of information provided within secondary care prior to treatment (Patient Referrals - Communication Following referral) - Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent.	Healthcare Inspectorate Wales (HIW)(2023/134)/NDS1	RCO bulletins provided about consent process in eye assessment. Information bulletins provided for any eye emergency care. Laser information. Cataract information. ECG information. Biophysics bulletins. CTM - information. Surgery information bulletins -> CHDOR. Cosmetic. Buphthalmia. • CHDOR. Cosmetic. Pseudo Surgery. • CHDOR. Cosmetic Surgery (phacemulabication) with Monocular Intracocular Lens Implant. • CHDOR. Buphthalmia. • CHDOR. Glaucoma Surgery (Trabeculectomy). • CHDOR. Retinal Detachment Surgery. • CHDOR. Corneal Transplant Surgery. • CHDOR. Corneal Graft Surgery (Keratoplasty). • CHDOR. Enucleation and Eyelid Repair. • CHDOR. Pseudo Surgery (Keratoplasty). • CHDOR. Corneal Graft Surgery (K						

MAST Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMA Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	Lack of incident reporting relating to WIG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to move various system failures.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	A FUMS Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow-up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To ensure patient pathway delays and identify the level of harm resulting from avoidable delays • To identify how much loss of vision represents a loss of function and whether this is a result of a delay in treatment • To ensure, when harm is established, the application of Patient Safety Policy and/or Service Incident management process. • To ensure there is an appropriate follow-up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUMS incident reporting.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2024 Update - Q&A follow-up review work continuing, completing outstanding NRI investigations and providing process learning for Ophthalmology teams in readiness for end of fiscal year project handover (March 2025). Central team providing coaching for RCA investigations to Ophthalmology senior MDTs and good practice of NRI RCA training in the team. Regular review and review RCA quality assurance panels continuing, with good substantially consistent representation and input. Action to be reviewed for approval for closure at Care Group SGT 30/12/24. August 2024 Update - No update received this period.	
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	Lack of capacity/quality of services of services due to over reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risk to patient care. These plans should aim to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	CTM has a well established optometry department which has a number of experienced, highly skilled and qualified optometrists working across glaucoma, medical retina, DMO, unclassified care, paediatric clinics and specialist contact lens. Recent expansion of the service to include community optometrists as a national base which has increased our capacity across three services whilst additionally improving training to community optometrists in to have reduce referrals and improve referral quality. Hospital based optometry due to start implementing an optometry based led pathway to improve SLT and learn capacity in the coming months.	Planned Care	01.04.2024	01.08.2025	Partially complete	December 2024 Update - Optometry led team pathway successfully implemented 12/22 with significant improvement in wait waiting time. MDT recruitment for glaucoma diagnostic hubs in progress (recruitment for phase 1 points to be completed Jan 2025). Nursing workforce development in progress to expand roles and responsibilities of Band 2/3/4s, with additional education to Band 3, to be completed April 2025. Longstanding vacancies in Head of Optometry & Optician roles, given this significant obstacle to MDT workforce development, a revised implementation date of 01/06/2025 is required. August 2024 Update - August 2024 Update - Recruitment in progress for additional permanent non-medical staff to create additional capacity in glaucoma clinics (Band 3 techs, Band 4 techs, Band 6 Optometrists)	Longstanding vacancies in senior MDT Head of Optometry & Head of Optician roles - obstacle to MDT workforce development
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	Lack of capacity/quality of services of services due to over reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health Boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre- registration placements to community optometrists. An AMD new referral refinement pathway (ARMS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow of new AMD referrals to be triaged to primary care. A DMO new patient scheme has been implemented over the last few months with low risk DMO patients reviewed by primary care with additional training. DMO waiting list has significantly dropped and allowed the majority of DMO patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete	December 2024 Update - External funding (2023) received from NISW to facilitate cross sector optometry placements (under consultant mentoring) to further upskill local primary care optometrists workforce. Recruitment in progress for 3 Zone B4 advice coordinator to support this. Continued operations use of dual sector/secondary care optometrist in primary care advisory role, for services interaction working. Strong consultant engagement in WGS2 (primary care optometry central) rollout of new pathway - glaucoma and AMD (further referral refinement) pathways now fully WGS2 compliant (autonomous in primary care). WGS Transformation Fund (2024) received to support primary care optometry central implementation (phase 1 clinical network). ECCS supporting hypermyopia/secondary care optometry training pathway, recruitment in primary care (start March 2025) and development of cross sector Regional Coordinator roles (for safe transfer of care of patients to primary care). Primary care central implementation is complex and in many cases novel, and with secondary care stakeholder concerns - a revised implementation date of 31.12.2025 is required. August 2024 Update - August 2024 Update - AMD referral refinement pathway working well, missing to direct optometrist inter practice referral 2/2024 (currently coordinated by hospital team). This will reduce advice burden and shorten turnaround time for patients.	Safe and effective primary care central implementation relies on cross sector implementation of electronic patient record & referral systems - national programme delayed, logistics and job description of regional coordinator role (3 posts) shared between 3 HMs is not yet defined, and funding for this is fixed term (3 years) with no plan from WGS to support this, with this beyond 2025 as yet. Secondary care stakeholder concerns regarding changing patients from shared care pathways to autonomous primary care management without DPM and adequate administrative support
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) A) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from both staff in other areas.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	Weekly performance meeting have been arranged between the Clinical Service Group Manager (CSMG) and Interim Director of Planned Care to discuss key performance measures and any ad hoc issues which arise. CSMA from other sites are in attendance for shared learning purposes.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2024 Update - CSMA engaged with national Ophthalmology CSM work, good cross discipline/MDT representation/engagement in CSM subgroups including CSM training establish the first national Hospital Optometry Wales forum (reporting to CSM) to view the profile of the profession in Wales and share best practice. Led a dissemination of new National Clinical Strategy for Ophthalmology completed, and good departmental attendance/engagement at strategy launch events. Action to be reviewed for approval for closure at Care Group SGT 30/12/24. August 2024 Update - No update received this period.	
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical triage.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	WGS to review	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2024 Update - strong CSM engagement with national Ophthalmology CSM, including referring national shared DPs, SOPs, letter templates etc. Learning from RCA shared with national CSM leads. Non-medical optician advised since 2020, with an established SOP and training pathway. Action to be reviewed for approval for closure at Care Group SGT 30/12/24. August 2024 Update - No further update, complete. Not marked as fully complete as need QSRF sign-off.	
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	ECCO - limited capacity (Device Support Staff - End Care Liaison Officer) Health Boards should ensure that there is ECCO for their eye care clinics at all times and consideration should be given as to whether one ECCO is sufficient for the eye care services.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	EDW - NHS ECCO coverage 4 days RGP / PCH - NHS ECCO for RGP, PCH, TCR - coverage 5 days 7 Communicating team - risk Elizabeth Beadell	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	December 2024 Update - 2 x substitute ECCOs in post (2 these areas of atp). Action to be reviewed for approval for closure at Quality & Safety Committee on Tuesday 23rd January 2025. August 2024 Update - No further update, complete. Not marked as fully complete as need QSRF sign-off.	
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	More clearly regulated to enable existing roles of optometrist to enable more effective utilisation of optometrists. Welsh Government must provide clarity to health boards relating to indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	This appears to be an action required by WIG, though we have assessed from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, staff roles and correct specialities and direct WIG funding has provided several optometrists to work within these areas. Higher level training and qualifications are underway and has been offered historically and currently, staff have received funding from NISW in order to gain higher qualifications from The Royal College of Optometrists in order to further develop services (such as the team to implement optometry based care pathway for glaucoma).	Planned Care	01.04.2024	01.08.2025	Partially complete	December 2024 Update - strong external engagement from CTM on this issue, including key role in national CSM workforce options for Optometry. Longstanding vacancy in Head of Optometry post obstacle to continued workforce development for secondary care - implementation of national primary care optometry central (WGS2) continues to progress, in light of head of service vacancy, a revised implementation date of 01/06/2025. August 2024 Update - August 2024 Update - CTM Optometry presented proposal to develop a Welsh Hospital Optometry forum, at CSM June '24 which was well supported. Initial planning meeting to develop national subgroups reporting to CSM & Heads of Service vacancies (Optometry/Ophthalmology) call ongoing.	Longstanding vacancy in Head of Optometry post an obstacle to continued optometry workforce development for secondary care
Healthcare Inspectorate Wales (HWI/2021/141)	30/01/2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (PDR) and reduce the burden on secondary care. (Evaluation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HWI/2017/141/NHS1/1)	See points above. CTM already utilising both hospital and primary care based optometrists in a range of role specialities. Primary care pathways and schemes include PDS / unclassified care, Glaucoma community monitoring schemes, AMD referral refinement and DMO.	Planned Care	01.04.2024	01.08.2025	Partially complete	December 2024 Update - Longstanding vacancy in Head of Optometry post an obstacle to continued workforce development for secondary care. Primary care optometry referral (referral refinement) pathways have for glaucoma & AMD, continued monitoring schemes for glaucoma & diabetic retinopathy under WGS2 transition, high volume PDS (acute care) and PCH (chronic care) of all of which reduce secondary care appointment demand/improve referral quality. Cross sector work underway to enable discharge/deflection of suitable patients from the Community to PDS (further reducing secondary care pressures). In light of head of service vacancy, a revised implementation date of 01/06/2025 is required. August 2024 Update - Additional Be optometrist for glaucoma services in recruitment.	Longstanding vacancy in Head of Optometry post an obstacle to continued workforce development for secondary care optometry.
Healthcare Inspectorate Wales (HWI/2022/139)	06/09/2020	Quality Check Summary Fylfyr Cwm Rhonda (Fylfyr Cwm Rhonda - Ward 4) (Ref: 202002)	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HWI/2020/139/NHS1/1)	A revised Emergency Procedures Escalation Plan has been drafted (30th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care & Community	01.10.2020	01.10.2020	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The Emergency Procedures Resilience and Response Manager is liaising up with Operational colleagues on the development of the Emergency Procedures Escalation Procedure. Draft version is developed and confirmation of approval is being sought. Once confirmed this action will be marked as closed.	
Healthcare Inspectorate Wales (HWI/2022/135)	30/04/2021	Quality Check Summary Senedd Royal Glamorgan Hospital (Senedd Royal Glamorgan Hospital - Ward 2) (Ref: 202005)	The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure house compliance with mandatory training.	Healthcare Inspectorate Wales (HWI/2022/135/NHS1/1)	RIS of applicable staff groups will be fully compliant with mandatory training in PANDA, ILS/SLT and Fire training. Progress towards this target and future training compliance rates will be managed using L&Q and monitored through the management of compliance and deviation from the proposed management strategy and values to maintain the target level of compliance will be evaluated at Clinical Service Group Performance Review meetings. Mandatory training compliance to be included as a standing agenda item during live management sessions. Compliance to be reported on and monitored in the Clinical Service Group (CSG) Workforce and Operational Review and L&Q Performance Review Meeting.	Mental Health & Learning Disabilities	10.08.2021	10.07.2021	Fully complete (Awaiting approval)	December 2024 Update - action completed QSRF Sept 2023. October 2024 Update - Closed - developed mandatory training monitoring in part of discharge review. August 2024 - Ongoing monitoring via the M&L2 Care Group in relation to compliance	
Healthcare Inspectorate Wales (HWI/2022/137)	30/09/2021	National Review of Mental Health Care Provision in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HWI/2022/137/NHS1/1)	Working group to be established between Primary Care and mental health to ensure co-ordinating of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete (Overdue)	December 2024 Update - Plans complete TOR within the physical health improvement forum group, and to then close by Feb 2025. October 2024 Update - Remains open to discuss at next QSRF. August 2024 - M&L2 has one outstanding action to be discussed at next QSRF in September 2024.	
Healthcare Inspectorate Wales (HWI/2022/138)	20/07/2021	Quality Check Summary Pweraed House (Pweraed House - Quality Check)	The health board must provide assurance on how it will meet principle one outlined by the Chief Nursing Officer for Wales for at least two registered nurses to be involved every shift, or determined as not necessary, that there must be the ability to deploy a second registered nurse without delay.	Healthcare Inspectorate Wales (HWI/2022/138/NHS1/1)	Undertake a review of the night time staffing resource across the rehabilitation service in CTM and develop an options appraisal to address the risk of one registrant by night.	Mental Health & Learning Disabilities	30.11.2021	30.11.2021	Fully complete (Awaiting approval)	December 2024 Update - completed Nov 2021, under EYE 6/6. October 2023 Update (Date of Review: 20/10/2021) - Further to discussions with the Head of Mental Health Nursing it has been advised that the CMO principles do not apply to Mental Health Rehabilitation areas. We will however, continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times.	
Healthcare Inspectorate Wales (HWI/2022/138)	20/07/2021	Quality Check Summary Pweraed House (Pweraed House - Quality Check)	The health board must provide assurance of its plans to ensure all staff are fully compliant with their mandatory training as soon as possible.	Healthcare Inspectorate Wales (HWI/2022/138/NHS1/1)	Review all core competencies across the rehab service with an improvement plan for BSL/c compliance.	Mental Health & Learning Disabilities	30.11.2021	30.11.2021	Fully complete (Awaiting approval)	December 2024 Update - COMPLETED NOV 2021 WHEN EYE 6/6. October 2023 Update (Date of Review: 14/10/2021) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&Q department: 1) Review training data. 2) Review Group alignment numbers as correct. 3) List all appropriate required compliance and accurate records and L&Q department will take forward to the subject experts on teams' behalf. Regular meetings with core L&Q representation to address and correct the issues associated with core mandatory training compliance.	
Healthcare Inspectorate Wales (HWI/2022/129)	01/11/2022	HWI & CSM Joint Community Mental Health Team (CMHT) Inspection Report (Announced in-Speld Health CMHT, Merthyr Community Hospital (HWI Improvement Plan Service - Bridgend Health CMHT (Ongoing Hospital) (Ref: 3185))	The health board must ensure that medical staff complete all safeguarding related refresher training in a timely manner	Healthcare Inspectorate Wales (HWI/2022/129/NHS1/1)	All medical staff to attend Safeguarding People Day	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	December 2024 Update - Completed, approved through QSRF November 2024. August 2024 Update - remains overdue Medical staff booked in to attend Safeguarding People Completed approved through QSRF	
Healthcare Inspectorate Wales (HWI/2022/131)	13/02/2022	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit) (Ref: 21233)	This Health Board should consider consult jobs that formally utilise a separate consultant to supervise the caseload action list and Operational work.	Healthcare Inspectorate Wales (HWI/2022/131/NHS1/1)	Business case under development for separate maternity elective theatre suite to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2023	01.08.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Business Case currently on hold as from early September 2024, there will be a temporary closure of the maternity and neonatal units at Princess of Wales Hospital (POWH) to allow for essential maintenance works on both units. This action will be revisited in January 2025.	
Healthcare Inspectorate Wales (HWI/2022/131)	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit) (Ref: 21233)	Risk assessments are undertaken and recorded in patient records. Medical discussions and decisions are accurately recorded in patient records.	Healthcare Inspectorate Wales (HWI/2022/131/NHS1/1)	The specific areas of risk assessment, medical discussions and decisions will be added to the record keeping audit and all service medical staff to participate in this annual audit to drive multi professional improvement in this area.	Children & Families	01.08.2022	01.08.2022	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Update requested from the Medical Director in the Children and Family Care Group.	
Healthcare Inspectorate Wales (HWI/2022/131)	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit) (Ref: 21233)	The Health Board must ensure that Additional welfare support is available for AET staff.	Healthcare Inspectorate Wales (HWI/2022/131/NHS1/1)	Workforce team asked for specific resources for AET staff going forward.	Children & Families	01.06.2022	01.10.2023	Overdue	September Update (Date of Review: 08/06/21) - email sent to Medical Director of care group for advice on how to progress this recommendation. December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - KIT update to be taken to next Care Group Workforce meeting on the 28th August and the Local Partnership Forum.	
Healthcare Inspectorate Wales (HWI/2022/131)	13/02/2023	Hospital Inspection (Announced) Princess of Wales Hospital - Maternity Services (Appendix C - POW Maternity Unit) (Ref: 21233)	This Health Board must ensure that: The backing of incidents are cleared and consideration of further funding should continue.	Healthcare Inspectorate Wales (HWI/2022/131/NHS1/1)	Incident backlog due to be closed by 31.12.23. Service agreed target: All incidents managed and closed within 1 month - using data action board for ongoing work.	Children & Families	01.08.2023	01.10.2023	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The issue around the incident backlog has not been provided on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcomes of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.	
Healthcare Inspectorate Wales (HWI/2022/133)	17/02/2022	Hospital Inspection Report (Announced) Emergency Department, Princess of Wales Hospital (Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department) (Ref: 1336)	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged	Healthcare Inspectorate Wales (HWI/2022/133/NHS1/1)	Plan to work with corporate nursing team to review options of creating a digital solution for audit surveillance and daily checks to further improve oversight of status.	Unscheduled Care	01.02.2023	01.02.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The USC Care Group are finalising the last AMAF audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign-off prior to run. June 2024 Update - We have progressed towards standardised audits on AMAF across the three sites, the ID audit report remains outstanding however we anticipate this will be in place within the next 6 weeks and will provide an update when achieved.	
Healthcare Inspectorate Wales (HWI/2022/133)	17/02/2022	Hospital Inspection Report (Announced) Emergency Department, Princess of Wales Hospital (Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department) (Ref: 1336)	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged	Healthcare Inspectorate Wales (HWI/2022/133/NHS1/1)	Work with Care Group Directors of Nursing and Medical and Heads of Nursing across the three acute sites and community hospital sites in establishing a consistent model of surveillance and checking practice.	Unscheduled Care	01.12.2023	01.12.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The USC Care Group are finalising the last AMAF audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign-off prior to run. June 2024 Update - We have progressed towards standardised audits on AMAF across the three sites, the ID audit report remains outstanding however we anticipate this will be in place within the next 6 weeks and will provide an update when achieved.	
Healthcare Inspectorate Wales (HWI/2022/130)	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023001)	Recommendation 10 The health board must continue to provide HWI with updates on the plans to implement the unified patient clinical record system. This must also include consideration of its impact and community awareness for CHD and Adolescent Mental Health Services across the health board	Healthcare Inspectorate Wales (HWI/2022/130/NHS1/1)	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes CHD and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Overdue	December 2024 Update - progress is being made, remains ongoing this time. October 2024 Update - Currently in process of drafting a local business case for CMAH to move rapidly with our own procurement process to obtain the single clinical record. August 2024 Update - This remains on going	
Healthcare Inspectorate Wales (HWI/2022/130)	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023001)	Recommendation 14 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	Healthcare Inspectorate Wales (HWI/2022/130/NHS1/1)	This standard is explicit within the Health Board Discharge Procedure (HMD) standards.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved in complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited	
Healthcare Inspectorate Wales (HWI/2022/130)	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023001)	Recommendation 20 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Healthcare Inspectorate Wales (HWI/2022/130/NHS1/1)	Workforce issues such as vacancies and sickness are reported, by clinical service group at monthly integrated performance meeting	Mental Health & Learning Disabilities	01.07.2023	01.07.2023	Fully complete (Awaiting approval)	August 2024 Update - The completion of this action was pre care group reconfiguration and the M&L2 are providing confirmation of the closure sign-off at the relevant QSRF meeting. December 2024 Update - Approved in complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited	
Healthcare Inspectorate Wales (HWI/2022/130)	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023001)	Recommendation 31 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and wellbeing support is available to staff when required.	Healthcare Inspectorate Wales (HWI/2022/130/NHS1/1)	The care group uses a range of methods to seek feedback and input from the staff group. A programme of feedback and analysis of a regular staff wellbeing survey is coordinated by the Health Board People's Services, a senior business partner of which works alongside the care group leadership team. Triangulation of these methods will enable the care group to more fully evaluate impact of the measures implemented.	Mental Health & Learning Disabilities	01.08.2023	01.08.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved in complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited	
Healthcare Inspectorate Wales (HWI/2022/130)	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023001)	Recommendation 38 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	Healthcare Inspectorate Wales (HWI/2022/130/NHS1/1)	This standard is explicit within the Health Board Discharge Procedure (HMD) standards.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved in complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited	
Healthcare Inspectorate Wales (HWI/2022/130)	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023001)	Recommendation 39 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Healthcare Inspectorate Wales (HWI/2022/130/NHS1/1)	Workforce issues such as vacancies and sickness are reported, by clinical service group at monthly integrated performance meeting	Mental Health & Learning Disabilities	01.07.2023	01.07.2023	Fully complete (Awaiting approval)	August 2024 Update - The completion of this action was pre care group reconfiguration and the M&L2 are providing confirmation of the closure sign-off at the relevant QSRF meeting. December 2024 Update - Approved in complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited	
Healthcare Inspectorate Wales (HWI/2022/130)	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023001)	Recommendation 31 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and wellbeing support is available to staff when required.	Healthcare Inspectorate Wales (HWI/2022/130/NHS1/1)	The care group uses a range of methods to seek feedback and input from the staff group. A programme of feedback and analysis of a regular staff wellbeing survey is coordinated by the Health Board People's Services, a senior business partner of which works alongside the care group leadership team. Triangulation of these methods will enable the care group to more fully evaluate impact of the measures implemented.	Mental Health & Learning Disabilities	01.08.2023	01.08.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved in complete November 2023. Fully complete (Awaiting approval) - Further Evidence Awaited	

Next Inspection Date	Date of Inspection	Inspection Title	Recommendation	Audit Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Notes
Healthcare Inspectorate Wales [HWI/2023/130]	07/09/2023	Renewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023062)	Recommendation 25 The health board must ensure that the audit process is reviewed within its mental health services, and that a robust and sustainable audit action management plan is implemented as applicable, to ensure actions are monitored and to ensure that all recommended improvements are being sustained.	Healthcare Inspectorate Wales [HWI/2023/130/MH/2]	This resource will work in partnership with the clinical teams to embed both a culture of improvement and shared learning. Engagement with staff at all levels will be a key objective of this team. The oversight of this recommendation will be via the Police Group. The newly established Policy Review group will have an operational scope to oversee & lead of ensuring the Police to establish practice going forward. • Develop a policies plan with inspectors for addressing the backlog of progress for all of Care Group level. • Maintenance of a register of policies for review following agreement of full set April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.07.2023	11.07.2023	Fully complete (Awaiting approval) - Further Evidence Awaited	December 2024 Update - Approved in complete November 2023 Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at all relevant QORE meeting	
Healthcare Inspectorate Wales [HWI/2023/130]	07/09/2023	Renewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023062)	Recommendation 26 The health board must provide HWI with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and where the health board would documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales [HWI/2023/130/MH/1]	The oversight of this recommendation will be via the Police Group. The newly established Policy Review group will have an operational scope to oversee & lead of ensuring the Police to establish practice going forward. • Develop a policies plan with inspectors for addressing the backlog of progress for all of Care Group level. • Maintenance of a register of policies for review following agreement of full set April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.08.2024	01.08.2024	Overdue	December 2024 Update - currently 16 policies to update. October 2024 remains on-going to discuss further at QORE August 2024 Update - +21 policies in date (up from 16 in July). +6 pending validation, awaiting comments by 2nd Sept., will then progress. +5 under review 27 have signed completion dates from June/July to Sept/Oct/Nov 24) in below:	
Healthcare Inspectorate Wales [HWI/2023/130]	07/09/2023	Renewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023062)	Recommendation 35 The health board must consider how it can assist the police in place for social worker identified incidents, which are documented within Data, and that feedback, learning and actions are shared with them as applicable.	Healthcare Inspectorate Wales [HWI/2023/130/MH/2]	Mental health boards will follow the agreed operational processes for notification. All MH specific policies were reviewed by 3 June 2023 and of the 49 MH specific policies: Review underway if 6 date and approved 13 August 22. With an agreement that those that require updating will be completed by 1st June 2024. The 12 expired policies have been prioritised with consultation of patient safety, prevent harm practice and clinical impact and evidence, which has been developed against this risk. The Mental Health Policy group will monitor this work through an update board. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all training and Medical staff across all Mental Health services within the care Group "Communication and Learning Framework". Recommendations All current and updated policies will be on the Mental Health Policies page on the staff resource site SharePoint.	Mental Health & Learning Disabilities	01.08.2024	01.08.2024	Overdue	December 2024 Update - 16 policies remain to be updated. October 24 - 21 policies in date to date. 12 under review 12 awaiting approval. August 2024 Update - 21 policies in date (up from 16 in July). +6 pending validation, awaiting comments by 2nd Sept., will then progress. +5 under review 27 have signed completion dates from June/July to Sept/Oct/Nov 24) in below:	
Healthcare Inspectorate Wales [HWI/2023/130]	07/09/2023	Renewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023062)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include ensuring that they are adequately trained in identifying risks and their management.	Healthcare Inspectorate Wales [HWI/2023/130/MH/1]	The oversight of risk registers will be daily via the Care Group Quality Safety Risk and Experience Group and the Performance, Planning and Finance Group. Accountability for the management of risk registers at Clinical Service Group will be via operational risk leaders.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	December 2024 Update - Approved in complete November 2023 Fully complete (Awaiting approval) - Further Evidence Awaited	
Healthcare Inspectorate Wales [HWI/2023/130]	07/09/2023	Renewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023062)	Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include ensuring that they are adequately trained in identifying risks and their management.	Healthcare Inspectorate Wales [HWI/2023/130/MH/2]	The organisational risk register includes risks with a score of over 15. The organisational risk register has been reviewed across the Health Board. Aggregate workforce shortage and training risks are included for CMU. Mental Health risks including clinical records and environmental risk register. Risk registers with scores over 15 are monitored at Care Group level via Quality Safety Risk and Experience Group – (See Appendix 1 for governance arrangements), and all other risks are monitored via the Clinical Service Group performance arrangements. The Head of Quality and Patient Safety will lead an operational care group governance meeting to monitor compliance with Rating Three/High action plans and risk management. Agenda item will be used to encourage escalation and culture of owning risks and mitigation at local level.	Mental Health & Learning Disabilities	30.11.2024	30.11.2024	Fully complete (Awaiting approval)	December 2024 Update - Approved in complete November 2023 Fully complete (Awaiting approval) - Further Evidence Awaited	
Healthcare Inspectorate Wales [HWI/2023/130]	07/09/2023	Renewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023062)	Recommendation 38 The health board must consider how it can assist the police in place for social worker identified incidents, which are documented within Data, and that feedback, learning and actions are shared with them as applicable.	Healthcare Inspectorate Wales [HWI/2023/130/MH/1]	The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental health Governance lead will establish a working group with the Lead Nurses and Local Authority heads of service to develop a mechanism for multi-agency incident reporting.	Mental Health & Learning Disabilities	30.06.2023	31.10.2024	Fully complete (Awaiting approval)	December 2024 Update - this was completed in QORE October 2024. August 2024 Update - No update received this period. February 2024 Update - Updated from Business Intelligence Team that they have explored ways for a social worker to be able to access the incident module of Data, however a solution has not been found. Action agreed: SOP to be developed to describe the process for feedback, learning and actions to be shared with social workers as applicable.	
Healthcare Inspectorate Wales [HWI/2023/134]	21/07/2023	Hospital Incident Report (Unscheduled)/Emergency Unit and Clinical Decision Unit, Prison Directorate, Hospital Appendix A - Immediate Improvement Plan, 12 July 23 (12 August 2023 Ref: 1000)	The health board is required to provide HWI with the details of the action taken: • An improvement standard self-rating compliance in respect of evacuation training • To promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales [HWI/2023/134/MH/1]	Cwm Taf University Health Board acknowledges that compliance for mandatory evacuation training is not where we want to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Completion rate is currently 58.24% and 100% for 1-78% demonstrated in scheduled training needs analysis. • As a Senior Nurse for Professional Education has been reported (July 2022) as part of the new ED Workforce Model report following the HWI review in September 2021. As Training Needs Analysis has been conducted and a Check Plan has been developed for all Registered Nurses and HCWs. Registered Nurses the Resuscitation Team have agreed to undertake template BLS and ALS training monthly with 12 spaces being allocated monthly. HCWs - the Resuscitation Team have agreed to undertake template BLS training monthly for 12-8 spaces An interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the matter to provide assurance that the resusc team has an BLS trained nurse on duty. CNU - Registered Nurse 15 currently 70.8% this should translate to BLS being achieved at 70.8% which was a data entry error to be immediately rectified by the resusc team as per CNU. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "New year Conversation", training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.08.2024	Partially complete (Overdue)	Previous Update - The Mental Health Care Group is exploring a way for social workers to be able to report incidents directly through Data with the Health Board Governance Team and CT team. This has been delayed by issues with allowing non HR personnel access to HR and NHS systems and organisational changes to the CTM governance and Data bases. In the meantime a process for reporting and feeding back on social worker identified incidents is multi-agency meetings and on that basis can be shared with HR implemented. December 2024 Update - An update against this recommendation has not been provided on this occasion. October 2024 - Discussion with Head of Healthcare within HMP Parc, Chester email sent to all contractors to request update on progress with implementation of recommendation.	
Healthcare Inspectorate Wales [HWI/2023/140]	16/09/2023	HMP Parc Prison	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for emergency response drugs.	Healthcare Inspectorate Wales [HWI/2023/140/MH/1]	A review of the current QP management process to be undertaken. To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. October 2024 - Discussion with Head of Healthcare within HMP Parc, Chester email sent to all contractors to request update on progress with implementation of recommendation.	
Healthcare Inspectorate Wales [HWI/2023/140]	16/09/2023	HMP Parc Prison	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales [HWI/2023/140/MH/1]	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include flow chart to be drafted and implemented with a process how staff/patients access medication in a timely manner. Implementation of robust medication policy. The process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. September 2023 Update - No update received August 2024 Update - Ongoing with Pharmacy lead and GP at HMP Parc. December 2024 Update - This work is ongoing and forms part of long term engagement and partnership working on the stroke programme board. Revised Due Date - Ongoing across 2024/25 Ongoing across 2024/25	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should engage with each other, learn from the good patient experience practices taking place across Wales. This could help the shared learning with themselves and with QP practices in their locality, to enable patients of risk for a stroke, to reduce the number of strokes across Wales.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	CTM	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. October 2024 - Discussion with Head of Healthcare within HMP Parc, Chester email sent to all contractors to request update on progress with implementation of recommendation.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside the NHS FAST campaign.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	This action to lead by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support. Revised Due Date - Ongoing across 2024/25 Ongoing across 2024/25	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and PHW should work closely with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing prevention care and ensure ongoing engagement with them to support better health outcomes.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement a key part of the CTM UHB Organisational Strategy Action Plan.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement a key part of the CTM UHB Organisational Strategy Action Plan. Revised Due Date - Ongoing across 2024/25 Ongoing across 2024/25	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practice taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily challenges, which ensure access throughout the day, and planning for subsequent days.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily SafeStart meeting which provides assurance around site based escalation, staffing, patient safety and clinical processes. The meeting allows the identification of clinical priorities, including stroke patients, and clear focus for improvement to appropriate registers/leads. All patient flow concerns are discussed and risk is shared across the each equipped ward and community sites in order to balance risk within the Emergency Department. This ensures an action-focused and delivery prior to the afternoon meeting. As part of this work, under the C-Guard national programme, the SafeStart template has been revised to include SPTS, Red/Green and both internal and external daily metrics. There was a delay in finalising the new template due to access required into SARECAT to display new staffing levels, this is being worked through by information colleagues with the new template expected to be completed and implemented by September 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Operations, a programme of work under the national flag programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Therapy team Assets (2024) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gained from other areas.	Unscheduled Care	01.11.2023	01.11.2023	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider similar processes of prescribing before medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	CTM UHB is aware that consideration needs to be given to dedicated specific pharmacist support as part of our review of the Stroke Pathways. The Pharmacy Team involved in consideration to improve consultation regarding estimated dates of discharge and full MDT involvement use of whiteboards, which includes planning the day before for potential discharge. Pharmacy colleagues are also part of the site based SafeStart meetings, which are aware of potential discharge across the acute site early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider the benefits of dedicated discharge pharmacists staff for managing the necessary blood tests, to assist with effective and timely discharge.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Currently, there is variation in the service provided across the CTM UHB footprint. In Process of Wales Hospital, pharmacy is provided through an SLA with Seamen Bay UHB. Prince Charles and Royal Gwent Hospital pharmacy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement to pilot within all hospitals to help manage similar patient flow.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Within Prince Charles Hospital there was a trial of the RTDC model with some positive support followed by improvement Cymru. There is a national move towards the North Bristol model of continuous flow, which has been explored by the CCG Group as an option which may have a positive impact on patient flow. We are currently collaborating with HBT Wales colleagues on the use of RTDC, with the plan for pilot to commence being Royal Gwentians. In order to undertake this piece of work, we need to understand the breakdown of our specialty demand and so information colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - we remain in collaboration with the NHS east on this however as an organisation we do not yet have predicted demand modelling available to us which constrains our ability to progress this work.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, as well as medical and surgical admissions.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes in building this as part of the development of an ESC Dashboard, which is now embedded for operational use and the future development of an ED Electronic Whiteboard system. There is the ability to roll this out to inform the CCG membership group around their potential demand. Our developments will allow the breakdown of this into capacity and also to further explore regional demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on our end at all levels of the organisation, in order to optimise the demand and flow of patients through the system. These additional developments have been built into the Informatics MDT proposals for 2024/25.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily review nursing clinical oversight for each deactivate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	See also response to Req 5. Within the CCG Group and under the umbrella of the national C-Guard programme, there is a significant focus on patient flow, aligned to SPTS, Red/Green and right patient, right time, within each ward. Part of this work includes the implementation of a standardised patient and ward needs, with senior nursing and medical teams being direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon SafeStart site based meeting. This piece of work is ongoing and focuses on value added care. This work is ongoing and a large scale transformation with a detailed project plan and timescale for implementation that are monitored and reported.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, the health board should consider how it can assist the police in place for social worker identified incidents, which are documented within Data, and that feedback, learning and actions are shared with them as applicable.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2025 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2025 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that their MDT and ED Departments ensure all regioned staff have received up to date A&F training, and they are competent with this. In addition, that appropriate escalation process is in place if a regionalist is or not cure a patient may be suffering with an A&F.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Due to significant changes within CTM UHB in relation to a large scale CCF process with multiple changes to staff groups and lines of reporting the review of current training in relation to A&F training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national A&F process being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of a 'red flagging' leading to an appropriate clinical triage category for patients who are representative of a stroke.	Unscheduled Care	01.10.2024	31.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15 minute target. This is to ensure that critical investigations and treatment are undertaken promptly.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and acute coming in our emergency department. In addition, we are currently reviewing our stroke speciality provision in order to create capacity to better support our early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	31.05.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - collaborative work with WAST in relation to patient pathways is ongoing.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a consistent focus on the analysis of flow, the bottlenecks impacting flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the Welsh Government to explore the implementation of a standardised patient and ward needs, with senior nursing and medical teams being direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon SafeStart site based meeting. This piece of work is ongoing and focuses on value added care. This work is ongoing and a large scale transformation with a detailed project plan and timescale for implementation that are monitored and reported.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that 10 staff undertake the triage of patients within the 15 minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Triage within 15 minutes is a national first year target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured in ED handles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Day and Done call to explore mitigation and actions to reduce any delays. Implementation of a triage will minimise delays in patient safety and will be clinically prioritised following this. If triage times are starting to increase then additional nursing resources are allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the triage for stroke alerts recognise the urgency of both thrombolysis and non thrombolysis stroke path. A patient may be represented whilst and of the thrombolysis window but may still be within the thrombolysis time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Significant work is ongoing within CTM UHB to ensure the clinical workforce required to receive stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombolysis are described in the thrombolysis pathway, which forms part of teaching given to junior doctors and the stroke CNU team who carry the triage for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional A&F capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure the provision of the CNU or A&F stroke specialist service at each acute site and consider how they can maximise their availability throughout the day.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Within CTM UHB, a review of the CNU Stroke services has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce more extended hours to support early recognition and treatment of stroke patients. Ongoing workforce moderation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every QMS committee as part of the board updates.	
Healthcare Inspectorate Wales [HWI/2023/155]	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke by ambulance and self-presenting, to drive improvement on assessment time, to people commencing on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales [HWI/2023/155/MH/1]	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke teams to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and progress is monitored via the C-Guard Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - remains ongoing with digital team - Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke teams to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and progress is monitored via the C-Guard Programme Board.	

AMAT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMAT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the KCSGR assessment tool. In addition, that staff are consistently using a validated tool, such as KCSGR, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the KCSGR assessment tool.	Unscheduled Care	01.12.2024	11.02.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This remains a priority. Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the KCSGR assessment tool.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnosis assessment tool for stroke	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/2	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnosis tool for stroke.	Unscheduled Care	01.10.2024	11.02.2025	In progress	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - USC Care Group continue to work towards equity across our sites and this forms part of stroke programme board discussion.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidelines.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/3	The work of the CTM LHM Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital from door to discharge. All branches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is continuing. The work of the CTM LHM Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital from door to discharge. All branches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/4	Within CTM LHM stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical register, Stroke CMO and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays and of hours due to waiting for Twilight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resourcing the regional Stroke Consultant rota. This would enable us to avoid Twilight delays by not reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - USC Care Group continue to explore regional solutions however this remains multifaceted and complex. Within CTM LHM stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical register, Stroke CMO and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays and of hours due to waiting for Twilight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resourcing the regional Stroke Consultant rota. This would enable us to avoid Twilight delays by not reporting by the stroke Consultants.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maintain their clinical outcome.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/5	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4-hour target. This is a key improvement metric within CTM LHM and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at KSH to transfer to the Stroke unit at PCH this is continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing as we work as part of the most 'best' target/finish. As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4-hour target. This is a key improvement metric within CTM LHM and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at KSH to transfer to the Stroke unit at PCH this is continuously monitored and re/evaluated as required.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must ensure have a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/6	As above, this continues to be a priority for CTM LHM, with non-stroke patients identified on a ward/board round, reported into the electronic white board, and moved to the appropriate urgent area. Ring fenced capacity is identified at the latest daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This continues to be a priority. As above, this continues to be a priority for CTM LHM, with non-stroke patients identified on a ward/board round, reported into the electronic white board, and moved to the appropriate urgent area. Ring fenced capacity is identified at the latest daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring fencing of stroke beds.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation services are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidelines.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/7	Current therapies within stroke data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day services. In order to achieve this, a case for resources to expand 7 day services is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day services. In order to achieve this, a case for resources to expand 7 day services is being developed.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/8	This service is fragile in CTM LHM and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neurorehabilitation service to 752 patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/reinvestment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This remains ongoing. This service is fragile in CTM LHM and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neurorehabilitation service to 752 patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/reinvestment opportunities.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider ensuring the provision of sufficient acute care services to comply with NICE guidelines, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SONAP.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/9	CTM LHM currently offers a 4 day clinical model. A 7 day clinical model remains the ambition for the Health Board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/reinvestment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This remains ongoing. CTM LHM currently offers a 4 day clinical model. A 7 day clinical model remains the ambition for the Health Board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/reinvestment opportunities.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/10	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reported.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - We continue to review this as a risk. Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reported.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/11	As part of the CTM Improvement Programme, a task and finish group was set up to improve delays in the event of Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the health Board. Delays are monitored through EWB and evaluated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 2 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Significant work ongoing under the optimise project to address MCA challenges with supported intervention from Head of nursing to maintain training and standards on their sites.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/12	Implementation of DSM in CTM LHM has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 100 staff. Key questions to increase uptake for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. The continue to monitor the volume of Home First pathways, with a balance to bed based pathway with the best shown below ("table removed for AMAT purposes").	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This is ongoing. Implementation of DSM in CTM LHM has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 100 staff. Key questions to increase uptake for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of Home First pathways, with a balance to bed based pathway with the best shown below ("table removed for AMAT purposes").	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/13	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly to the SGUCC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan includes actions highlighted through the market stability statement published by the region. A PwC action plan addressing community delays has been collaboratively agreed with all partners. A work programme is in place with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This is ongoing but being prioritised. "A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly to the SGUCC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for intermediate care, domiciliary care and care homes. This action plan includes actions highlighted through the market stability statement published by the region. A PwC action plan addressing community delays has been collaboratively agreed with all partners. A work programme is in place with WG guidance for Enhanced Community Care has been set up under an Integrated Director."	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/14	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This remains ongoing and requires capital funds. The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/15	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	
Healthcare Inspectorate Wales (HWI)/2022/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed is become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HWI)/2023/151/MSB/16	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push' report that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - This work is ongoing with digital colleagues. The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push' report that would notify the site team that a patient has been discharged.	
Healthcare Inspectorate Wales (HWI)/2022/156	21/09/2023	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital of Gwent/C. Princess of Wales Hospital, Paediatric Ward 2 & 36 September 2023 (Ref: 034212)	The health board should display information on healthy eating and smoking cessation.	Healthcare Inspectorate Wales (HWI)/2023/156/MSB/1	Health promotion board to display on Childrens ward. Healthy diet and smoking risks, with signposting for additional advice and support will be added to the health promotion board.	Children & Families	31.12.2023	31.08.2024	Fully complete (Awaiting approval)	December 2024 Update - Display boards received and new motifs, all parts of action completed. August 2024 Update - refurbishment of area now complete. Awaiting display boards and once in situ this action will be completed. May 2024 Update - The above iteration was actioned December 2023 - However the childrens ward is currently undergoing refurbishment of the painting and decorating in the area new display boards are being purchased and the Health promotion elements of the action will be a priority on completion of the estates works. New literature added.	
Healthcare Inspectorate Wales (HWI)/2022/157	14/11/2023	Appendix C - Improvement Plan: Angelfish Clinic, Clwydwr Hospital (Ref: 03445)	The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Healthcare Inspectorate Wales (HWI)/2023/157/MSB/1	Angelfish Clinic has a dedicated Physiotherapy. We have identified an area within Angelfish Clinic to be used to support physical exercise, patient health and promotion. Appropriate equipment has been identified and is in place.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	December 2024 Update - Care Group agreed completed 28/12/2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MRSG are providing confirmation of the closure sign-off at the relevant QDR meeting.	
Healthcare Inspectorate Wales (HWI)/2022/157	14/11/2023	Appendix C - Improvement Plan: Angelfish Clinic, Clwydwr Hospital (Ref: 03445)	The health board should consider reinstating the hospital's dedicated wheelchair accessible vehicle to promote timely patient care.	Healthcare Inspectorate Wales (HWI)/2023/157/MSB/2	Angelfish Clinic has always had access to a wheelchair accessible vehicle however unfortunately was involved in an accident and now repairable, a replacement is on order.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	December 2024 Update - Care Group agreed completed 28/12/2023. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MRSG are providing confirmation of the closure sign-off at the relevant QDR meeting.	
Healthcare Inspectorate Wales (HWI)/2022/157	14/11/2023	Appendix C - Improvement Plan: Angelfish Clinic, Clwydwr Hospital (Ref: 03445)	The health board must undertake measures to improve mandatory Welsh language training compliance.	Healthcare Inspectorate Wales (HWI)/2023/157/MSB/3	Welsh Language Awareness training levels to reach a minimum of 85% whilst working toward 100% Ward 1 is currently 100% Ward 2 is currently 78.9%	Mental Health & Learning Disabilities	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QDR 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MRSG are providing confirmation of the closure sign-off at the relevant QDR meeting. Completed 28/12/2023 (see Appendix 1) April 2024 Update - Ward 1 > 82% Ward 2 > 81.38% Previous Update - In Progress Performance date for completion January 2024 (see Appendix 1)	
Healthcare Inspectorate Wales (HWI)/2022/157	14/11/2023	Appendix C - Improvement Plan: Angelfish Clinic, Clwydwr Hospital (Ref: 03445)	The health board must ensure that hospital systems and processes can be robustly filtered to extract ward specific data to support effective supervision, governance oversight and shared learning.	Healthcare Inspectorate Wales (HWI)/2023/157/MSB/4	The incident management system Data Cloud CI can be filtered down to show specific data relating to area, incident type and severity. The Head of Nursing is working with the Patient Care and Safety Business Intelligence officer to ensure all Lead Nurse, Senior Nurse and ward Managers have access to and training on Data dashboards.	Mental Health & Learning Disabilities	31.01.2024	30.07.2024	Overdue	December 2024 Update - reviews on going has been escalated to Nigel Gwynne and Greg Os. October 2024 - requiring updates to national system. August 2024 Update - The H&N is working with the Business Intelligence Manager in the Patient Care and Safety team on the development of a Quality Dashboard, the mapping of the new Care Group structure is complete and we are awaiting implementation. June 2024 Update - Working with Corporate and Patient Care Safety to sign SMTS to new structure. Action updated as at May 2024 - Update 14/07/2024 - The Head of Nursing continues to work with the Data team regarding this action. The new care group structures have created some delay. Revised completion date set for 14/07/2024. April 2024 Update - In progress. Work is ongoing between the Head of Nursing and the Data team.	
Healthcare Inspectorate Wales (HWI)/2022/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22 and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.	Healthcare Inspectorate Wales (HWI)/2023/158/MSB/1	The Health Board is reviewing the current ward environment. With consideration of the ward footprint, clinical need and bed capacity within the Adult Mental Health Directorate it is not possible at present to provide a fully single bedroom provision possible. To mitigate potential impact of the present arrangements the nursing teams ensure that all shared rooms are single sex, with identified curtained private space for each person. The specific need for single rooms is identified at point of admission/assessment, with consideration of individual need (i.e., gender, sexual orientation, or physical risk), and care plan developed as required. The nursing team identify patients who wish to have shared rooms e.g. for company. If requested, an individual room if there is no other pressing clinical need.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QDR 28.12.23 completed. Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MRSG are providing confirmation of the closure sign-off at the relevant QDR meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2022/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22 and Psychiatric Intensive Care Unit (Ref: 03414)	The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.	Healthcare Inspectorate Wales (HWI)/2023/158/MSB/2	The Health Board undertakes a fair and equitable recruitment process, in order to ensure that all staff are employed based on the qualities, values, skills and the experience they demonstrate during recruitment. It is, of course, not based on discrimination or male and females based on gender. The Royal Glamorgan Hospital (RGH) Senior Nursing team work across adult and older persons wards and will support each ward to ensure that there is an optimal mix, and when possible, gender mix. All shift requirements are monitored as the daily staffing "buddy" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate Prevention and Management of Violence and Aggression (PMVA) trained staff on shift. Daily Buddy Documentation, Evidence 1 There is opportunity to offer staff shift and when necessary, gender mix to address needs of an individual e.g. if patient is sexually discriminated or targeting staff due to gender. In extremis the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and GABHS Mental Health wards, and there have been examples of good guard practice.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QDR 28.12.23 completed Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MRSG are providing confirmation of the closure sign-off at the relevant QDR meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2022/158	20/11/2023	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22 and Psychiatric Intensive Care Unit (Ref: 03414)	The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.	Healthcare Inspectorate Wales (HWI)/2023/158/MSB/3	It is a priority of the Health Board to support the communities we work with to make positive decisions about their health, and we maintain a commitment to support all patients and staff to give up smoking. Since the "Smoke-free Premises and Vehicles (DfW) Regulations 2007" came into force in the Mental Health Unit (MHU) in September 2022, smoking on there has been prohibited. Following implementation, the significant challenges this presented to individuals who found smoking cessation measures to be ineffective or unworkable were noted, and after discussion with staff and patients the Mental Health Smoking Cessation group agreed that in the RGH MHU unit we would create small designated outside smoking areas for restricted use. This seemed to be well-received by the patient group, but following an anonymous concern being raised with the Health Inspectorate Wales in summer 2023, this arrangement was halted while the measures were reviewed. Following presentation of a mitigating paper to the Health Board Executive Leadership Group, a "Designation in compliance" was agreed for a period of six months while the Mental Health Care Group develop options for a permanent solution across all Mental Health sites. It is recognised by the Health Board that this temporarily contravenes the Smoke-free Premises and Vehicles (DfW) Regulations 2007. Mental Health Directorate Smoking Mitigation Paper, Evidence 1.1 Practically, as the RGH MHU, this means that there is an availability of managed smoking spaces at designated times in a space within the footprint of the MHU on the premises directly off the ward corridor. This is an arrangement that is clearly documented within the care plan of all patients who identify this as being their wish following smoking cessation assessment. The conditions and restrictions of the designated smoking area are made clear to all patients and signposted across the ward. Ash trays are being purchased for designated smoking area, there is a bin currently in place as an alternative. Patio Photos, Evidence 2 Patio Photos, Evidence 3 There is a routine discussion within the patient community groups around smoking arrangements and support by the patient groups of self-regulation of cleanliness of such areas by smokers. This is checked by ward staff regularly and understood cleaning requested if facilities if required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update - QDR 28.12.23 completed Fully complete (Awaiting approval) - Further Evidence Awaited August 2024 Update - The completion of this action was pre care group reconfiguration and the MRSG are providing confirmation of the closure sign-off at the relevant QDR meeting. Completed	

AMAT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMAT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must ensure that a full review is undertaken on the appropriateness and reliability of the current personal alarm systems used.	HWI/2023/158/MS/1	One of the HWI inspection (December 2023) there was an ‘Standard Operating Procedure (SOP) in place that directed that a dual personal alarm system was in place on the RSD MRIU for all clinical staff. This was due to a recent increase in the frequency of incidents whereby the patient alarm failed to activate when tested. MRIU Dual Alarm SOP, Evidence 6 A full diagnostic review of the ‘dual call’ system was undertaken in November 2023, with the system noted to be returned to a serviceable and operational state. This issue however remains on the Directorate Risk Register for the immediate future and evidence of action taken will be reviewed and reported on the Data system. The SOP also remains in place on the MRIU. A review of any activation failures will be undertaken by the MRIU/Intensive Senior Nurse and Assistant Directorate Manager for Inpatient services for discussion at Directorate Quality Safety Risk and Experience meeting (QSER) in June 2024. Subsequently a decision will be made by the Adult Mental Health Senior Leadership Team as to whether the Safe System of working for a dual alarm system can be ceased down or will remain in place with the risk remaining on Directorate Risk Register.	Mental Health & Learning Disabilities	30.06.2024	30.06.2024	Fully complete (Awaiting approval)	December 2024 Update – completed QSER July 24. October 2024 – completed approval in QSER. Evidence to follow. COMPLETED JULY 24 August 2024 – Update requested. June 2024 Update – update due in August 2024.	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must address the environmental issues and resolve them in a prompt and timely manner.	HWI/2023/158/MS/1	The ward 22 damaged chair, with exposed foam filling which is not compliant with the relevant legislation has been condemned and removed with a temporary replacement now in place. A specialist furniture manufacturer has provided a quotation for new seating within the interview room and a replacement of fixed armchair. Ward 22 Interview Room Photo, Evidence 7 Psychiatric Intensive Care Unit (PICU) mixing ceiling tiles have now been replaced. PICU Ceiling Photo, Evidence 8 Water damaged ceiling tiles in the Ward 22 office have all been replaced. There remain 6 water damaged tiles between the lounge & dining room awaiting replacement which have been tagged with Estates Department. These have been prioritised by Estates as non urgent, as they are considered decorative rather than safety sensitive, and the progress on replacement is monitored weekly by the Inpatient Deputy Directorate manager. Ward 22 Ceiling Photo, Evidence 9 Ward 22 Ceiling Photo, Evidence 10 After consultation with a specialist furniture manufacturer the Inpatient Senior Nurse confirmed the suitability of the dining chairs currently in place in Ward 22. The dining room chairs are multipurpose and need to be moved between dining room and lounge for group discussions/activities and therefore need to be of a manageable weight. The Adult Mental Health Senior Leadership Team acknowledged that the weight of the current chair would allow them to be picked up and potentially transferred as a weapon, however this risk would not be completely eradicated unless the chairs were of a weight that would disadvantage patients with mobility restrictions and potentially increase risk of injury to staff when moving for dining purposes. The Learning team mitigate risk of furniture being used in this way through individual risk assessment and monitoring/observation of these areas when in use. Ward 21 Bedroom walls and privacy curtains have been replaced. Ward 21 Curtain Photo, Evidence 11 There are long standing difficulties with inadequacy of wastewater/ storage capacity within the RSD MRIU site. As a result, the PICU Estate Care Area (ECA) offers a semi fit macerator system to move waste from ECA to the main sewage system. This can result in issues when foreign objects are placed in toilet in ECA. Groundwork investigation report that a permanent solution to connect ECA to main sewage system would require extensive excavation works with significant capital spend and long term closure of the PICU. The Adult Mental Health Senior Leadership are of the opinion that this is not viable at present due to disruption of service. The development of a new Mental Health patient facility systems on the Health Board Risk Register.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER 28.12.23 completed. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Healthcare Inspectorate Wales (HWI)/2023/158	The health board must ensure that COVID equipment is stored correctly.	HWI/2023/158/MS/1	All wards on the MRIU have Removable tables where all Laundry undergoes are stored. It is the responsibility of all Health Board staff to be aware of and undertake their responsibilities when using COVID materials. The Inpatient Senior Nurse has emailed a reminder to all staff including HCW about COVID and equipment to storage. Standards for storage of COVID materials, Evidence 13 Checks on the environment are undertaken by ward managers as part of weekly environmental checks (Ward Managers Assurance Audit) and matters of concern addressed with staff at the time or escalated in line with MRIU Maintenance SOP, Evidence 12	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER 28.12.23 completed. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must ensure that out of date medication is disposed of appropriately.	HWI/2023/158/MS/1	Following the HWI Review in November 2023, all medication cabinets across the MRIU were inspected and no further out of date medications were found. Review of all medication dates and returns to pharmacy is monitored through the “Ward Managers Assurance Audit” which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit, Evidence 14 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSER) through monthly exceptions report and action taken as required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER 28.12.23 completed. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must ensure that MMR charts are fully completed.	HWI/2023/158/MS/1	The Inpatient Senior Nurse and Mental Health pharmacist will review the risk of pharmacist technicians to ensure that review of MMR charts will be included in their routine checks. An email has been sent by the Clinical Director to all medical team to reaffirm the documentation standards required on drafting and reviewing medication. A sample of MMR charts are reviewed through the “Ward Managers Assurance Audit” which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit, Evidence 15 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSER) through monthly exceptions report and action taken as required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER November 2023 completed. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the ward and in clinical rooms.	HWI/2023/158/MS/1	Reminder email from Senior Nurse reminding staff of agreed standard Safe Storage of medication, Evidence 16 Security arrangements of medication trolley are reviewed through the “Ward Managers Assurance Audit” which is undertaken monthly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSER) through monthly exceptions report and action taken as required.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER 28.12.23 completed. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must ensure that there are more variety of choices for patients with specific dietary requirements.	HWI/2023/158/MS/1	All Health Boards in Wales follow a menu which is based on The All Wales Caring & Nutrition Standards. The Health Board Catering Service works with clinical teams to adapt the patient menu to patient specific requirements. The present patient menu changed in September 2023 to a two week rolling menu which replaced an ‘a la carte’ style menu. The new menu was reviewed by the All Wales dietitians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing team seek feedback from patients via the Inpatient Community Group and “How Your Say” suggestion boxes (which are regularly monitored). This feedback informs discussion with the wider service i.e. Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Team recognise the need to increase the frequency of the menu review and change and are currently working on the new version for 2024.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER 28.12.23 completed. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must review staffing levels to ensure they meet the demands of the patient group.	HWI/2023/158/MS/1	The Mental Health Head of Nursing has recently concluded a thorough nursing establishment review that has considered levels of acuity and demand across the Mental Health Inpatient units. This review acknowledged the changing picture of inpatient work and environments since the last Mental Health inpatient staffing review in 2022 and recognised the challenges of maintaining a motivated and engaged workforce when pressures within these clinical settings are increasing. Using principles drawn from All Wales Mental Health Workbrain on the implementation of the Nurse Staffing Levels Act, the report makes recommendations about amendments to skill mix and enhancement of nursing leadership roles the better to improve opportunities for recruitment and particularly staff retention. The Staffing review report will be presented to the Mental Health Nursing Workforce meeting on 25 January 2024, for consideration by Director of Nursing on subsequent actions. Considerations of staffing levels day to day are a core role of the Ward Managers and Senior Nurse, with all shift requirements monitored initially at the daily staffing “huddle” to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate staff on shifts. Review of clinical need is a dynamic process that involves all members of the Nursing team, and staffing levels are increased in response to increased levels of acuity e.g. 1:1 patient observations to maintain safety or a need for intensive personal care. At this time, there is an operational acknowledgement of the particular challenges to recruitment of committed and motivated nurses into Mental Health posts as a result the Health Board engages on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER 28.12.23 complete. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/158	20/11/2023	Appendix C – Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03416)	The health board must ensure that staff resources are filled, and future initiatives are explored to encourage recruitment into the hospital.	HWI/2023/158/MS/1	While there is a high degree of volatility around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership. Recruitment of band 5 registered nurses remains a challenge and the HR is taking steps to ensure that vacancies are being filled. The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are currently exploring the financial implications and opportunities of the recommendations. The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maintain SSP opportunities for recruitment.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	December 2024 Update – QSER 28.12.23 completed. Fully complete (Awaiting approval) – Further Evidence Awaited August 2024 Update – The completion of this action was pre care group reconfiguration and the MRIU2 are providing confirmation of the closure sign-off at the relevant QSER meeting. Completed	
Healthcare Inspectorate Wales (HWI)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decision Unit, Prince Charles Hospital Appendix C – Improvement Plan, 31 July 01 & 02 August 2023 (Ref: 3395)	The health board is required to provide HWI with an update on the plans to reconfigure the ECU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	HWI/2023/167/MS/4	PCR is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the ECU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	In progress	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – capital work ongoing – PCR is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the ECU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	
Healthcare Inspectorate Wales (HWI)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decision Unit, Prince Charles Hospital Appendix C – Improvement Plan, 31 July 01 & 02 August 2023 (Ref: 3395)	The health board is required to provide HWI with an update on the plans to reconfigure the ECU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	HWI/2023/167/MS/6	CTM has implemented a pre-emptive training and briefing process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update – capital work ongoing to December 2024. December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – work ongoing Awaiting dates from Welsh Government following a successful bid for Funding. This will supply an extra toilet and showering facilities.	
Healthcare Inspectorate Wales (HWI)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decision Unit, Prince Charles Hospital Appendix C – Improvement Plan, 31 July 01 & 02 August 2023 (Ref: 3395)	The health board is required to provide HWI with an update on the plans to reconfigure the ECU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	HWI/2023/167/MS/7	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	Overdue	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – part of ongoing capital plans – We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area this will facilitate improved observation of patients within the area to ensure patient care and safety.	
Healthcare Inspectorate Wales (HWI)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decision Unit, Prince Charles Hospital Appendix C – Improvement Plan, 31 July 01 & 02 August 2023 (Ref: 3395)	The health board is required to provide HWI with an update on the systems in place to improve patient flow through the ECU.	HWI/2023/167/MS/12	We are currently reviewing through legal operational change, the operational structure that will be key to patient flow and ensure senior leadership is present on site and part CTM Health Board. Through the 8-week programme work we are progressing improved patient flow as this is a multi-professional/whole system approach involving our Local Authority colleagues. The ECU White Board has been introduced across the organisation and is key to patient flow and implementation of RedCrest as a quality metric for patient care. This will increase bed capacity through time efficient and collaborative processes where we explore what additional measures internal and external delays and focus on marginal gains in length of stay. Consequently, this will improve flow through ECU. As part of this work the senior team are also exploring the continuous flow model to move if this is achievable for the ECU. The ECU team are also reviewing the registration system and standard as part of the ECU Patient Safety Review. When it is identified that these Teams are beginning to increase, there are internal escalation processes in place to ensure timely support and assessment of patients which additional staff being deployed to support. The ECU Clinical Team will also support the ECU team through the ECU team to support any delays in triage. When there will be an initial assessment and consulting at the end of the day of patients. ECU has recently introduced 2.8 Patient Flow Coordinators to support timely patient flow and escalation of patient flow delays. The USC group have developed updated Escalation Cards to support actions and provide assurances that ambulance delays are avoided. There are ongoing evaluations in place, and when any patient is delayed over 4 hours an internal investigation is undertaken to provide assurances that no harm has occurred.	Unscheduled Care	01.03.2024	01.03.2024	Overdue	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – this work is ongoing. This work continues to progress via the Optimise Project which formally reports into 8 goals programme board and onto NHS Executive colleagues. This work continues to progress via the Optimise Project which formally reports into 8 goals programme board and onto NHS Executive colleagues.	
Healthcare Inspectorate Wales (HWI)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decision Unit, Prince Charles Hospital Appendix C – Improvement Plan, 31 July 01 & 02 August 2023 (Ref: 3395)	The health board is required to provide HWI with details of the action taken to improve staff compliance with Departmental Fire Safety (D1) and Mental Capacity and D&S (D2) training.	HWI/2023/167/MS/6/1	The Senior Nurse for Professional Education is key to progressing this agenda to ECU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving action which is monitored by the Senior Nurse for professional education. The ECU has been undertaking bespoke training sessions for the PCR role weekly to improve compliance as part of the resourcing post Covid-19 pandemic where training was unavailable as of Aug 23 fire training for staff is as follows: D1 100% compliance D2 86/97.36% HCW 56.33%	Unscheduled Care	01.04.2024	01.06.2024	Overdue	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months. ECU MCA now 77% and fire 85%. Monthly training offered to staff for fire, Violence and Aggression and D&S. Compliance with fire training and Mental Capacity continues to improve. CBU – MCA training compliance is 77% and fire is 85%. D2 MCA compliance is 56% and fire is 75% (MCA overall compliance is reduced as a result of a number of newly recruited Registered Nurses and Health Care Support Workers, yet to complete training). There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.	
Healthcare Inspectorate Wales (HWI)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decision Unit, Prince Charles Hospital Appendix C – Improvement Plan, 31 July 01 & 02 August 2023 (Ref: 3395)	The health board is required to provide HWI with assurance Violence and Aggression, Mental Capacity and D&S training compliance is effectively tracked for the ECU.	HWI/2023/167/MS/6/1	Monthly mandatory training study days and reports now include Y & A D&S, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings, trends are monitored for improvements, where there is deterioration action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional education.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months. CBU fire is 100%. Monthly training offered to staff for fire, Violence and Aggression and D&S. Compliance with fire training and Mental Capacity continues to improve. CBU – MCA training compliance is 77% and fire is 85%. There are monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% or above within the next 3 months.	
Healthcare Inspectorate Wales (HWI)/2024/165	06/02/2024	Appendix 8 Immediate Improvement Plan, PCR Maternity Unit, 9-13 January 2024 (Ref: 03603)	Midwifery staffing levels on night shifts The health board are required to provide HWI with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	HWI/2024/165/MS/7	Working with finance colleagues to develop a new model for obstetric theatre nursing (enhancing maternity time).	Children & Families	01.02.2024	01.02.2024	Partially complete (Overdue)	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 – activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PWH). Commenced September 2023. Due for completion February 2024. A meeting held place with the lead nurse for Periparturient services and finance to explore the feasibility for periparturient services to cover emergency and elective theatre 24/7, costing did not align with funding. The financing is now being tested to cover 3 elective theatres in the first instance, with meetings being arranged for May 2024	
Healthcare Inspectorate Wales (HWI)/2024/165	06/02/2024	Appendix 8 Immediate Improvement Plan, PCR Maternity Unit, 9-13 January 2024 (Ref: 03603)	Midwifery staffing levels on night shifts The health board are required to provide HWI with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	HWI/2024/165/MS/9	Review safe care tool to ensure that red flag according to NICE safe staffing 2015 are included in the tool.	Children & Families	31.01.2024	31.01.2024	Partially complete (Overdue)	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation. Review of safe care tool has been undertaken to ensure that red flags according to NICE safe staffing 2015 are included in the tool	
Healthcare Inspectorate Wales (HWI)/2024/165	06/02/2024	Appendix 8 Immediate Improvement Plan, PCR Maternity Unit, 9-13 January 2024 (Ref: 03603)	Midwifery staffing levels on night shifts The health board are required to provide HWI with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	HWI/2024/165/MS/10	Work with the Corporate Communications department to develop a Comics Recruitment strategy to demonstrate the benefits to attract staff to work in CNU Unit.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCR site.	
Healthcare Inspectorate Wales (HWI)/2024/165	06/02/2024	Appendix 8 Immediate Improvement Plan, PCR Maternity Unit, 9-13 January 2024 (Ref: 03603)	Midwifery staffing levels on night shifts The health board are required to provide HWI with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	HWI/2024/165/MS/17	CTM team are working with the wider Health Board initiative to ensure maternity services are included as part of ‘Safe to Survive’.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 – included in ‘Safe to Survive’ meetings and working with the corporate team to ensure the mat res template is fit for purpose.	
Healthcare Inspectorate Wales (HWI)/2024/166	06/01/2024	Appendix 8 Improvement Plan, PCR Maternity Unit, 9-13 January 2024 (Ref: 03603)	UNICEF Baby Friendly Initiative The health board must work to achieve the UNICEF Baby Friendly Initiative accreditation.	HWI/2024/166/MS/1	There are dedicated office feeding on obstetric in place across the perinatal service who are working together toward BF re-accreditation. The service is currently undertaking a number of audits in readiness for re-assessment which is planned for April 2024. Recent PROM data shows that infant feeding experience is positive. The service has implemented a feeding audit partnership.	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – In response to a recent positive inspection audit there are a few actions underway. Accreditation being sought in the next couple of months.	
Healthcare Inspectorate Wales (HWI)/2024/166	06/02/2024	Appendix 8 Improvement Plan, PCR Maternity Unit, 9-13 January 2024 (Ref: 03603)	Staffing levels detailed in Appendix 8 The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical duties where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	HWI/2024/166/MS/16	Working with finance colleagues to develop a new model for obstetric theatre nursing (enhancing maternity time).	Children & Families	01.03.2024	01.03.2024	Overdue	December 2024 Update – An update against the recommendation has not been provided on this occasion. August 2024 Update – activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PWH)	

AMAT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMAT Reference Number	Action	Care Group	Original Due Date	Current Due Date	Progress Status	Comments/Updates	Barriers
Healthcare Inspectorate Wales (HIW)/2024/166	05/11/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (vnl 03030)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/WIS11/8	Review safe care tool to ensure that red flags according to NEC safe staffing 2015 are included in the tool	Children & Families	01.01.2024	01.02.2024	Overdue	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.	
Healthcare Inspectorate Wales (HIW)/2024/166	06/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (vnl 03030)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/WIS11/9	Work with the Corporate Communications department to develop a Comm Recruitment strategy to demonstrate the benefits of attracting staff to CTM Unit.	Children & Families	28.02.2024	29.02.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. Update 11/03/24: Filling of staff has commenced, currently on hold due to pressures due to PHSF temporary closure. August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.	
Healthcare Inspectorate Wales (HIW)/2024/166	06/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (vnl 03030)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/WIS11/10	The team are working with the wider Health Board relative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the new template is fit for purpose.	
Healthcare Inspectorate Wales (HIW)/2024/166	06/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (vnl 03030)	Safe reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	Healthcare Inspectorate Wales (HIW)/2024/166/WIS12/1	All moderate and above are reviewed by the MDT and SMDT. A review of all no and low level incidents is underway to explore any emerging themes, trends and ensure that the service is addressing any concern / incident in a robust manner. A wider review of governance process is underway to ensure that there is sustainability and assurance in accordance with the Duty of Quality and Maternity and Neonatal Assurance Escalation Framework. The review was discussed in the Maternity and Neonatal Safety Board in February 2024, the outcome of this work and any recommendations will be presented at the Maternity and Neonatal Safety Board in April 2024.	Children & Families	01.04.2024	01.04.2024	Partially complete (Overdue)	December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.	

Cwm Taf Morgannwg University Health Board

Audit & Risk Committee Internal Audit Progress Report

February 2025

NWSSP Audit and Assurance Services

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Appendix A – Tables showing detailed progress against audit plans



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

Disclaimer notice - please note

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

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

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

1 Introduction

- 1.1 This progress report provides the Audit & Risk Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at 06 February 2025. This report provides information on the status of progress of our reviews.
- 1.2 We report the progress made to date against individual assignments along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

- 2.1 Since the December meeting of the Committee five reports have been finalised, two reports are in draft, including one from the prior year. We have ongoing fieldwork in relation to 13 reviews, which includes two reviews for the Joint Commissioning Committee (JCC). A summary of the position of the finalised reports, including a summary of number of recommendations, is provided below in Table 1.

Table 1 – Summary of finalised reports

Assignments	High	Medium	Low	Total	Assurance rating
Vaccination policy implementation	2	1	-	3	Limited
Regional integration fund	-	3	-	3	Reasonable
Medical job planning	3	-	-	3	Limited
Service level agreements – follow up	-	2	-	2	Reasonable
PCH Supply chain management	2	4	-	6	Reasonable

3 Delivering the Plan

- 3.1 While our work in relation to 2024/25 is ongoing, at the last Audit Committee we reported that we were having difficulty progressing a number of reviews. The position as at the date of this paper, excluding audit work relating to the JCC, is set out in table 2, below.

Table 2

Review status	Opinion count	Percentage
Defer	5	13%
Planning	10	26%
Work in progress	11	28%
Draft	1	3%

Review status	Opinion count	Percentage
Final	12	30%
Total	39	

3.2 Possible that a further two reviews in planning will need to be deferred.

3.3 The detail of our work is included in appendix A to this report.

4 Performance reporting

4.1 We monitor aspects of the Internal Audit service and report this information in our annual report. Our agreed performance indicators, as at the time of this progress report, are set out in table 3 below:

Table 3 – Performance Indicators 2024/25

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	92% (12/13)	95%	v>20%	10%<v ≤20%	v≤10%
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Green	75% (9/12)	80%	v>20%	10%<v ≤20%	v≤10%
Report turnaround: time from management response to issue of final report [10 days]	Green	92% (11/12)	95%	v>20%	10%<v ≤20%	v≤10%

5 Feedback

5.1 A post audit questionnaire is issued to the key health board staff that we have worked with have alongside our final report. This is one of our ways of getting feedback on the audit process so that we can look to make improvements. So far, this year to date, we have issued eight feedback questionnaires and received feedback in relation to four reviews.

6 Other activity

Joint Commissioning Committee (JCC)

6.1 We have agreed a programme of work for 2024/25 with officers of the JCC (Appendix A – Table 6). We have finalised one report and have ongoing fieldwork for our second review.

Meetings

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

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

Appendix A – Programme of work**Table 4: Status of reports included in annual opinion for 2023/24 as draft**

Plan Ref.	Review	Rating	Status	Notes
4	Estates condition	Limited	Draft	Part of all Wales review - Updated draft report issued 18.10.23. Following management feedback, updated report issued July 2024 and report in new format issued January 2025. Meeting with management scheduled for 18.02.25.

Table 5: 2024/25 Core programme of work for Q1-Q4

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
-	Embedding the quality framework - Brought forward from 2023/24	Reasonable	-	Oct	Final	Y	N	-
T07	Information provision – Intelligence led organisation	Reasonable	Q1	Oct	Final	Y	Y	-
T27	Follow up – Facilities governance arrangements	Substantial	Q1	Oct	Final	Y	Y	-

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
-	PCH Validation of Management Actions	Substantial	Q2	Dec	Final	Y	Y	-
T20	Charitable funds	Reasonable	Q2	~~Oct~~ Dec	Final	Y	N	-
T16	Additional medical pay	Limited	Q1	~~Oct~~ Dec	Final	Y	Y	-
T17	Medical job planning	Limited	Q2	~~Oct~~ Feb	Final	Y	N	-
T23	Regional integration fund	Reasonable	~~Q2~~ Q3	~~Oct~~ Feb	Final	Y	Y	-
T33	Follow up – SLA arrangements	Reasonable	Q2	~~Oct~~ -Feb	Final	Y	Y	-
-	PCH – Supply chain partner management	Reasonable	-	~~Oct~~ Feb	Final	Y	Y	-
T22	Vaccination policy implementation	Limited	Q2	~~Oct~~ Feb	Final	Y	Y	-
T19	Energy management	Reasonable	Q2	~~Oct~~ Dec	Final	Y	Y	-
T10	Duty of candour	Reasonable	Q1	~~Oct~~ May	Draft	N	-	Draft report issued 09.01.25.
T18	Capital systems	-	Q2	~~Oct~~ May	WIP	-	-	Fieldwork complete.

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T31	Follow up – Financial savings	-	Q1	~~Oct~~ May	WIP	-	-	Fieldwork ongoing.
T28	Follow up – Performance management – 4-hour target	-	Q2	~~Oct~~ May	WIP	-	-	Delays getting meetings/responses. Fieldwork now complete.
T15	New PDR process	-	Q1	~~Oct~~ May	WIP	-	-	Management request November start. Fieldwork now complete.
T02	Cancer tracking process	-	Q3	~~Feb~~ May	WIP	-	-	Fieldwork started 05.12.24.
T08	Digital benefits realisation	-	Q4	May	WIP	-	-	Fieldwork started 14.01.25
T13	Service user experience	-	Q4	May	WIP	-	-	Fieldwork started 07.02.25
T14	Welsh Risk Pool	-	Q4	May	WIP	-	-	Fieldwork started 04.02.25
T30	GI Pathways - Follow up	-	Q4	May	WIP	-	-	Fieldwork started 06.02.25
-	PCH Delivery of Project Objectives	-	Q4	May	WIP	-	-	Fieldwork started 21.01.25

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
-	PCH Equipment	-	Q4	May	WIP	-	-	Fieldwork started 27.01.25
-	PCH Financial and Technical compliance	-	Q4	May	Planned	-	-	Fieldwork due to start
T01	New care group model	-	Q2-Q4	Dec May	Planning	-	-	Initial discussion planned for September, but met early November. Agreed move to Q4.
T03	Elective care criteria – access to diagnostics	-	Q3	Feb May	Planning	-	-	Initial discussion planned for September. Detailed planning in January. Draft brief issued 05.02.25.
T04	End of life care management	-	Q3	Feb May	Planning	-	-	Initial discussion planned for September. Detailed planning meetings in January. Draft brief issued 05.02.25.
T1	Continuing Health Care Electronic White Board	-	Q3-Q4	Feb May	Planning	-	-	Planning meeting in November. Focus has changed to three-part review with electronic whiteboards first. CHC will follow on 25/26 plan. Scoping meeting

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
								28.01.25 Draft brief issued 05.02.25.
T12	Ensuring quality when commissioning care services	-	Q3	Feb May	Planning	-	-	Initial meeting November. Meeting with Executive 18.02.24
T21	Core financial systems	-	Q3	Feb May	Planning	-	-	Initial scoping meeting October. Information now received on areas of coverage. Brief being drafted.
T24	Stroke	-	Q3	Feb May	Planning	-	-	Scoping meeting 31.01.25. Second meeting 12.02.25
T05	Discharge planning	-	Q4	May	Planning	-	-	Scoping meeting 28.01.25
T26	Risk management	-	Q4	May	Planning	-	-	Scoping meeting 21.01.25
T32	Decarbonisation – Follow up	-	-	-	Proposed defer	-	-	To allow completion of actions.
T06	Primary care	-	Q4	-	Proposed defer	-	-	To allow transformation/ cluster work to bed in.

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T09	Clinical coding	-	Q3	-	Defer	-	-	DHCW has recently undertaken work and reported in this area.
T29	Follow up - INNU	-	-	-	Defer	-	-	Brief agreed. Has been delayed due to all Wales working group – Defer to 2025/26.
T25	Llantrisant Health Park	-	-	-	Defer	-	-	Project has had gateway review in year, so propose to undertake audit in early 2025/26.

Table 6: Plan for Joint Commissioning Committee (JCC) 2024/25

Ref.	Review	Rating	Status	Notes
1	Mental Health quality assurance process	Reasonable	Final	-
2	Governance systems	-	WIP	Fieldwork started 11.12.24
4	Traumatic stress Wales	-	WIP	Fieldwork started 07.01.25
3	Financial systems	-	Planning	Draft brief issued 09.01.25

Supply Chain Management

Final Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-SSU-2425-40

October 2024 – December 2024

Sally May, Executive Director Finance

February 2025

Sally May, Executive Director Finance

Huw Richards, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit



Executive Summary

Purpose

This audit originates from the 2024/25 integrated audit plan, which was developed in collaboration with management and approved by the Audit & Risk Committee. The purpose of this audit was to review and assess the effectiveness of project delivery, with a specific focus on the performance of the Supply Chain Partner (SCP). Given the critical role of the SCP in ensuring the successful execution of the project, the review evaluates their adherence to contractual obligations and agreed protocols.

By identifying any potential weaknesses or risks in the SCPs delivery, this audit seeks to provide assurance that their performance aligns with contractual expectations. Additionally, the findings aim to support continuous improvement, ensuring that the partnership contributes effectively to achieving project objectives and maintaining overall governance and accountability.

Overview

We have concluded that this area provides **reasonable** assurance. Overall, the level of control demonstrated by the SCP has been positive, with several key areas of strength identified. Notably, the SCP has exhibited robust practices in Health and Safety management, ensuring a safe working environment across the project. Similarly, effective site control measures have been implemented, contributing to the orderly management of activities on-site.

Furthermore, the handover arrangements for completed areas were well-organised, facilitating a smooth transition and minimising disruption to ongoing project delivery. These positive practices reflect a proactive approach by the SCP in meeting contractual obligations and supporting project success.

While these strengths are commendable, there are several matters that require management attention, including but not limited to:

- Lessons to be learned to inform the Capital Resource Limit for 2025/26.
- The level of cost confirmed for Section 4 appears low, and there's a lack of breakdown to the Section 5 costs. Improved planning, monitoring and reporting to the Project Board is needed to ensure effective financial management.
- Multiple iterations of the project programme have been rejected by project management between June – November 2024 due to a disagreement over the time and cost implication of the extensions to the Intensive Care Unit. Given the Project Manager has made an assessment as required by the contract, The SCP should be instructed to produce a reflective programme (and challenge the assessment separately using the appropriate contract mechanisms).
- Delays with regards to processing of changes had been highlighted throughout June – November 2024.

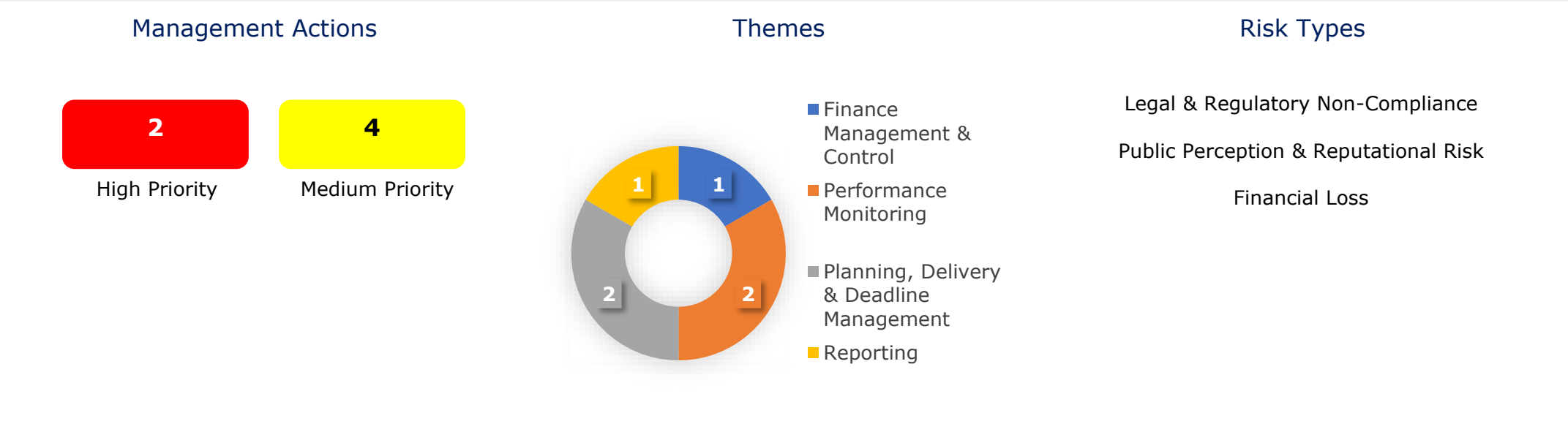
Full details of matters arising are detailed within the Findings & Agreed Action Plan.

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Arithmetic checks were conducted on the cost information reported to the Project Board, and an anomaly was identified in the September 2024 report. This discrepancy, amounting to approximately £3 million, could not be reconciled with the total cost figures presented. Upon investigation with the Project Manager, it was determined that certain additional fields, which were necessary to balance the totals, had been omitted from the report. These fields related to additional fees that had not been presented within the reported figures. As a result of this issue, revised reporting was prepared and presented to the Project Board to address the inconsistency. The updated reports provided greater transparency by ensuring that all relevant fields were included, enabling a more accurate representation of the total costs. This step underscores the importance of robust data validation processes to prevent such discrepancies and maintain confidence in financial reporting.

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Resource Management: to assess how the Supply Chain Partner managed resources such as staff/ labour, materials, equipment, and subcontractors to ensure efficient utilisation and cost-effective project delivery.	1,2	Limited
2 Site Records/ Controls: to ensure that appropriate site controls operated e.g. to include site records, health & safety records, control of sub-contractors etc.	-	Substantial
3 Monitoring and Reporting: to evaluate application of appropriate project management tools, risk management, programme management, and reporting by the Supply Chain Partner to provide appropriate assurances to the Health Board.	1,3	Reasonable
4 Responsiveness: to assess the Supply Chain Partner's responsiveness to the various contractual timescales in respect of information requests, design development/ updates and project changes etc.	4,5	Limited
5 Handover: to review the handover and post-handover arrangements, which included timely rectification of identified issues, treatment of post-contract changes etc.	6	Reasonable
6 Performance Management: to ensure that appropriate arrangements were in place to capture performance information from all stakeholders, including the establishment of processes to capture/ monitor agreed corrective action.	4,5 & 6	Reasonable



At a Glance

Time Position:

The contract start date was the 30th of November 2020. As of the November 2024 progress report, the works were in week 200 of an overall contract period of 294 weeks. The works were split into 6 sections with a summary of the position below:

Item	Position
Section 1	Completed on 8th April 2022.
Section 2	Completed on 6th December 2022
Section 3	Completed on the 16th of September 2024
Section 4	Revised contractor's planned completion as the 23rd of January 2026. This has been impacted by the omission of the MRI extension. This does not affect the overall contract completion date only the sectional completion date.
Section 5	Programmed for commencement on the 17th of December 2024. Following conclusion of the review, this section was started as planned.
Section 6	Completed on 21st March 2023

Contract completion remains as the 20th of July 2026. It should be noted that a change to the completion date for a 6-week delay has been instructed as part of the project manager's assessment for Intensive Therapy Unit issued on the 12th of April 2024. This contract completion date should now be included within the programme as the 1st of September 2026.

Cost Position:

The November 2024 reported anticipated outturn costs of the project are referenced below:

Item	Cost
Approved Sum (inc. VAT)	£220.060m
Forecast Outturn costs (inc. VAT)	£233.149m
Potential increase in project outturn costs (inc VAT)	£13.089m*

**Note the potential increase in outturn cost was mainly due to forecast inflation i.e. inflation assessment included within approved sum (£22.926m with approved/forecast inflation £36.015m)*

Please note, this review does not assess the overall project performance against key project objectives; this will be undertaken within the Key Project Objectives Audit scheduled to start in Quarter 4 2024/25.

Findings & Agreed Action Plan

Objective 1: Resource Management	Limited
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Overview / Summary of Observations

The PCH Phase 2 Ground and First Floor Works project comprises six sections of works. The NEC contract for the project has been amended to provide for Target Costs, sectional completion, gain share and associated defects periods for each defined section of works. Although levels of volatility in materials prices have cooled recently, increases in labour rates linked to inflation still drive price increases.

The SCP reports average resource requirement per section. Staff resource was monitored via the monthly valuation process that was subject to a separate audit during 2024/25. The Health Board’s appointed Cost Adviser provided scrutiny of the monthly valuation of works completed, a signed payment certificate was issued by the externally appointed Project Manager to offer assurance to the Health Board that the costs were deemed appropriate, and payments to the SCP should proceed.

There have been significant variances in the SCP cashflow and certified figures in the 24/25 financial year (up to October 2024 of circa £4M). Volatility in cash flow can pose significant challenges for financial management due to the uncertainty and risks it introduces; specifically for the Health Board meeting its obligations to the Capital Resource Limit. Additionally, sections 4 and 5 are largely based on estimated costs, rather than costs agreed with subcontractors – given these works are ongoing, it would be expected that a higher number of packages would be agreed with subcontractors.

Key Findings		Risk & Impact	Agreed Management Action
1	Cashflow - Fluctuations The September 2024 project progress report highlighted that <i>'The SCP has been requested to provide a report on the cashflow and explain how these variances have occurred and what actions are being taken to improve financial management'</i> . Some evidence of assessment had been shared by the SCP, but this was not comprehensive and does not negate the need for a formal report. Movements in the cashflow need to be easily reconciled so that ongoing reporting and scrutiny can take place at the Project Board. Additionally, lessons can be learned from the SCP to inform the setting of the CRL for 2025/26.	The Health Board may need to divert funds from other operational areas or reduce the scope/pace of the project.	CTMUHB to seek assurance from the Supply Chain Partner that measures have been put in place as a result of lessons learned at the closure of the financial year 24/25 that will give assurance for better cash-flow management for CRL 25/26.
			Expected Evidence of Implementation: Report to be provided to Project Board surrounding lessons learned into cashflow management.
		Medium Priority	Officer: Responsible Officer – Prince Charles Hospital Programme Target Implementation Date: April 2025
Theme: Planning, Delivery & Deadline Management		Control Operation	

2 Cashflow – Defined Cost As of November 2024, Section 4 was live, and Section 5 was planned to start in December 2024. The current cashflow forecast for Section 4 (start: January 2024; target completion: January 2026), summarised in the Level 2 report, was as follows: • Target Allowance: £1,392,869.06 (6%) – Based on agreed Target Cost items yet to be procured. • Forecast Defined Cost: £5,632,869.84 (26%) – Based on supply chain orders placed. • Anticipated Spend: £14,730,160.69 (68%) – Includes costs not yet identified as defined, such as anticipated steelwork and staff costs. Given Section 4 was mid-programme, the defined cost percentage appears low. Additionally, there was no percentage breakdown of defined costs for Section 5. The above would benefit from enhanced monitoring and reporting to the Project Board in the short term; to ensure these percentage are appropriate to provide more effective financial management. Consideration should be given to formally escalating this issue to ensure alignment with financial targets and tighter control over project expenditures.	Undefined costs create uncertainty and could lead to unplanned expenditures as the project progresses. Limited oversight of percentage breakdowns for defined costs may hinder proactive financial management and decision-making.	Responsible Officer to include an analysis of overall cost status in Project Board paper, to identify the level of Defined Cost in the remaining Sections. Expected Evidence of Implementation: Project Board reporting to include breakdown of sectional defined cost percentages.
Theme: Finance Management & Control	High Priority Control Operation	Officer: Responsible Officer – Prince Charles Hospital Programme Target Implementation Date: March 2025

Overview / Summary of Observations

Controlling contractors on a construction site is critical for ensuring safety, quality, and compliance with regulations. The SCP has approved subcontractors working on site that have been through a pre-qualification and selection process including:

- **Assessment of Competence:** Verify contractors' qualifications, certifications, and previous experience.
- **References:** Check past projects and feedback from previous clients.
- **Health & Safety Record:** Review the contractor's safety performance, accident history, and procedures.

The above had been undertaken by the SCP and forms part of the national framework requirements for the supply chain.

The contractor confirmed that they have implemented the Site Operating Procedure (SOP) issued by the Construction Leadership Council (CLC). Contractors/ SCP staff clock in and out of site via facial recognition software that was available at multiple locations.

There was also specific Permit to Work Systems operating such as Activity-Specific Permits: For high-risk activities like hot works, confined space entry, or electrical work.

The SCP also undertakes monitoring and supervision with specific Health and Safety officers for the site. Their work includes regular site inspections to ensure compliance with safety and quality standards.

Overview / Summary of Observations

A robust risk register is a critical tool in project management, particularly in complex and invasive construction works. The risk register is intended to operate as a live document that is regularly updated, allowing for continuous monitoring and control of risks throughout the project lifecycle. The project risk register was last reviewed and updated in November 2024. This review included a revaluation of costs associated with risks in accordance with good practice. At the time of reporting, the high risks constituted £1,417,596 with £1,441,668 remaining in the contingency.

Following the review:

- Number of risks that have a lower risk score – 22
- Number of risks that have an increased risk score – 1
- Number of risks that have been removed – 3
- Number of risks added – 0
- Number of risks remaining – 94

The SCP provided a monthly contractor’s report that were included in the progress report to the Project Board. The report included items such as:

- Overall Programme Summary
- Section Specific Programme Summary
- Health and Safety Update
- Commercial Update
- Upcoming Works

Although regular reports were being received by the Project Board, areas were highlighted where the quality of the information being supplied could be improved.

Key Findings		Risk & Impact	Agreed Management Action
3	Supply Chain Partner Reporting The SCP monthly contractor report formed a part of the progress update submitted regularly to the Project Board. While it effectively documented the work packages that had been awarded, it did not include details on outstanding work packages and their associated sections. This lack of visibility could hinder proactive planning and co-ordination. By including a more detailed breakdown of the remaining work packages, along with anticipated timelines for their award, the report could provide a clearer roadmap for upcoming activities. Additionally, a more informed view of	The absence of clear timelines for awarding work packages can hinder accurate cost forecasting and budgeting. A lack of foresight may force reactive scheduling, increasing the risk of errors or conflicts	Responsible Officer to include an analysis of works packages that remain to be Defined Cost for remaining Sections.
			Expected Evidence of Implementation: Updated Project Board report to include monitoring of remaining work packages yet to be let.

	pending work packages would aid in optimising programme scheduling and strengthening financial oversight and forecasting.	between work streams.	
		Medium Priority	Officer: Responsible Officer – Prince Charles Hospital Programme
	Theme: Reporting	Control Operation	Target Implementation Date: April 2025

Overview / Summary of Observations

The SCP had been regularly sharing a monthly programme with the Health Board’s advisers for review, as required by the contract. However, a specific issue arose when the SCP submitted programmes that did not reflect the project manager’s assessment of a specific compensation event – with the SCP disputing the Project Manager’s assessment.

The change management process applied at construction projects is crucial for maintaining control, minimising disruptions, managing risks, and ensuring that changes are well-documented and properly communicated. The change management process contributes to the overall success of the project by allowing it to adapt to evolving conditions, while maintaining a structured and controlled environment. Clause 62 of the NEC (New Engineering Contract) Option C highlights that the SCP must submit a quotation within three weeks of being instructed to do so by the Project Manager. This is the default timescale unless an alternative period is agreed upon by both parties. Issues had been identified in the timeliness of response to requests for quotations during June – November 2024.

Requests for Information (RFI) are recorded within the SCP contractor’s report The SCP commented that they had a positive relationship with estates. The SCP have also not claimed for any delays through the compensation event process for information or action not being taken by the Health Board.

Key Findings		Risk & Impact	Agreed Management Action
4	Programme Management	The absence of a clear programme prevents effective budget management, and delays often lead to increased costs.	The SCP’s grievance with the PM Assessment has led to a dispute being instigated through the Dispute Resolution Procedure. Following completion of this process the programme will be updated with Contract Completion Date.
	As of the November 2024 project progress report, contract completion remains as 20 th of July 2026. It should be noted that a change to the completion date for a 6-week delay had been instructed as part of the project manager’s assessment for expanding the ITU (issued on the 12 th of April 2024). This assessment was being challenged by the SCP; however, the time taken to enact this challenge had been circa 7 months since the initial assessment by the Project Manager.		Expected Evidence of Implementation: Following the conclusion of the dispute resolution procedure, the contract completion dates will be updated.
	The Health Board's advisers have not accepted the SCP's subsequently submitted programs (Revisions 43, 44, and 45) because the contract completion date remained unchanged and had not been updated; despite repeated attempts from the Health Board to escalate the issue. Not having an agreed programme could undermine the coordination, accountability, and the ability to deliver the project on time, within budget. Noting that there are clauses within the contract for the SCP to challenge the Project Manager’s assessment, a compliant programme should be tabled whilst those clauses are pursued.		
		High Priority	

	Theme: Planning, Delivery & Deadline Management	Control Operation	Officer: Responsible Officer – Prince Charles Hospital Programme Target Implementation Date: June 2025
5	Change Management An examination was undertaken of 39 approved changes from June – November 2024 across sections 3 and 4 of the works. Delays were identified in 19 changes from when the Project Manager initiated a request for the SCP to provide a quotation for the relevant change (three-week target). The duration of these delays varied, ranging from 1 day to 67 days over the three-week timescale. Although Clause 62.5 allows the Project Manager to extend the submission deadline with mutual agreement before the due date, documenting such extensions proved challenging due to the intricate nature of most changes. In the event of the SCP not being able to submit their quotation in the requisite timeframe, an extension to the date for submitting should be requested.	Delayed responses to change requests (can lead to disruptions in planned work activities, causing delays in the overall project schedule)	Responsible Officer will write to the SCP requiring observance of contract procedure in this regard. Expected Evidence of Implementation: Email correspondence with the Supply Chain Partner.
	Theme: Performance Monitoring	Control Operation	Medium Priority Officer: N/A - Actioned since audit fieldwork Target Implementation Date: N/A

Overview / Summary of Observations

Due to the nature of the project, the contract was split into 6 sections of construction (with the target cost split by section). Regular reporting (monthly) was observed to the Project Board, in respect of the handover of areas/sections. Fourteen areas had been handed over between April – October 2024 with documentation provided for a sample of areas such as building control sign off to give assurance that areas were satisfactory.

Managing defects in a construction project is crucial, as defects can compromise the project's quality, safety, and long-term performance, leading to financial, operational, and reputational consequences. The appointed Supervisor utilised the SnagR (defects system) to raise and close off defects, observations etc. Monthly reports were provided to the Project Manager on the performance relating to the management of these defects, including items that were outstanding beyond set timeframes. It was highlighted that performance had been improving with the reduction of defects outside of stated time parameters. However, no documented plan was noted to ensure timely rectification of defects outside the time parameters and if these defects were significant or minor.

Key Findings		Risk & Impact	Agreed Management Action
6	Defects Management According to the September 2024 Supervisor’s report, 148 defects were overdue for rectification, which improved to 61 by the November 2024 report, demonstrating progress. However, it was unclear whether any overdue defects, including potential health and safety issues, were serious or minor. Additionally, within areas handed over to the Health Board, defects and observations reduced from 152 in September 2024 to 39 in November 2024, reflecting further improvement. Despite this progress, no documented plan was identified to ensure timely rectification or assess defect significance.	Delayed rectification of defects, particularly health and safety-related ones, can pose significant risks to workers, users, and the public.	The Supervisor report to identify those outstanding defects that have over-run that are of significant concern.
		Medium Priority	Expected Evidence of Implementation: Updated supervisory report
	Theme: Performance Monitoring	Control Operation	Officer: Responsible Officer – Prince Charles Hospital Programme Target Implementation Date: March 2025

Overview / Summary of Observations

Key Performance indicators (KPIs) were produced every 6 months to assess the SCP, Cost Adviser, Project Manager and principal designer's performance. These KPIs are a key requirement of the NHS Building for Wales Framework.

A summary dashboard of the performance of the project from the commencement of stage 4 in November 2020 was produced and included within the monthly progress reports. Subsequent reports will include sections with a swing in performance from the previous month highlighted in the performing colour.

Items that have negatively affected the project as of November 2024 included:

- Impact of adjustment to the VAT reclaim, and inflation with a potential impact on the budget
- Suspension of Principal Designer due to fees issues. Whilst this was resolved, it had impacted on design progress and programme.
- There is also one Compensation that was in dispute, which has a potential risk of impacting the project.

This report highlights several performance issues, as detailed in Key Findings 4, 5, and 6. To avoid duplication, these issues are not reiterated here. However, it is important to note that their impact has influenced the overall opinion provided for this section. The interconnected nature of these findings has contributed to a broader effect on performance, underscoring their significance in shaping the conclusions drawn in this report.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence presents of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Medical Job Planning

Final Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



Limited Assurance

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Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-2425-17

September to November 2024

January 2025

February 2025

Dom Hurford, Medical Director

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



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Executive Summary

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the system and controls in place for medical job planning within Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation').

Overview

Job planning became a key aspect of consultants' roles with the agreement of the 2003 amendment to the National Consultant Contract in Wales. Job plans are mandatory and align the objectives of the NHS, the organisation and clinical teams, with agreed outcomes to allow consultants, clinical academics, managers and the wider NHS team to plan and deliver innovative, safe, responsive, efficient and high-quality care. A job plan is a professional and contractual obligation for consultants and employers, and sets out the duties, responsibilities, accountabilities and outcomes of the consultant, and the support and resources provided by the employer for the coming year. The Health Board uses the Allocate system to capture job plans, where a record of the work that a consultant will undertake for the Health Board is split by Direct Clinical Care (DCC) and Supporting Professional Activities (SPA).

We have concluded limited assurance on this area. The key findings requiring management attention are:

- The majority of job plans that we reviewed did not contain any personal or service outcomes.
- Agreed job plans were not being reviewed annually. At the time of our fieldwork only 30% of consultants and SAS doctors had agreed and fully signed off job plans that were dated within the last 12 months.
- The presumed sign-off procedure is not regularly used.

Full details of the key matters are detailed within the Findings & Agreed Action Plan below. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The 'e-Job Planning User Guide', issued in September 2022, may benefit from a review by management.
- As job plans are reviewed and renewed, efforts should be made to adhere to the 8:2 DCC:SPA split set out in recent guidance.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	There are relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	-	Substantial
2	Job plans accurately reflect both the individual and organisation activity requirements and have links to the Health Board's objectives.	1	Limited
3	Job plans are completed in a timely manner to allow departments to manage and their demand and forward plan.	2, 3	Limited
4	Completed job plans reconcile to system records and session payments are correct.	-	Substantial
5	The completion rates of job plans are monitored and regularly reported to an appropriate forum, with further escalation if there is low compliance.	-	Substantial

Management Actions

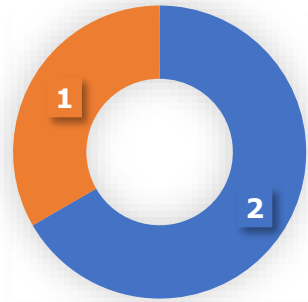


High Priority



Medium Priority

Themes



■ Information, Data
Quality & Data
Accuracy

■ Performance
Monitoring

Risk Types

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: There are relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	Substantial
There is detailed job planning guidance in place that is readily available to all Health Board staff. The all-Wales NHS job planning guidance is available to staff through the Health Board’s intranet. The guidance was published by the Welsh Government (WG) in 2014 and is the most recent guidance available. The intranet site has a variety of Health Board job planning guidance documents. The most recent job planning guidance was issued in July 2024 and has links to the WG all-Wales guidance, core SPA guidance for Health Board consultants and departmental managers, and an e-job planning user guide. The core SPA guidance for Health Board consultants and departmental managers was also issued in July 2024 and sets out the Health Board’s position in relation to the split between DCC and SPA sessions. The e-job planning user guide, was created by the workforce team in 2022, and is a detailed reference guide to the administrative aspects of job planning and the use of the Allocate e-job planning system. This job planning guide does not specify a timescale for the completion of a job plan for new starters and does not have an identifiable review date. Given the more recent updates to other job planning guidance documents, management should review this guide to ensure that it is up to date.	

Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and have links to the Health Board’s objectives.

Limited

The Health Board's job planning guidance requires consultants and SAS doctors to record personal outcomes, service outcomes, and Health Board outcomes for the year ahead. In particular, the guidance states that 'Agreed outcomes for SPA activity will be recorded in the 'Personal Outcomes' tab on e-job planning'.

Our testing on a sample of signed off job plans confirmed that while all had the standard Health Board outcomes, not all contained information on personal outcomes, and none had information on service outcomes.

The job plans that we reviewed had timetabled activity covering job planned sessions, although a small number of the plans lacked activity detail for both DCC and SPA sessions. The guidance issued in July 2024 allows for a 8:2 split between DCC and SPA, meaning eight DCC sessions and two SPA sessions in a ten session week. Some of the job plans that we sampled had higher levels of SPA than set out in the current guidance. As the majority of the job plans sampled pre-dated the current guidance, we have not made a recommendation in relation to this at this time.

Key Findings		Risk & Impact	Agreed Management Action
1	Lack of personal & service outcomes The e-job planning system enables personal outcomes to be linked to service outcomes. We tested a sample of 32 fully signed off job plans: 17/32 job plans had no personal outcomes relating to SPA activity recorded. 0/32 job plans had service outcomes recorded. We also noted that 4/32 job plans contained little or no detail in relation to the SPA activity to be undertaken.	SPA time is not used in a way that achieves Health Board and Service outcomes. Personal outcomes cannot be monitored and do not contribute to wider Health Board / Service outcomes.	Agreed Action: To ensure all job plans record personal and service outcomes that are linked.
			Expected Evidence of Implementation: Personal and service outcomes are recorded and linked on job plans.
		High Priority	Responsible Officer: AMD for Workforce Target Implementation Date: Sept 2025
Theme: Performance Monitoring		Control Operation	

The Health Board's job planning guidance makes it clear that job planning is an annual process, and that the completion of a job plan is a contractual responsibility for consultants and SAS doctors. However, neither the national guidance, or the Health Board guidance, sets out the timescale for completion of an initial job plan for newly appointed staff.

Our analysis of the 680 job plans on the e-Allocate system identified that while some job plans have been reviewed annually, most are not.

The Health Board guidance requires job plans to be signed off once mutually agreed 'as soon as possible'. The guidance includes information on the 'presumed sign off process'. Where consultants have verbally agreed their job plan, but not signed it off in the Allocate system, a series of emails are sent to them over a 10-week period. If at the end of 10 weeks the consultant has still not signed off their job plan, the Health Board will consider it signed off. Our testing has identified numerous plans where the presumed sign off process has not been applied. We have also identified a number of consultants / SAS doctors who do not appear to have ever logged into the Allocate system.

Key Findings		Risk & Impact	Agreed Management Action
2	Creation and annual review of job plans The national and Health Board job planning guidance requires the annual job planning review to be undertaken 'in good time' but does not specify a timescale by which a job plan must be completed for new starters. To meet WG targets, the Health Board has aimed to complete 60% of job plans by August 2024, and 85% by December 2024. Our analysis of the data, based on 'job plan start date' recorded in Allocate, has shown that of the 680 consultants and SAS doctors: • 204 (30%) had a signed off job plan that started within the last year, so the targets have not been achieved. • 171 (25%) had a signed off, but out of date job plan, some of which date back to 2019. • 21% were at discussion, appeal, sign off or lockdown stage. • 24% have never had a signed off plan. Our analysis of the 171 job plans that were out of date identified 10 that were last agreed before 2021, 22 signed off in 2021, and 75 in 2022.	Lack of up-to-date job plans means the Health Board cannot properly identify the capacity it has.	Agreed Action: • To agree and update guidance with a timescale for completing job plans for new starters. • To reduce the presumed sign off timescales from 10 weeks to support an improvement in job planning compliance. • Arrange job plan review meeting with consultant / SAS doctor to review and facilitate sign-off of rolled forward job plan. • Monitor at MWPP:PEG
		High Priority	Expected Evidence of Implementation: Improved compliance rates for fully signed off and in date job plans.
	Theme: Information, Data Quality & Data Accuracy		Responsible Officer: Asst Director for SWP Target Implementation Date: • To agree and update guidance with a timescale for completing job plans for new starters. Jun 2025 • To reduce the presumed sign off timescales from 10 weeks to support an improvement in job planning compliance. May 2025 • To review job plans that have sat in discussion since 2019 or before for appropriate action. Sept 2025 • Monitor job planning changes in activity and compliance at MWPP:PEG May 2025

3	Presumed sign-off procedure We reviewed the number of job plans that are classed as 'in-discussion' to determine if the presumed sign off process is applied. At the time of our fieldwork 83/187 'in discussion' job plans had been in discussion since 2023, with the oldest in discussion since 2016. We also identified 64 users (consultants / SAS doctors) that had never accessed the Allocate system.	Resources are not used effectively and efficiently to ensure the delivery of high-quality patient care.	Agreed Action: To reinforce Care Group scrutiny of the job planning data set issued monthly, specifically around those who have not had a job plan or those out of date. Monitor at MWPP:PEG
			Expected Evidence of Implementation: Improved job planning compliance rates.
		High Priority	Responsible Officer: Executive Medical Director Target Implementation Date: December 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 4: Completed job plans reconcile to system records and session payments are correct.**Substantial**

When a job plan is signed off in the Allocate system by the consultant / SAS doctor and their managers, the system sends an automated e-mail notification to a senior HR manager within the medical workforce team. Where there is a change to the number of sessions, the manager notifies the medical recruitment team who adjust the sessions payable and the effective date of the change. The consultant / SAS doctor is copied into the notification.

Our testing to ensure that the sessions recorded on the job plan reconciled to the number of sessions in ESR / payroll initially identified a number of discrepancies. However, these have since been reviewed by management who have confirmed that some differences related to rounding up or down of session times and the timing of information being submitted to payroll. Checks have now been made between the job planning and payroll data and management are confident there are no discrepancies where signed off job plans are in place.

Objective 5: The completion rates of job plans are monitored and regularly reported to an appropriate forum, with further escalation if there is low compliance.**Substantial**

Data in relation to job planning completion rates is regularly reported to the Board. Updates are also reported to the Audit and Risk Committee in relation to the completion rate and the actions being taken to address the low level of completion.

We note that completion rates are also reported to the Medical Workforce Productivity Programme, Performance and Escalation Group (PEG). The PEG meet monthly, and each meeting has a deep dive into two care groups. Job planning compliance rate data is reported as part of these deep dives.

Whilst we acknowledge that completion rates are below the targets set internally by the Health Board and also by WG there is regular monitoring at various forums throughout the Health Board.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Follow-up: Arrangements for managing Service Level Agreements

Final Internal Audit Report

January 2025

Cwm Taf Morgannwg University Health Board



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University Health Board



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Review reference:	CTM-2425-33
Report status:	Final
Fieldwork commencement:	15 October 2024
Fieldwork completion:	4 December 2024
Draft report issued:	20 December 2024
Management response received:	17 & 28 January 2025
Final report issued:	29 January 2025
Auditors:	Emma Samways, Deputy Head of Internal Audit Geoffrey Woolley, Principal Internal Auditor
Executive sign-off:	Linda Prosser, Executive Director of Strategy & Transformation
Distribution:	Elizabeth Beadle, Assistant Director of Transformation
Committee:	Audit and Risk Committee



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

Acknowledgement

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

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Executive Summary

Purpose

The overall objective of the audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the 'Arrangements for Managing Service Level Agreements' review that was reported as part of our 2022/23 work programme.

Overview of findings

Our previous report had five matters arising of which three were 'High' priority and two were 'Medium' priority. Of these, three are now closed and two remain open with a 'Medium' priority rating.

Management have undertaken work to:

- Develop guidance and templates.
- Put in place routine meetings with care groups which provide a structure to discuss and monitor commissioning agreements.
- Update the central register of agreements.

However:

- The register of agreements needs additional work to fully reflect all known agreements.
- Our fieldwork identified that some information is not recorded on the register of agreements, or is not always accurately recorded.
- Full template agreements have not been issued for all agreements.

Follow-up Report Classification

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

Progress Summary¹

Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1 SLA guidance is in place	High		Closed
2 A system to accurately capture SLA agreements	High		Medium
3 Timeliness of SLA sign-off	Medium		Medium
4 Timely review of SLAs	Medium		Closed
5 Provision of information to undertake monitoring	High		Closed

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

1. Introduction

- 1.1 The follow-up review of ‘Arrangements for managing Service Level Agreements’ was completed in line with the 2024/25 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the ‘Health Board’). The opinion provided through this review will inform the Head of Internal Audit’s Annual Opinion.
- 1.2 Our original ‘limited’ assurance audit report was finalised in June 2023 and made three high and two medium priority recommendations. Since issuing our report, regular updates on the progress to implement the agreed actions have been provided to the Audit & Risk Committee via the audit tracker.
- 1.3 The Lead Executive Director for this review is the Executive Director of Strategy & Transformation.
- 1.4 The associated risks considered in our original review were as follows:
 - Patient harm and reputational damage if services provided on behalf of Health Board are not of a suitable quality.
 - Inability to effectively monitor performance and take corrective action if performance data is not provided or inaccurate.
 - Financial pressures arise if service delivery and associated costs are not monitored.
 - Opportunities for improvement are either not identified or implemented.

2. Findings

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

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

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

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

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

- Developing guidance which covers new agreements, cessation of agreements, and reviewing and managing queries on existing agreements.
- Developing service specification and agreement templates.
- Putting in place routine meetings every other month between the commissioning team and the Health Board's six care groups. This provides a structure to discuss and monitor commissioning agreements and update the central register of agreements. Although we note that not all planned meetings had taken place.
- A 'Teams' channels has been set up for each care group which includes documentation such as meeting agendas, its issues / action log and copies of agreements.
- The register of agreements has largely been updated following input from the care groups.
- Our testing of a sample of agreements confirmed that they had been reviewed in good time and that there was satisfactory information to undertake performance monitoring.

2.4 The actions listed above have either resulted in the recommendations being categorised as implemented or partially implemented. Two of the three recommendations originally categorised as High priority are now closed, with the other reassessed to a Medium priority.

Appendix A: Management Action Plan

Previous Matter Arising 2: A system to accurately capture SLA agreements (Operation)		
Original Recommendation	Original Priority	
- Data in the register of agreements should be checked to confirm its accuracy and completeness. - Once the current completeness and accuracy of the register of agreements has been confirmed, procedures will need to be put in place to ensure that changes are promptly notified so that it remains accurate and up to date. - The register of agreements should be checked before setting up an SLA agreement with a provider to ensure that multiple SLAs are not set up with the same provider for the same service and that no issues have been identified which would suggest that setting up the SLA agreement should not proceed. - The columns for end date and review date in the register of agreements should be regularly used to identify when periodic reviews are due and whether they have been completed on schedule.	High	
Management Response	Target Date	Responsible Officer
The register of agreements will be reviewed by a process of sharing with all corporate and service (Care Groups) teams for review and supported by a structure of meetings between the Strategy and Transformation Team (Commissioning leads) and the Care Groups to manage and monitor SLAs. All third sector SLAs have been reviewed and the register will be updated to reflect the latest status.	31 August 2023	Assistant Director of Transformation supported by the Commissioning Manager and Planning Assistant
Current findings	Residual Risk	
Bi-monthly meetings have been put in place with the Health Board's six care groups which provide a structure to discuss and monitor commissioning agreements and update the central register of agreements. To support these meetings, 'Teams' channels have been set up for each care group, which are accessible by relevant staff and include documentation such as, meeting agendas, issues arising, action logs and copies of agreements.	Financial loss and reputational damage if the system in place for SLA agreements does not fully allow centralised capture,	

However, 4/7 of the last Unscheduled Care Group meetings and 3/7 of the Primary & Community Care Group meetings have been cancelled. We understand this is often due to operational pressures and we understand that any urgent issues that need addressing would be actioned by alternative means such as email or 1:1 discussion with key staff.

While the register of agreements has been updated following input from the care groups, we understand that work remains ongoing to further update the register. From our review of agreements where the data on the register has been updated, we identified that:

- Some fields were rarely completed. These fields included the 'frequency of monitoring', who the SLA has been 'signed by', and the 'review date'.
- 'End date' information was missing or has passed for a number of agreements. We note that these largely relate to SLAs with other health boards and would be updated as part of the annual commissioning cycle.
- In a small number of agreements, key information such as the Health Board lead was not captured.

monitoring and oversight on a regular and timely basis.

Conclusion: We consider this matter arising to be partially implemented.

New Recommendations		Priority	
2.1	The commissioning team should reiterate to care group management the importance of attending the routine meetings in order to have proactive governance arrangements in relation to managing their SLAs.	Medium	
2.2	Management should complete the ongoing work to ensure agreements not yet updated on the register are reviewed, and the register updated accordingly.		
2.3	Key fields, such as the 'CTM lead' and 'end date for the SLA' should be recorded on the register. Fields that are not currently populated in the register, such as 'monitoring frequency', should be either completed for all agreements or removed if not considered beneficial.		
Management Response		Target Date	Responsible Officer
2.1	A schedule of dates has been set up for commissioning meetings with care groups during 2025.	January 2025	Assistant Director of Transformation & Head of Commissioning

	To reiterate the importance of the meetings, written communication will be provided to care group directors seeking care groups to review the proposed schedule and confirm in advance if dates are not suitable. This action has been completed.		
2.2	The commissioning team will undertake a review of the RoA as part of the process to close the 2024-2025 copy of the RoA and will set up a 2025-2026 copy. Corporate and care group teams will be asked to review the agreements that they hold as part of this process.	April 2025	Assistant Director of Transformation & Head of Commissioning
2.3	The review of the key fields identified (SLA lead and SLA end date) will be updated as part of the review set out in action 2.2	April 2025	Assistant Director of Transformation & Head of Commissioning

Previous Matter Arising 3: Timeliness of SLA sign-off (Operation)		
Original Recommendation		Original Priority
When SLAs are agreed the documentation should be completed to include the details of the lead contact for the Health Board. SLAs should be signed on behalf of the Health Board as the commissioning body and by the provider before the start of the period to which it applies to confirm agreement with its terms and conditions.		Medium
Management Response	Target Date	Responsible Officer
The guidance to be developed will include clarity on processes for signing and storing of agreements.	September 2023	Assistant Director of Transformation and project team
Current findings		Residual Risk
We tested a sample of five agreements from the register of agreements. We found: • We saw evidence that those responsible for managing the SLA on behalf of the Health Board was recorded, with one managed by the Commissioning Team and the remaining four managed by the relevant care group. • One SLA followed the full template agreement, and four used funding continuation documentation instead. In three cases, documentation was not signed by either the Health Board or service provider. • In three cases, the register of agreements did not accurately reflect contract information such as the start date, end date and funding amount. Conclusion: We consider this matter arising to be partially implemented.		The Commissioner and provider's responsibilities may be unclear.
New Recommendations		Priority
3.1	For new agreements and where existing agreements are renewed, the updated full template agreements should be used.	Medium
3.2	Agreement documentation should be signed by both the Health Board and service partner.	

3.3	The register of agreements should accurately reflect contract information such as start date, end date and funding amount.	
Management Response		Target Date
3.1	New agreements are developed on the updated SLA template. The SLA template will be re-issued to all care groups and corporate teams to ensure that renewals are able to be transferred to the new agreement document.	February 2025
3.2	Alongside action 3.1 the guidance for agreeing SLAs will be recirculated with a reminder that all documents must be signed by both partners.	February 2025
3.3	Please refer to action 2.3.	April 2025

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Regional Integration Fund

Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



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Review Reference

CTM-2425-23

Fieldwork

October – December 2024

Executive Sign Off

15 January 2025

Audit Committee

February 2025

Executive Lead

Linda Prosser. Executive Director of Strategy & Transformation

Audit Team

Paul Dalton, Head of Internal Audit
Emma Samways, Deputy Head of Internal Audit

Executive Summary

Purpose

To review the arrangements that the Health Board has in place to engage with the projects and initiatives supported by the Regional Integration Fund (RIF), and to ensure they are being used effectively to deliver sustainable services that achieve better outcomes for service users.

Overview

The RIF brings together several existing funding streams to provide a renewed focus on community-based care, emotional health and well-being, supporting families to stay together safely, care experienced children, home from hospital services, and accommodation-based solutions (six national models of integrated care). Regional Partnership Boards (RPBs) can determine which projects and services align to these models of care, but in doing so need to ensure they meet the needs of relevant population groups; and are innovative, integrated, and transformative.

Alongside representatives from social services, housing and the third sector, the Health Board is a member of the Cwm Taf Morgannwg Regional Partnership Board (CTMRPB). Of the £144.7m nationally available through RIF, CTMRPB have an allocation of £22.3m. The Welsh Government has issued guidance to support the introduction of the RIF: the Health and Social Care Regional Integration Fund (Revenue Guidance 2022–27). This requires RPBs to establish a memorandum of understanding to include the agreed governance, accountability and decision-making processes, and appropriate arrangements to enable scrutiny of investment decisions. It also sets out RIF funding allocations and ‘architecture’, such as areas which require match funding or scheme length.

We have concluded reasonable assurance on this area. The matters requiring management are:

- The Memorandum of Understanding is still to be signed, but we acknowledge that the Health Board is awaiting confirmation of all-Wales wording for this document.
- RIF funding is currently heavily weighted towards adult services and there is a marked difference in Health Board representation at the Adult and Children’s programme boards.
- While there is regular formal reporting of RIF activity back to the Health Board, it is not in a consistent format.

Full details of the key matters arising are detailed within the Findings & Agreed Action Plan below. The following opportunity for enhancement has been identified. This did not impact the overall opinion and is highlighted for management information:

- Funding letters issued to recipients of RIF monies were not signed by the Head of the Regional Commissioning Unit, and one letter was still awaiting signature by the recipient organisation.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	The Health Board’s responsibilities are clear within the wider partnership arrangements to support oversight of RIF schemes.	1	Reasonable
2	There is collaboration to ensure RIF projects are developed to reflect the national funding guidance, local RPB priorities, and include clear identifiable goals or outcomes.	2	Reasonable
3	The Health Board receives sufficient information on scheme funding, delivery, and outcomes, to meet its responsibilities which are reported appropriately within the organisation.	3	Reasonable

Management Actions

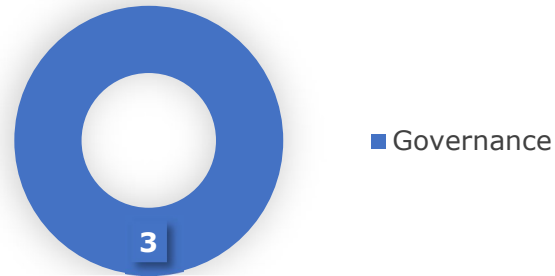


High Priority



Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: The Health Board’s responsibilities are clear within the wider partnership arrangements to support oversight of RIF schemes.

Reasonable

Overview / Summary of Observations

The Health Board is a statutory partner within the Regional Partnership Board (RPB) and is required by the Social Services & Well-being (Wales) Act 2014, alongside Bridgend, Merthyr Tydfil, and Rhondda Cynon Taff local authorities (partner organisations), to assess the needs of the population, identify the services to address those needs, and use resources effectively.

The Integrated Leadership Board (ILB) reports into the RPB and in turn, is supported by separate programme boards for adult and children’s services. The Health Board is well represented across these four boards with two chaired by members of the Health Board (ILB and Adult Services Programme Board), the vice-chair of the RPB is the Chair of the Health Board, and whilst the Children’s Services Programme Board is chaired by the Director of Social Services for Merthyr Tydfil County Borough Council, she is also an Associate Member of the Health Board.

A draft memorandum of understanding is in place between the Health Board and its partners, setting out the responsibilities of all parties in relation to the RPB and oversight of RIF schemes.

Key Findings		Risk & Impact	Agreed Management Action
1	MoU is in draft format RIF guidance states a MoU is required to set out the governance, accountability and decision-making processes, which should include ‘ <i>appropriate arrangements to enable scrutiny of investment decisions by relevant sovereign bodies</i> ’. Prior to a MoU being agreed, some concerns were raised nationally as to what the respective parties were being asked to sign up to following changes to the rules regarding tapering of funding. Consequently, one RPB took the lead in trying to produce, with legal support, a template MoU that could be used across Wales. The results of this work are still awaited, hence the CTMRPB MoU is still in draft.	The lack of a signed Memorandum of Understanding potentially weakens the commitment to joint governance, accountability, and decision-making processes.	<i>As soon as the MoU format is confirmed, the MoU will be negotiated, agreed and signed by all statutory partners.</i>
		Medium Priority	Expected Evidence of Implementation: Finalised and signed version of the MoU.
	Theme: Governance	Control Operation	Officer: Linda Prosser Target Implementation Date: March 2026

Overview / Summary of Observations

Although RIF funding came into effect in 2022 and covers a five-year period until March 2027, a number of projects were already in existence, funded by former funding streams such as the Integrated Care Fund. Prior to March 2022, all existing projects were evaluated against their original objectives to ensure that they remained in line with RPB priorities, and that the funding had achieved the desired health and social care outcomes and equally to ensure that key lessons could be learned and shared to inform future projects and activity. A 'Project Evaluation Questionnaire and Exit Strategy' was developed to be used for this purpose. The results were reviewed at either the Adult or Children's Services Programme Boards with the recommendations presented to the RPB for approval. This led to a large number of projects being decommissioned.

We tested a sample of 13 RIF projects. Ten related to projects and had been subject to review as part of the move to the RIF scheme, with the remaining three being new projects. In all cases we could confirm the project aligned to the RPBs priorities and for the new projects, we could evidence the approval process. A funding award letter had been issued for all projects that we sampled. The letter sets out the financial and performance reporting expectations and should be signed by the Project Lead and returned. Our testing of award letters and recording of financial allocations did not identify any issues, although the funding letters had not been signed on behalf of the RPB. We also saw one instance where a letter was awaiting the signature of the funding recipient.

As part of our review, we met a number of members of the various boards, covering both the Health Board and external members. The consensus view was that good progress had been made in implementing RIF projects. We established that, despite the pressures arising from the current financial climate, relationships across organisations were generally constructive and there was demonstrable evidence of effective integration on a number of initiatives. We are aware that concerns have been raised by various board members that some of the RIF allocation is being used to support core activity, rather than funding new innovation and ideas. For example, where projects should have moved to a 'business as usual' state but funding has prevented this. This is seen by the board members as an inevitable consequence of the current financial climate. It was also felt that not all projects funded by RIF were totally aligned to the strategic goals for the Health Board and its partners. We are aware of a current review being undertaken by the Director of Integration (seconded from Welsh Government) to review all funding decisions, albeit that this is focused on Adult Services for the time being.

Key Findings		Risk & Impact	Agreed Management Action
2	Variations in Adult's and Children's approaches Our fieldwork identified: - Adult Services currently receive the bulk of RIF funding due to these services being rolled over from the Integrated Care Fund, which we understand was focused on Adult Services. - The Adult Programme Board has more senior Health Board representation than the Children's Programme Board, where there is more of a clinical presence in the membership and attendance. - Reporting formats to each Board are different with the Adult Board using traffic light reports on progress, whilst the Children's Board sets out further actions. This again reflects the differences between the two boards where Adult	There is a risk that Children's services are being overlooked in the allocation of RIF funding, and the monitoring of progress with each scheme.	<i>Membership and attendance at the Children's Programme Board will be reviewed and adjusted as necessary.</i> <i>Reporting formats to the Children's Board will be reviewed as projects progress.</i> <i>Health Board representatives at the Children's Programme Board will raise RIF funding allocations at Board meetings with a focus on achieving a percentage shift in allocation between Adults and Children (in favour of children).</i>

Services tend to be longer established in terms of funded projects, whilst Children’s projects are less mature.		Expected Evidence of Implementation: Revised membership in Terms of Reference Revised reporting process if deemed appropriate Minutes from meetings – attendance and discussion topics (funding) are evidenced
	Medium Priority	Officer: Lucy Smothers
Theme: Governance	Control Operation	Target Implementation Date: March 2026

Objective 3: The Health Board receives sufficient information on scheme funding, delivery, and outcomes, to meet its responsibilities, which are reported appropriately within the organisation.

Reasonable

Overview / Summary of Observations

Ensuring that information relating to the RIF is reported back to the Health Board is achieved in a number of ways. The number and seniority of Health Board representatives in attendance at the RPB and its sub-committees provides assurance that information is being reported back at a senior level. The Population Health & Partnerships Committee of the Health Board regularly receive updates on RIF funding, but there is not a consistent format.

Both the Adult and Children’s Services Programme Boards receive detailed information on progress with RIF projects. The ILB receives a summary of discussions at the two boards and the RPB receives a summary of the ILB meeting. In addition, an annual end-of-year report is produced for RIF projects, and this is taken through the governance structure, culminating in the RPB reviewing the 2023/24 report at its August 2024 meeting. The annual RPB report also includes a specific section on RIF funded projects and was also taken to the meeting of the Improving Care Board (ICB) in September 2024.

The Population Health & Partnerships Committee, along with a number of other committees, is being replaced as part of a new governance structure approved by the Health Board in September 2024. The remit of these committees is to be transferred to an Operational Development Committee (ODC) and Strategic Development Committee (SDC). The SDC in particular has a remit which includes to ‘provide assurance to the Board that, wherever possible, CTMUHB plans are aligned with partnership plans developed with Regional Partners, Local Authorities, Universities, Collaboratives, Alliances and other key partners’. They will also be seeking assurance on the strategic development of a number of plans and programmes including the Population Health Strategic Delivery Plan and Partnership Engagement, particularly with the RPB and Public Services Boards (PSBs). We understand that this will cover RIF funding, which can be difficult to isolate from the wider work of the RPB.

Key Findings		Risk & Impact	Agreed Management Action
3	Reporting Whilst RIF updates were provided on a regular basis to the Population Health & Partnership Committee, the means of reporting was not always been consistent, as updates were often in relation to the wider RPB. This made it difficult to easily monitor the progress or performance of specific RIF projects. With the disbandment of the Population Health & Partnership Committee, and its replacement with the Strategic Development Committee, there is an opportunity to revisit what information is reported and in what format. It would also be helpful to include trend analysis as this would better demonstrate whether the outcomes of the funding allocations are helping to achieve the desired goals.	The Health Board may not be receiving timely and meaningful information on how effectively RIF funding is being used.	<i>Reporting on RIF will be included as part of the regular RPB report to the Strategic Development Committee</i>
			Expected Evidence of Implementation: RPB reports to SDC to include update on RIF SDC minutes
			Medium Priority
	Theme: Governance	Control Operation	Target Implementation Date: April 2025

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

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

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Vaccination Policy Implementation

Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



Limited Assurance

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Findings & Agreed Action Plan 4

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Review Reference	CTM-2425-22
Fieldwork	November 2024 – January 2025
Executive Sign Off	31 January 2025
Audit Committee	February 2025
Executive Lead	Philip Daniels, Executive Director of Public Health
Audit Team	Paul Dalton, Head of Internal Audit
	Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

The purpose of our audit was to review the vaccination strategy implementation process and plans for ensuring equity for vaccine uptake.

Overview

In October 2022 the National Immunisation Framework (NIF) for Wales was launched by the Minister for Health and Social Services for Wales. The framework was developed from identifying and using the lessons Welsh Government learnt when delivering the COVID vaccine. The framework sets out a requirement for health boards to develop vaccination equity strategies to clearly set out ways inequities are being actively reduced. In May 2024, the Minister reiterated Welsh Government’s commitment to ensuring equitable access to vaccinations for every citizen in Wales as a core priority.

Following the publication of the NIF, in November 2023 the Health Board published its Vaccination and Immunisation Strategic Plan 2023-26. The plan highlights the areas the Health Board needs to focus on within the three-year period, in order to achieve an equitable level of vaccination. The Health Board has also published a Vaccine Equity Strategic Plan that is an integral part of its overarching strategic plan.

We have concluded **Limited** assurance on this area. The matters requiring management attention are:

- Although there is demonstrable evidence of the action taken to improve vaccination equity and take-up rates, there is no overarching implementation plan in place to support either the Vaccination and Immunisation Strategic Plan or the Vaccine Equity Strategic Plan. We understand that a lack of resources impacted the production of an implementation plan. However, this has now been addressed and a plan should be completed in the near future.
- The current winter vaccination campaign has been challenging and current staff vaccination rates are very low. A plan to appoint a network of Vaccination Champions to increase staff vaccination rates received a very limited response from Health Board staff.
- Current reporting arrangements are through multiple boards, committees and groups which could lead to a duplication of effort and lack of clarity.

The full details of the matter arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	The Health Board has suitable operational plans in place to implement its Vaccination and Immunisation Strategic Plan.	1	Limited
2	Appropriate structures, resources and processes are in place to ensure accountability for effective delivery and implementation of the strategic plan.	1,2	Limited
3	There is ongoing work with partners to ensure effective communication with the population, including vulnerable people and underserved communities and internally with staffing groups. Support and information are provided for delivery and equity for the uptake of vaccines.	1	Reasonable
4	There is regular monitoring and reporting of progress against plans and targets at various levels within the Health Board, with actions taken to address areas of underperformance.	3	Reasonable

Management Actions

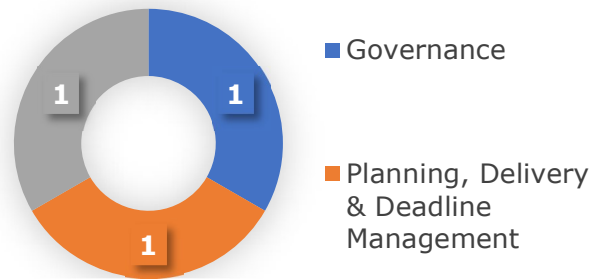


High Priority



Medium Priority

Themes

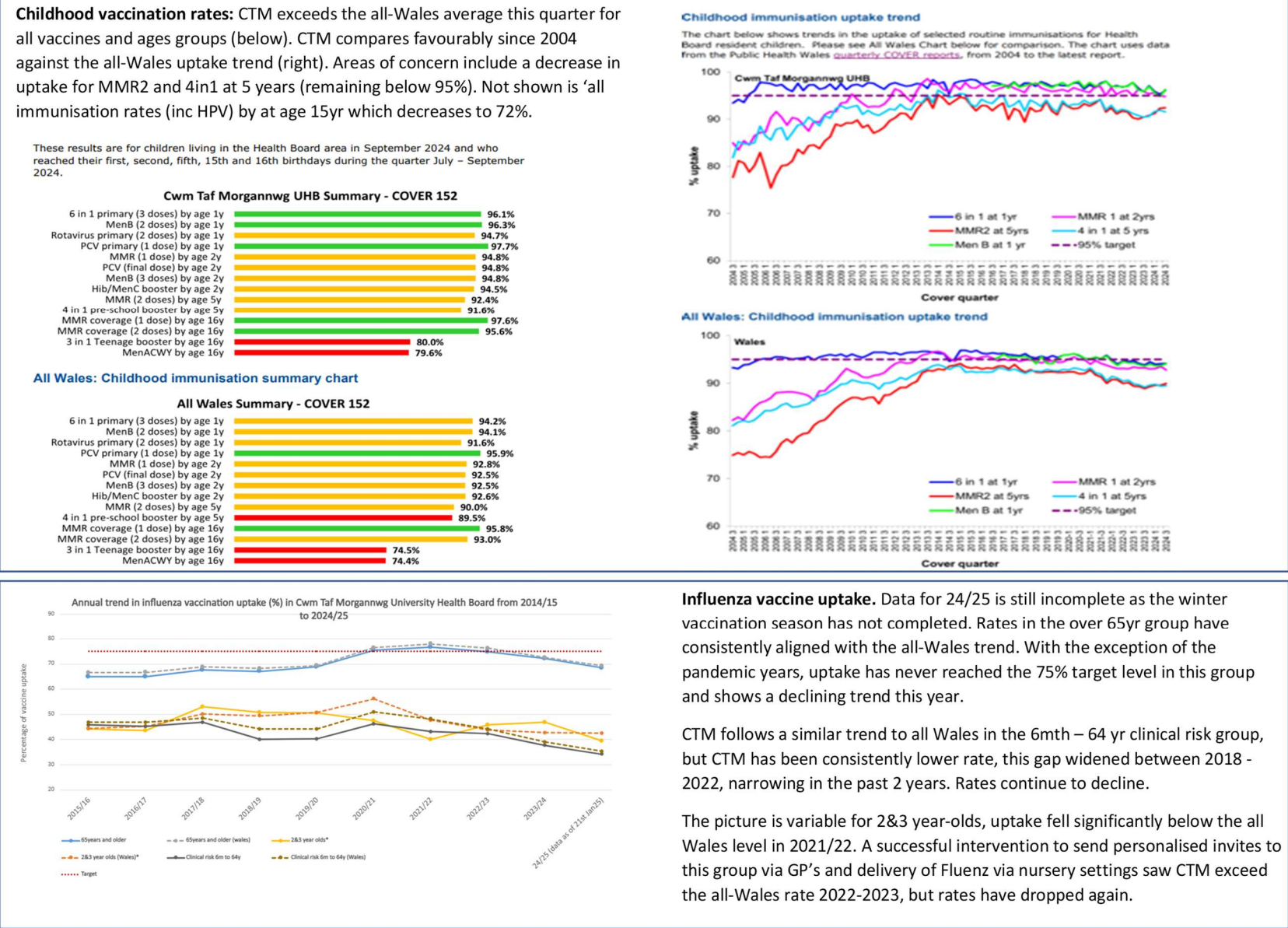


Risk Types

Public Perception & Reputational Risk

Vaccination Data

The tables below provide information on current vaccination performance.



Findings & Agreed Action Plan

Objective 1: The Health Board has suitable operational plans in place to implement its Vaccination and Immunisation Strategic Plan.

Limited

Overview / Summary of Observations

The Vaccination and Immunisation Strategic Plan 2023-26 and the supporting Vaccine Equity Strategic Plan were approved by the Health Board in November 2023. The Vaccination and Immunisation Strategic Plan sets out the requirement for a detailed three-year vaccination and immunisation implementation action plan, supported by operational plans at department/directorate level. Whilst both of the strategic plans set out specific intentions to be delivered, there is currently no over-arching implementation action plan or any department/directorate operational plans in place. We understand that the development of action plans has been delayed due to capacity issues. However, recent appointments should ensure that implementation action plans are produced within the next few months.

Management undertook an interim review of the Vaccine and Immunisation Strategic Plan in June 2024, and a full annual review is due imminently.

Despite the lack of an overarching implementation plan, there has been significant activity to try and improve vaccination rates, which remain challenging due to a number of factors. As part of the National Immunisation Framework, the Health Board is contributing to and reporting progress on workstreams that have been established on an all-Wales basis. Our review focused specifically on the Mumps, Measles & Rubella (MMR), Hepatitis B and Pertussis (whooping cough) vaccines, and in all cases, there is evidence of the proactive measures taken, and effective integration with external partners.

Key Findings		Risk & Impact	Agreed Management Action
1	Whilst there are clear strategies in place which include specific deliverables for the Health Board to achieve, there is no overarching implementation plan to provide specific names, dates, and actions to achieve this, and to ensure that such actions are co-ordinated across the Health Board so that they are delivered in the most effective manner.	The lack of an overarching strategic plan, supported by operational plans, results in the significant efforts to improve vaccination rates currently being undertaken by the Health Board not being planned, delivered and monitored in a coordinated way.	Following recent recruitment activity, resource is now in place to produce an overarching implementation plan. Once this is complete, we will review planning at an operational level.
	Similarly, there are no department or directorate operational plans, although we do acknowledge that specific plans are often produced for individual vaccination campaigns.		Expected Evidence of Implementation: Completed Implementation Plans supported by detailed operational plans across the various department/directorates.
		High Priority	
Theme: Planning, Delivery & Deadline Management		Control Design	Officer: Julie Keegan Target Date: 30 June 2025

Objective 2: Appropriate structures, resources and processes are in place to ensure accountability for effective delivery and implementation of the strategic plan.

Limited

Overview / Summary of Observations

The overall responsibility for achieving Welsh Government (WG) targets in uptake for the different vaccinations sits at an executive level with the Director of Public Health. The strategic lead for Health Protection is delegated to a consultant within the Health Board’s Public Health team and the strategic lead for vaccination and immunisations is delegated to the Deputy Director for Planning and Commissioning (NIF). During 2024/25 there has been significant development in health protection, which includes, but is not limited to, vaccination and immunisation. Overall, oversight of these developments is the responsibility of WG but also the Health Protection Board, which has representation from external partners, including local authorities and Public Health Wales NHS Trust (PHW). There are regular meetings with WG, and regular updates are provided to the Executive Leadership Group within the Health Board.

As there is currently no overarching implementation plan in place, it is difficult to conclude if the Health Board has appropriate resource dedicated to this area. We are aware that additional resources have been put in place to strengthen the approach to vaccinations, but once the implementation plan is produced this will need to be reassessed.

Key Findings		Risk & Impact	Agreed Management Action
2	The current model (permanent and bank staff) to deliver the winter respiratory campaign has struggled to acquire the additional staff availability needed. Bank staff availability has been especially low during the 24/25 season, and the Health Board anticipate that this will worsen in the future due to increasing nurse retirement. This has led to a more fragile vaccine offer across a variety of settings. Given national and local issues around vaccination engagement, especially for winter respiratory virus, a growing ‘hard to reach’ group puts additional pressure on resources and implementation approaches. Staff flu vaccination rates have also been decreasing in recent years. 2022/23 saw a decrease in uptake from 63.7% to 50% for patient facing staff, and in 2023/24 a further decrease to 41.4%. As at 13 January 2025 the staff vaccination rate was 31.4%. The Vaccination Strategy contains a planned action of introducing a network of vaccination champions across the Health Board to try and improve vaccination rates amongst staff. We understand that there has been little enthusiasm from staff to put themselves forward to be a vaccination champion, but we are aware that this approach is due to be reconsidered for the 2025/26 vaccination campaign.	Low rates of vaccination amongst the population increase pressure on health board services. Low staff vaccination rates leads to a higher level of staff absences through sickness and can potentially result in closure of wards and services.	Review existing vaccination resource and effectiveness against the implementation and equity plans. Determine that appropriate delivery models, resources and processes are in place to ensure accountability for effective delivery and implementation of the strategic plan, focusing on winter respiratory vaccines and staff vaccine uptake.
			Expected Evidence of Implementation: Demonstrable incremental improvement for population and staff vaccination rates.
		High Priority	Officers: Julie Keegan/Mark Dunford Target Date: 30 June 2025
Theme: Resourcing		Control Design	

Objective 3: There is ongoing work with partners to ensure effective communication with the population, including vulnerable people and underserved communities and internally with staffing groups. Support and information are provided for delivery and equity for the uptake of vaccines.

Reasonable

Overview / Summary of Observations

Our review focused on the following three specific vaccines:

Hepatitis B - There is a three-year plan to eliminate both Hepatitis B & C as a public threat. The plan aligns to World Health Organisation policy which has been adopted by WG. A working group has been set up with a range of stakeholders including PHW, the Hepatitis Trust, the prison service, a range of service representation from across the third sector, and multiple professionals from across the Health Board. The main work in this area has been with the prison population, where notable improvements have been seen in recent months in the numbers agreeing to have the vaccination. The rates of Hepatitis B testing for young children is also extremely good and is currently the best across NHS Wales.

MMR - The Health Board has undertaken work over recent months to bring together pathways and policies and to be able to cope with a surge in measles infection rates. The work included a desktop exercise with partner organisations which identified some issues with staff vaccination rates which impacts staffing of key services, isolations of cases and contact tracing with the hospital. A task & finish group has been established to look into these issues. There have also been active campaigns to vaccinate staff, and a significant focus on improving vaccination rates in schools through increasing the resource and improving the effectiveness of the School Nursing Service, making it easier for consent to be given for a child to have the vaccine.

Pertussis - This has been heavily signposted to pregnant women by midwives, and it has been promoted as part of the childhood vaccination programme. Work is on-going with the Occupational Health Service to highlight and better target staff in need of both Pertussis and MMR vaccinations.

The Health Board is responsible for the delivery of a wide range of vaccination programmes and there are a number of success stories in terms of vaccination rates. Uptake of primary pneumococcal conjugate vaccination (PCV) in children reaching their first birthday is at 97.7%, which is the highest across Wales as is the uptake of the first dose of MMR2 in children reaching their second birthday which is at 94.8%. However, there are equally other vaccines and groups where performance is not so good (e.g. COVID) and work is planned to try and improve the overall picture, which is not inconsistent with the rest of Wales and indeed most of the UK.

Although we have not raised a finding in this area, we have rated this objective as 'reasonable assurance' due to the lack of an overarching implementation plan that would aid this work and support the need to improve overall vaccination coverage.

Overview / Summary of Observations

There have been significant changes in the arrangements for Health Protection, which includes the responsibility for vaccination campaigns. These largely stem from an instruction from WG requiring health boards to establish an agile and co-ordinated multi-agency Health Protection system. The key reporting link is to the Health Protection Board, meeting quarterly, which is supported by the monthly meetings of the Health Protection Coordination group. Both of these groups are, in line with the WG instructions, multi-agency and therefore include external partner representatives. Specific reporting solely into the Health Board has been through a variety of routes including the Population Health and Partnerships Committee, and the Planning, Performance and Finance Committee, both of which have been recently disbanded to be replaced by the Strategic Development Committee and the Operational Delivery Committee. Reports still go to the Primary Care and Community Care Group for governance reporting as well as the Infection Prevention and Control Committee, the Creating Health Board, and the Executive Leadership Group.

Key Findings		Risk & Impact	Agreed Management Action
4	Reporting into the Health Board on vaccination performance is through multiple committees and groups, in addition to the external reporting that is also taking place. There is therefore a risk of duplication of effort and a failure for the Health Board to have a single, co-ordinated view of the vaccine programmes and performance. We acknowledge that there is an intention to streamline the governance framework in the coming months.	The number and range of reporting lines into the Health Board is inefficient and creates the opportunity for duplication, omission, and confusion.	There is a planned intention to review the current reporting arrangements for Vaccination programmes with a view to streamlining the current governance structure.
		Medium Priority	Expected Evidence of Implementation: Revised governance and reporting structure
	Theme: Governance	Control Design	Officer: Emmeline Watkins Target Date: 30 June 2025

Appendix A

Assurance Opinion

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

Date issued: February 2025

Document reference: 4695A2025

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

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

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About this document

- 1 This document provides the Audit, Risk and Assurance 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 Charitable Funds Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2023-24 Annual Report and Accounts.	Completed.	The Auditor General certified the Annual Report and Accounts on 31 January 2025.

Audit of the Health Board's 2024-25 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2024-25 Annual Report and Accounts.	We have recently commenced our audit planning.	The Welsh Government's deadline for audit certification is 30 June 2025.
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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
Structured Assessment – core	Director of Corporate Services / Board Secretary	This work reviewed the following core areas: • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements.	Report finalised and included in today's committee papers	February 2025

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Annual Audit Report 2024	Chief Executive Officer	This report summarises the findings from our 2024 audit work at the Health Board.	Report finalised and included in today's committee papers	February 2025
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). We are also reviewing progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Part 1 – Regional report drafting Part 2 – Fieldwork Underway	May 2025 May 2025

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
Structured Assessment 2024 – Deep Dive – Digital	Director of Digital	This work will examine digital arrangements, with a particular focus on how the Health Board is investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	To be confirmed
All-Wales thematic review of planned care	Chief Operating Officer	This work follows on from the national report on <u>tackling the planned care backlog</u> and considers: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork underway	To be confirmed
Review of Eye Care Services	Chief Operating Officer	This work will assess the Health Board's eye care services to ensure they are	Fieldwork Underway	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs. The work will also seek an update from the Health Board on its progress in addressing previous audit recommendations arising from the review of follow up outpatient appointments, particularly in the context of ophthalmology patients.		

Other relevant publications

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

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

Title	Publication Date
<u>Cancer Services in Wales</u>	January 2025
<u>National Fraud Initiative Self-Assessment Checklist</u>	December 2024
<u>The National Fraud Initiative in Wales 2022-23</u>	October 2024
<u>NHS Wales Data tool</u> and <u>press release</u>	August 2024

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.
- 8 We have published our **Fee Scheme** for 2025-26 which identifies an average increase in fee rates of 1.7% as compared to the 1.8% increase anticipated in the consultation.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Audit Quality Report 2024: Strengthening trust in audit</u>	January 2025



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

Annual Audit Report 2024 – Cwm Taf Morgannwg University Health Board

Audit year: 2023-24

Date issued: January 2025

Document reference: 4662A2025

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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.

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

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Summary report

About this report

- 1 This report summarises the findings from my 2024 audit work at Cwm Taf Morgannwg University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:
 - examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
 - satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
 - satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.
- 2 I report my overall findings under the following headings:
 - audit of accounts; and
 - arrangements for securing economy, efficiency, and effectiveness in the use of resources
- 3 This year's audit work took place at a time when NHS bodies were continuing to respond to a broad set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.
- 4 We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.
- 5 The audited accounts submission deadline was shortened by two weeks from the previous year to 15 July 2024. The financial statements were certified on 12 July 2024, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.
- 6 The focus and approach of my performance audit work continues to be aligned to the post-pandemic challenges facing the NHS in Wales and is conducted in line with INTOSAI¹ auditing standards.
- 7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.

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

- 8 **Appendix 2** presents the latest position against the audit fee set out in the 2024 Audit Plan.
- 9 **Appendix 3** sets out the audit of accounts risks set out in my 2024 Audit Plan and how they were addressed through the audit.
- 10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We will be presenting it to the Audit and Risk Committee on 13 February 2024. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the [Audit Wales website](#) after the Board have considered it.
- 11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

- 12 I concluded that the Health Board's 2023-24 accounts² were properly prepared and materially accurate and I therefore issued an unqualified true-and-fair opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).
- 13 However, I qualified my regularity opinion because the Health Board breached its revenue resource limit. For the three-year period 2021-22 to 2023-24, the Health Board expended £24.200 million over the three-year revenue limit that the Welsh Government had authorised. The Health Board did not exceed its authorised capital resource-limit for the for the three-year period 2021-22 to 2023-24.
- 14 I found no other regularity matters of a material adverse nature. I did, however, report that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in place for the period 2023-24 to 2025-26. This financial duty requires health boards to prepare, and have approved by the Welsh Ministers, a rolling three-year integrated medium-term plan.
- 15 I reported seven audit recommendations to the Health Board's Audit and Risk Committee. Management fully accepted all the recommendations and have put actions in place to implement them. I also reported that some past audit recommendations (i.e. prior to the 2023-24 audit) are ongoing actions and remain open. I will review the Health Board's progress with all new or ongoing actions as part of my 2024-25 audit.

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

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

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

- The Health Board is sufficiently focused on its significant workforce challenges. Its recently commissioned work on strategic workforce planning has increased overall understanding of current data shortfalls. Whilst starting from a low baseline, this presents an opportunity to both address data needs and support longer term workforce transformation. The Health Board needs to finalise its People Plan and consolidated workforce implementation plans, deliver them and measure overall impact across the short- to medium-term.
- The Health Board has made good progress in addressing the recommendations arising from my 2021 Review of the Temporary Closure of the Minor Injuries Unit at Ysbyty Cwm Cynon, However, it still has further work to do around learning and applying the lessons arising from the temporary closure of the Minor Injuries Unit.
- The Health Board has made reasonable progress in addressing the recommendations arising from my 2018 Primary Care Review. Whilst the Health Board has an appropriately structured and resourced Primary and Community Care Group, it is experiencing capacity challenges in some areas. Primary care is appropriately reflected in Health Board strategies and plans, but coverage of primary care matters at Board requires improvement.
- Whilst the Health Board has delivered its savings target and a break-even financial position for 2023-24, it now needs to initiate a more future orientated approach focussing on service transformation to maintain its long-term financial sustainability.
- The Health Board's governance arrangements are operating generally effectively, but opportunities remain to strengthen them further. The Health Board achieved a financial breakeven position in 2023-24. However, its focus on achieving this position in 2024-25 poses some potential risks to the delivery of strategic objectives and solutions designed to achieve longer-term financial sustainability.

17 These findings are considered further in the following sections.

Detailed report

Audit of accounts

- 18
- Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation’s financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use (‘regularity’) of public monies.
- 19
- My 2024 Audit Plan set out the key risks for audit of the accounts for 2023-24 and these are detailed along with how they were addressed in **Exhibit 4, Appendix 3**.
- 20
- My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2023-24 accounts

- 21
- I concluded that the Health Board’s accounts were properly prepared and materially accurate (true and fair), and I issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board’s internal controls (as relevant to my financial audit).
- 22
- I reported seven audit recommendations, to management and to the Health Board’s Audit and Risk Committee. Management accepted all the recommendations and formally agreed management actions and dates of implementation. I also reported on management’s progress with any recommendations from my previous audits, which are yet to be fully actioned. As part of my 2024-25 audit, I will review management’s progress with all my live recommendations.
- 23
- I must report issues arising from my work to those charged with governance (the Members of the Board), for their consideration before I issue my audit opinion on the accounts. My audit team reported these issues on 11 July 2024. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors’ comments
Uncorrected misstatements	There were no non-trivial uncorrected misstatements.

Issue	Auditors' comments
Corrected misstatements	I reported the ten most significant areas of corrected misstatements. They related mainly to accounting classifications and the completeness of certain disclosures. One of the matters related to a pay award that was confirmed by the Welsh Government after the Health Board's submission of the draft accounts, and therefore could not be known when the accounts were prepared by management.
Other significant issues	I reported seven recommendations for improvement, with management's formal responses. Management formally accepted all the recommendations. On 17 October 2024, the Health Board's Audit and Risk Committee considered the recommendations and management's responses.

- 24 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2024 and the return was prepared in accordance with the Treasury's instructions.
- 25 My separate audit of the Health Board's Charity's annual report and accounts is substantially complete, and I will be reporting my findings to Trustee Members on 30 January 2025. I expect to certify the annual report and accounts on 31 January, being the Charity Commission's deadline.

Regularity of financial transactions

- 26 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.
- 27 Where a Health Board does not achieve financial balance, its revenue and/or capital expenditure exceed its powers to spend, and so I must qualify my regularity opinion.
- 28 I qualified my regularity opinion because the Health Board breached its revenue resource limit. For the three-year period 2021-22 to 2023-24, the Health Board expended £24.200 million over the three-year revenue limit that the Welsh Government had authorised.

- 29 The Health Board did not exceed its authorised capital resource limit for the for the three-year period 2020-21 to 2022-23. For the three-year period 2021-22 to 2023-24, the Health Board expended £119,000 below the three-year capital limit that the Welsh Government had authorised.
- 30 I have the power to place a substantive report on the Health Board's accounts, alongside my opinions, where I want to highlight an issue(s). Due to the regularity issue set out above, I issued a substantive report setting out the factual details of my qualification of my regularity opinion.
- 31 My substantive report also highlighted that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in place for the period 2023-24 to 2025-26. This financial duty requires health boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. The duty is an essential foundation to the delivery of sustainable quality health services.

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

- 32 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:
- reviewing the effectiveness of the Health Board's workforce planning arrangements;
 - assessing the extent to which the Health Board has implemented my 2021 recommendations on the issues surrounding the temporary closure of the Minor Injuries Unit at Ysbyty Cwm Cynon;
 - assessing the extent to which the Health Board has implemented my 2018 recommendations on primary care, as well as the extent to which there is appropriate capacity and capability to deliver priorities as well as the extent to which the Board and its committees consider matters relating to primary care;
 - reviewing the effectiveness of the Health Board's cost savings arrangements; and
 - undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

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

Workforce planning arrangements

- 34 My local review examined whether the Health Board has effective arrangements to support workforce planning. It focussed on strategic and operational workforce planning, how it uses workforce information, and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.
- 35 My work found that the Health Board was sufficiently focused on its significant workforce challenges. The work it had commissioned on strategic workforce planning has increased overall understanding of current data shortfalls. Whilst starting from a low baseline, this presents an opportunity to both address data needs and support longer term workforce transformation. At the time of my audit, the Health Board needed to finalise its People Plan and consolidated workforce implementation plans, deliver them and measure overall impact across the short- to medium-term.
- 36 My work highlighted the absence of an overarching strategic workforce plan but noted that action was underway to develop a clearer People Plan to achieve its intent for workforce in its long-term strategy - CTM2030. The Health Board has utilised external consultants to support strategic workforce improvements. I noted that once this work was complete, the Health Board will need to develop underpinning operational workforce plans which are based on financially sustainable service models.
- 37 The organisation has an improving understanding of current and future service demand and capacity trends. But it needs to do more to ensure that it properly understands its funded workforce establishment which, in part, will require strengthening the quality of data that underpins it. The Health Board has improving arrangements for engaging internal and external stakeholders to inform workforce strategy and plan development.
- 38 The levels of corporate resources committed to supporting strategic workforce improvement are reasonable. My work noted that the Health Board had recently committed more time and resources towards scoping long-term workforce planning and service transformation. However, it needs to do more to determine whether its workforce planning capacity is sufficient to support its evolving operational clinical services workforce plan development.
- 39 The organisation has a good high-level understanding of the risks that might prevent the delivery of its workforce ambitions. It also has a good high-level understanding of its wider operational workforce risks. However, it is currently hard to determine the local impact of the actions the Health Board is taking to mitigate these risks. The Health Board is attempting to tackle its current workforce challenges. Whilst it is proactively recruiting staff, its approach to staff retention is too reactive. However, I found that there is a clear attraction, recruitment, and

retention approach in place for nursing. Whilst the Health Board is delivering some positive staff well-being work, its sickness and staff turnover rates (which were amongst the highest in Wales at the time of my work) suggests the need for a much greater focus on staff well-being.

- 40 The Board and its People and Culture Committee appropriately oversee progress of ongoing workforce development initiatives and actions. However, the committee needs to strengthen its focus on the 'system impact' resulting from delivery of the Health Board's workforce strategy. The Health Board has benefited from its recent consultancy support to improve benchmarking. It benchmarks with other health bodies in Wales and has also reviewed some examples from 'best in class' organisations and clinical models from across the UK. However, my work identified the need to capitalise on this by using its workforce benchmarking as a basis for adopting best workforce practice and workforce models, to inform frontline workforce transformation.

Follow-Up Review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit

- 41 My work considered whether the Health Board has addressed the recommendations arising from my 2021 review of the issues surrounding the temporary closure of the Minor Injuries Unit (MIU) at Ysbyty Cwm Cynon (YCC). I found that the Health Board has made good progress in addressing my recommendations; however, it still has further work to do around learning and applying the lessons arising from the temporary closure of the Minor Injuries Unit.
- 42 The Health Board has strengthened its arrangements for providing managerial oversight of remotely operating services, including the Minor Injury Units in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda. It has introduced a new operating model, consisting of several Care Groups. The YCC MIU, along with the Ysbyty Cwm Rhondda MIU, are now part of the Unscheduled Care Group. The Health Board has agreed a clear scope of practice and standard operating procedure for its MIUs, which set out managerial oversight arrangements. The Care Group maintains appropriate oversight of MIU activity and issues, with regular reporting from the MIUs to the Care Group's Quality and Safety Committee. As the review of the remotely operating services was part of the organisational change process, this was reported directly to the Board rather than the Quality and Safety Committee. However, since the implementation of the new operating model, the Quality and Safety Committee provides good oversight of the quality and safety of the services provided by the Care Groups.
- 43 The Health Board has taken positive steps to improve its arrangements for competency-based training which is explored as part of an individual's annual Performance Appraisal and Development Review (PADR). There are also specific arrangements now in place to support Emergency Nurse Practitioners to complete the relevant competency-based training. This includes the appointment of a full-time Senior Nurse for Professional Education, who is responsible for the governance of the education and training of Emergency Department nurses and is

currently supporting the YCC MIU and Emergency Department at Prince Charles Hospital. There are further plans to support Emergency Departments and the Ysbyty Cwm Rhondda MIU over the next few months.

- 44 Professionally trained staff, such as doctors or nurses, are required to undertake and evidence relevant continuing professional development as part of their on-going registration with their respective professional bodies. However, there is no computer system in place for them to record this. As a result, the Health Board continues to rely on manual records. Within the Unscheduled Care Group, mandatory training compliance is discussed at a bi-monthly Care Group meeting for unscheduled care and planned care. However, there has been no formal reporting on these matters to the Quality and Safety Committee or the People and Culture Committee.
- 45 The Health Board has revised its approach to PADRs, recognising their importance on staff development, performance, and well-being. As a result, the Health Board has seen an increase in PADR compliance. However, the Health Board continues to experience challenges in achieving the PADR compliance target of 85% across all staff groups. At the time of my audit, all but two staff³ within the MIU had an up-to-date performance appraisal, which is a significant improvement since my initial review.
- 46 The Health Board reported no incidents of patients coming to harm following the temporary closure of the MIU. However, further work is needed to capture and apply the learning from the temporary closure. The Health Board did not undertake a listening and learning exercise at the time of the temporary closure; however, it indicated that there were plans to carry out such an exercise by December 2024 to explore opportunities to learn from the temporary closure.

Primary care follow-up review

- 47 My review examined the extent to which the Health Board has implemented my previous 2018 recommendations relating to primary care. I also assessed the extent to which the Board and its committees regularly consider matters relating to primary care, and whether the Health Board's central primary care services team has the appropriate capacity and capability.
- 48 My work found that the Health Board has made reasonable progress in addressing the recommendations arising in my 2018 Review of Primary Care Services. Whilst the Health Board has an appropriately structured and resourced Primary and Community Care Group, it is experiencing capacity challenges in some areas. Primary care is appropriately reflected in Health Board strategies and plans, but coverage of primary care matters at Board requires improvement.
- 49 The Health Board has made reasonable progress in addressing my previous recommendations. It has taken positive steps to review cluster maturity, widen

³ At the time of the follow-up, one was on maternity leave, and one was on a long-term absence.

cluster membership, and support cluster leadership. It also has good arrangements in place for systematically capturing information on the number and skills of staff within general practice, but not for other parts of the primary care sector. Evaluations and sharing learning from new ways of working are undertaken on a cluster basis, but not to a standard approach agreed with the Health Board. There are good arrangements in place to promote new ways of working and alternative points of contact with the public, including various social media platforms, but it is unclear whether this activity is reducing demand for GP appointments. However, the Health Board has not yet established a baseline position for its current investment in primary and community care against which it can assess its progress in shifting resources from secondary care. Whilst it has moved some services from secondary to primary care, this has been facilitated largely by additional Welsh Government funding in support of specific initiatives.

- 50 The Health Board's new Primary Care and Community Care Group is appropriately structured, resourced, and underpinned by clear leadership, governance, and reporting arrangements. However, the Care Group is experiencing capacity challenges in some areas as it tries to fill vacancies and manage sickness absences. These capacity challenges are preventing it from progressing work in some areas, particularly dental services. The Care Group is managing the risks associated with these challenges appropriately. The Care Group has appropriate arrangements in place to support staff learning and development.
- 51 Primary care is adequately reflected in the Health Board's long-term strategy – CTM 2030 – with detailed priorities for 2024-25 set out in the organisation's Integrated Medium-Term Plan for 2024-27. The Health Board is also progressing work on its long-term Acute Clinical Services Plan and Integrated Community Services Plan to support the shift of resources and services to primary and community care. Although primary care is reflected in the Board's terms of reference, it did not receive any specific reports on primary care during 2023-24. Instead, matters relating to primary care were largely covered in other routine reports on performance, quality, and finance. Furthermore, the Health Board no longer publishes a dedicated annual report on primary care and there is limited coverage of primary care matters in its overall Annual Report. The Population Health and Partnerships Committee provided good oversight of the Health Board's overall arrangements for primary and community care services, with other committees providing oversight of specific matters relating to quality, performance, and finance. However, the Population Health and Partnerships Committee was disbanded at the end of December 2024. The Health Board, therefore, needs to provide clarity on which committee will be responsible for providing assurance to the Board on primary care services under the new committee structure being introduced in 2025.

Review of cost savings arrangements

- 52 My review examined whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. It

considered the impact these arrangements had on the Health Board's 2023-24 year-end position and highlighted where arrangements may need to be strengthened for 2024-25 and beyond.

- 53 My work found that whilst the Health Board has delivered its savings target and a break-even financial position for 2023-24, it now needs to initiate a more future orientated approach focussing on service transformation to maintain its long-term financial sustainability.
- 54 The Health Board has a good understanding of the factors driving its costs, however, variation in operational financial performance suggests differing potential for savings delivery within Care Groups and Clinical Service Groups. During 2023-24, the Board provided a clear steer and focus on achieving a balanced financial position. However, this approach has led to several difficult investment decisions for some services and has impacted on the pace of delivering some key strategic objectives, such as development of the Acute Clinical Services Plan, which is key to creating more sustainable models of secondary care.
- 55 The Health Board's arrangements for using data and intelligence to inform cost savings identification and selection require further strengthening. It has a reasonably effective approach for selecting cost savings opportunities. However, due to the limited progress on service transformation, savings schemes remain predominantly short term and transactional in nature to meet in-year savings requirements.
- 56 The Health Board's track record for savings delivery is improving, resulting in the achievement of its overall savings target for 2023-24. It is also progressively increasing its recurrent savings. However, the financial situation during 2024-25 is looking increasingly challenging due to the impact of both predicted and some unforeseen risks. The Health Board has sufficient processes in place for turning high-level savings requirements into deployable savings plans. However, the performance of individual savings schemes during 2023-24 suggests that stronger accountability for operational savings delivery is required. The Health Board is developing its skills and capacity in respect of the operational aspects of savings delivery. However, it needs to align resources across corporate and operational teams to support longer term transformational change to deliver financial sustainability.
- 57 The Health Board has reasonably effective arrangements for monitoring and reporting delivery of savings. Financial performance, including savings, is reported to the Board, Planning, Performance and Finance Committee (PPFC), and Executive Leadership Group. This information is sufficient to oversee progress of savings delivery, and it enables the Board to scrutinise or recommend action where savings schemes are off-track. The Health Board has adequately documented the risks around its wider financial position within its Board Assurance Framework and Corporate Risk Register. Finance risks, controls and remedial actions are also set out in the routine finance reports to the PPFC and Board.
- 58 The Health Board applies a RAG (Red, Amber, Green) rating to its savings schemes to determine the risk of non-delivery. During 2023-24, it was able to

address savings risks quickly. However, the picture during 2024-25 is more challenging. While the Health Board does not identify 'red' savings schemes in its finance reports, it does provide assurance on the actions being undertaken to recover schemes which are under-delivering.

- 59 The Health Board has indicated that its Project Management Office and Change Hub will provide increased opportunities for learning at an operational level. There have also been some innovative service changes in progress to improve savings delivery. The Health Board should identify the key lessons from these experiences and apply the learning to build savings delivery capability within the Care Groups and Clinical Support Groups.

Structured assessment

- 60 My 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe, and responsive services, and that public money is being spent wisely.
- 61 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.
- 62 At the time of my structured assessment work, the Health Board was subject to Level 3 for finance, strategy and planning; Level 3 for performance and outcomes relating children and adolescent mental health (CAMHS); and Level 4 for performance and outcomes relating to urgent and emergency care, cancer and planned care under the [Welsh Government's escalation and intervention arrangements](#).

Board transparency, effectiveness, and cohesion

- 63 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:
- Public transparency of Board business
 - Arrangements to support the conduct of Board business;
 - Board and committee structure, business, meetings, and flows of assurance;
 - Board commitment to hearing from staff, users, other stakeholders; and
 - Board skills, experiences, cohesiveness, and commitment to improvement.

- 64 My work found that the Health Board has a stable and cohesive Board which generally conducts its business appropriately, effectively, and transparently. The introduction of a new committee structure in early 2025 provides an opportunity to strengthen these arrangements further.
- 65 The Health Board continues to demonstrate a commitment to public transparency of Board and committee business and remains committed to continuous improvement. The Health Board has generally good arrangements in place to support the effective conduct of Board business, but it still needs to strengthen its policy management arrangements.
- 66 The Board and its committees continue to operate generally effectively, with planned changes to the committee structure in 2025 focussed on strengthening oversight of strategic matters and building on current good arrangements.
- 67 The Health Board remains committed to hearing from patients, service users and staff. The Board, the Quality & Safety Committee, and the People & Culture Committee receive a shared listening and learning story⁴ and spotlight presentation⁵. The Board also uses stories to follow-up on investment decisions. However, there is scope to introduce more systematic arrangements for identifying and monitoring actions arising from them.

Corporate systems of assurance

- 68 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:
- overseeing strategic and corporate risks;
 - overseeing organisational performance;
 - overseeing the quality and safety of services; and
 - tracking recommendations.
- 69 My work found that the Health Board's systems of assurance are operating generally effectively, but opportunities remain to strengthen arrangements further and to take urgent action to address overdue recommendations and improvement actions.
- 70 The Health Board maintains a detailed and comprehensive Board Assurance Framework (BAF), which the Board reviews at each meeting. The BAF is owned by the Board, who use it to oversee, scrutinise and manage strategic risks. However, the Health Board could strengthen its approach by clearly reporting the impact of the actions it is taking to mitigate its strategic risks.
- 71 The Health Board has generally effective performance management arrangements; however, it needs to fully update its draft performance management framework. The Health Board continues to have appropriate Board-level arrangements to

⁴ Patient and staff stories describing their experiences.

⁵ Deep dive presentation on a specific service.

oversee and scrutinise organisational performance. However, while reports identify actions to improve underperformance, they do not clearly articulate whether those actions are achieving their intended impact. Executive Directors share collective ownership for organisational performance. Scrutiny of the performance information presented is reasonably effective, with Independent Members pursuing knowledgeable and insightful lines of questioning. However, the unforeseen critical incident with the roof at the Princess of Wales Hospital in October 2024 is likely to have a notable and ongoing effect on operational performance. The Health Board has responded with a range of actions to mitigate the impact of the roof issues although it will need to ensure that these mitigating actions achieve their intended impact.

- 72 The Health Board has generally effective arrangements for overseeing the quality and safety of services. However, it needs to fully embed its quality governance arrangements across the organisation and strengthen reporting on the Duty of Quality and Candour. The Health Board continues to make good progress in addressing the outstanding areas highlighted in our 2023 Joint Review of Quality Governance Arrangements. In August 2024, we followed up this work and found that the Health Board has addressed our original areas of concern. However, it needs to ensure continued improvement in relation to the Annual Quality Work Plan, Clinical Audit, and organisational culture and behaviours.
- 73 The Health Board continues to develop its arrangements for tracking Internal and external audit recommendations and Health Inspectorate Wales improvement actions. It is currently transitioning to the 'AMaT'⁶ system although this is taking longer than anticipated. More work is required to address overdue recommendations. The Corporate Governance Team and Executive Team are commencing a focussed programme of work to address this. Nevertheless, the Health Board should strengthen ownership and accountability amongst Executive Directors to secure sustained improvements in this area.

Corporate approach to planning

- 74 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:
 - producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and
 - overseeing the delivery of corporate strategies and plans.
- 75 My work found that the Health Board has an effective approach to developing corporate strategies and plans and setting its well-being objectives. However, it needs to strengthen its approach to monitoring and reporting strategy delivery and

⁶ AMaT is an audit management and tracking tool, which utilises dashboards to give intelligence, and enables staff to update progress in real time reducing the burden on governance teams as it automates many of the processes, such as asking for progress updates.

impact and better align its well-being objectives to the national well-being goals and the well-being objectives of partners.

- 76 The Health Board continues to work towards delivering its long-term strategy – CTM 2030. The Health Board also continues to have effective arrangements for preparing its 2024-27 Integrated Medium-Term Plan (2024-27 IMTP), culminating in its approval by Welsh Government. It also has an effective approach to developing wider corporate strategies and plans. Independent Members are given the opportunity to provide feedback on draft corporate strategies and plans as part of Board Development sessions, or at various committees before the final versions receive formal approval at public Board meetings. Draft corporate strategies and plans are also discussed and shared with internal and external stakeholders to maximise input.
- 77 While the Board receives routine updates on aspects of strategy delivery, the development of clear actions and outcomes measures for its high-level strategic objectives remains in progress. The 2024-27 IMTP is appropriately aligned to CTM 2030 and sets out how the Health Board's strategy groups are used to deliver the key priority areas. While the 2024-27 IMTP delivery requirements are reasonably clear for year 1, milestones and targets for years 2 and 3 are less clear. The Health Board has also not formally set out Executive Director lead responsibilities for deliverables, which may limit appropriate accountability.
- 78 Quarterly IMTP progress reports are presented to the Board and PPFC. While there is reference to the Integrated Performance Dashboard in the report, there continues to be an opportunity to more clearly link progress in delivering priorities to the Health Board's performance. The Health Board also needs to develop an appropriate suite of population outcome measures to demonstrate the impact of its strategy delivery. While routine updates on wider corporate strategy and plan delivery provide sufficient information to demonstrate progress, they do not clearly articulate where delivery is off-track, mitigating actions, and revised delivery timescales.
- 79 CTM 2030 sets out the Health Board's long-term strategic objectives which are also its wellbeing objectives under the Well-being of Future Generations (Wales) Act 2015. The strategic / well-being objectives were shaped in line with the sustainable development principle and clearly articulate the Health Board's vision to become a population health organisation and 'anchor institution'⁷. They were developed and agreed by the Board following detailed research into population health and inequality and informed by extensive clinical and community exercises. Due consideration was also given to wider national policy such as 'a Healthier Wales', as well as Value-Based Healthcare, and carbon net zero reduction. The strategic / well-being objectives are cross cutting, future focussed and underpinned by the five ways of working. However, while CTM 2030 demonstrates alignment to

⁷ Anchor institutions are large organisations that are connected to their local communities and have a significant impact on their health and wellbeing. They are typically non-profit, public-sector organisations that are unlikely to relocate.

the 'five ways of working', the Health Board's strategic / well-being goals have not been aligned to the seven national well-being goals or the well-being objectives of its partners.

Corporate approach to managing financial resources

- 80 My work considered whether the Health Board has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:
- achieving its financial objectives;
 - overseeing financial planning;
 - overseeing financial management; and
 - overseeing financial performance.
- 81 My work found that financial planning, management, monitoring, and reporting arrangements are generally effective, but the organisation's focus on addressing its immediate financial challenges is presenting risks to the delivery of longer-term solutions to achieving financial sustainability.
- 82 The Health Board met its financial objectives to breakeven for both revenue and capital expenditure in 2023-24. However, because of a £24.5 million deficit in 2022-23, it did not meet its statutory financial duty to breakeven against its revenue resource limit over the three-year rolling period 2021-22 to 2023-24. Nevertheless, the Health Board's 2023-24 financial position represents a significant achievement and provides increasing confidence in its strategic financial management. The Health Board forecasts a breakeven year-end position for 2024-25. However, there are significant risks to achieving this.
- 83 The Health Board has a clear framework for developing its Financial Plan for 2024-27 which the Board approved in March 2024 as part of the 2024-27 IMTP approval process. The Health Board continues to have generally effective arrangements for overseeing and scrutinising financial management and financial reports provide sufficient information to enable effective scrutiny and challenge and are clear on the impact of action taken to improve the financial position.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2024.

Report	Date
Financial audit reports	
Health Board: Audit of Accounts Report	July 2024
Health Board: opinion on the accounts	July 2024
Health Board: Audit of Accounts Addendum Report	October 2024
Charitable Funds: Audit Accounts Report (2022-23); and the opinion on the accounts.	January 2025
Performance audit reports	
Review of Workforce Planning Arrangements	May 2024
Temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit Follow Up Review	August 2024
Primary Care Follow Up Review	January 2025
Review of Cost Savings Arrangements	January 2025
Structured Assessment 2024	January 2025

Report	Date
Other	
2024 Audit Plan	May 2024

My wider programme of national value-for-money studies in 2024 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the [Audit Wales website](#).

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Review of Unscheduled Care – Flow out of hospital	March 2025
Discharge Planning Follow Up Review	March 2025
Review of Planned Care Services Recovery	April 2025
Review of Eye Care Services	April 2025
Review of Unscheduled Care – Arrangements for managing demand	May 2025
Review of Digital Transformation	June 2025

Appendix 2

Audit fee

My 2024 Audit Plan set out a fee estimate of £487,162 (excluding VAT, which is not chargeable). I also set a fee estimate of £30,590 in the 2024 Audit Plan for my audit of the Health Board's Charity's annual report and accounts. My staff will determine the final audit costs once all audits are fully concluded. My audit team will then notify management of the closing position, which I will set out as usual in my 2025 Audit Plan.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2024 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board’s 2023-24 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	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.	I reviewed numerous accounting estimates and samples of transactions, which included journal entries. I did not identify any significant transactions outside the normal course of business. No significant risks arose relating to management override. The overall results of my testing in in these areas was satisfactory.
There is a significant risk that the Health Board will fail to meet its first statutory financial duty to break even over a rolling	I will: • monitor the Health Board’s financial position for 2023-24 and the cumulative	As set out in this report, my audit confirmed that the Health Board met its three-year capital resource limit, but did not meet its three-year <u>revenue</u>

Audit risk	Proposed audit response	Work done and outcome
three-year period; against its revenue and capital resource limits. The reported <u>revenue</u> 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 <u>capital</u> position at month 12 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 other key financial targets agreed with the Welsh Government.	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 report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.	resource limit. I therefore qualified my regularity opinion and placed a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen. I also reported on the fact that the Health Board did not meet its financial duty to have a Welsh-Government-approved three-year integrated medium-term plan, for the period 2023-24 to 2025-26.



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Structured Assessment 2024 – Cwm Taf Morgannwg University Health Board

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 structured assessment work at Cwm Taf Morgannwg University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Health Board's corporate approach to setting new well-being objectives in accordance with the sustainable development principle is being undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015.
- 2 Our 2024 Structured Assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.
- 3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on;
 - Board transparency, cohesion, and effectiveness;
 - Corporate systems of assurance;
 - Corporate approach to planning; and
 - Corporate approach to financial management.

We have not reviewed the Health Board's operational arrangements as part of this work.

- 4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:
 - Model Standing Orders, Reservation and Delegation of Powers
 - Model Standing Financial Instructions
 - Relevant Welsh Government health circulars and guidance
 - The Good Governance Guide for NHS Wales Boards (Second Edition)
 - Other relevant good practice guides.

We undertook our work between September and November 2024. The methods we used to deliver our work are summarised in **Appendix 1**. Our work was

conducted in accordance with the auditing standards set by the International Organization of Supreme Audit Institutions.

- 5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

- 6 **Overall, we found that the Health Board's governance arrangements are operating generally effectively, but opportunities remain to strengthen them further. The Health Board achieved a financial breakeven position in 2023-24. However, its focus on achieving this position in 2024-25 poses some potential risks to the delivery of strategic objectives and solutions designed to achieve longer-term financial sustainability.**
- We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. We found that **the Health Board has a stable and cohesive Board which generally conducts its business appropriately, effectively, and transparently. The introduction of a new committee structure in early 2025 will provide an opportunity to strengthen these arrangements further.**
 - We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. We found that **the Health Board's systems of assurance are operating generally effectively, but opportunities remain to strengthen arrangements further and take urgent action to address overdue recommendations and improvement actions.**
 - We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery. We found that **while the Health Board has an effective approach to developing corporate strategies and plans, it is experiencing challenges in progressing key elements of its long-term strategy. It also needs to strengthen its approach for monitoring and reporting strategy delivery and impact.**
 - We considered whether the Health Board has a sound corporate approach to managing its financial resources. We found that **financial planning, management, monitoring, and reporting arrangements are generally effective, but the organisation's focus on addressing its immediate financial challenges is presenting risks to the delivery of longer-term solutions to achieving financial sustainability.**

Recommendations

7 **Exhibit 1** details the recommendations arising from our work. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2024 recommendations

Recommendations	
R1	The Health Board should strengthen arrangements for monitoring, reviewing and updating Health Board policies and routinely report progress to the relevant Committee of the Board. (Paragraph 25)
R2	The Health Board should introduce arrangements for identifying and monitoring actions arising from its listening and learning stories. (Paragraph 36)
R3	The Health Board should strengthen the Board Assurance Framework (BAF) by clearly reporting the impact of actions that the Health Board is taking to mitigate its strategic risks. (Paragraph 48)
R4	The Health Board should strengthen its Integrated Performance Dashboard by clearly articulating whether actions to improve underperformance are achieving their intended impact. (Paragraph 55)
R5	The Health Board should strengthen its reporting on the Duty of Quality and Candour by: R5.1 ensuring that future annual reports are clearer around the challenges it is experiencing in embedding the requirements; and R5.2 including appropriate milestones and targets to help the reader understand when it is aiming to achieve priorities. (Paragraph 63)
R6	The Health Board should: R6.1 ensure that it rapidly completes its work to strengthen the audit recommendations tracker; and R6.2 strengthen ownership and accountability for delivery of audit recommendations. (Paragraph 67)

Recommendations

- R7 The Health Board should set out how each individual well-being objective aligns to the national well-being objectives and well-being objectives of its partners. **(Paragraph 78)**
- R8 The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery. **(Paragraph 84)**
- R9 The Health Board should strengthen Board and committee corporate strategy and plan reporting by clearly articulating where delivery is off-track, mitigating actions, and revised delivery timescales. **(Paragraph 85)**
- R10 The Health Board should:
- R10.1 monitor and manage any immediate quality and performance risks that may arise as a result of limited or no investment in services as it seeks to achieve financial balance in the short-term; and
 - R10.2 develop a long-term financial plan, beyond its 2024-27 Integrated Medium-Term Plan, aligned to its organisational strategy in order to achieve financial sustainability. **(Paragraph 95)**

Detailed report

Board transparency, effectiveness, and cohesion

- 8 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.
- 9 We found that **the Health Board has a stable and cohesive Board which generally conducts its business appropriately, effectively, and transparently. The introduction of a new committee structure in early 2025 will provide an opportunity to strengthen these arrangements further.**

Public transparency of Board business

- 10 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of:
- Board and committee meetings that are accessible to the public;
 - Board and committee papers being made publicly available in advance of meetings; and
 - Board and committee business and decision-making being conducted transparently.
- 11 We found that **whilst the Health Board remains committed to public transparency of Board and committee business, it still has further work to do to fully address our previous audit recommendations in this area.**
- 12 The Health Board has generally effective arrangements in place to support public transparency of Board and committee business. It operates both virtual and in-person Board and committee meetings. Whilst it no longer livestreams public Board meetings, recordings of meetings are made available on its website and YouTube channel as soon as possible following the end of the meeting. However, this practice has not been extended to committee meetings.
- 13 Public Board meetings are signposted effectively on the Health Board's website and social media platforms with clear guidance on how members of the public can request to attend in person if they wish to do so. It also endeavours to provide simultaneous Welsh translation and British Sign Language upon request. (See **Appendix 2 - 2023 Recommendation 1**).
- 14 The Health Board aims to publish the agenda and papers for Board and committee meetings on its website a week in advance of meetings. However, a Standing Order Breaches update to the Audit and Risk (A&R) Committee in August 2024 highlighted some instances where timescales were not met (see **Appendix 2 - 2022 Recommendation 1b**). The Health Board does not publish papers of private Board and Committee meetings, the Remuneration and Terms of Service

Committee or the Board Advisory Groups¹ on its website due to the sensitive nature of the information discussed.

- 15 The Health Board has included some videos of staff and patient stories presented during its Board and committee meetings on its website. However, this arrangement is not consistently applied. For example, videos of the patient story presented at the September 2024 Board and Quality and Safety (Q&S) Committee were not uploaded. However, the papers did include accompanying presentation slides for the item presented at Board. (See **Appendix 2 - 2023 Recommendation 2**)
- 16 The Board continues to make appropriate use of private sessions, ensuring that they meet requirements of the Freedom of Information Act and reserving them for confidential and sensitive matters only. Agendas for public Board and committee meetings include an item on matters to be discussed in private. (See **Appendix 2 – 2022 Recommendation 1a**)
- 17 Draft Board and committee meeting minutes continue to be produced quickly; however, they are not made publicly available until the papers of the subsequent meeting are published. As committee meetings are not livestreamed or recorded for public use, the Health Board still needs to put arrangements in place to ensure the public have timelier access to records of committee meetings (see **Appendix 2 – 2023 Recommendation 3**). The Health Board still needs to ensure timely upload of confirmed committee minutes to its website (see **Appendix 2 – 2023 Recommendation 4**).
- 18 Our observations of Board and committee meetings found that they support good openness and transparency amongst participants, particularly in relation to the challenges facing the organisation.

Arrangements to support the conduct of Board business

- 19 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:
 - a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
 - formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
 - formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.

¹ The Health Board's Board Advisory Groups are the Clinical Advisory Group (CAG), Local Partnership Forum (LPF), and Stakeholder Reference Group.

- 20 We found that **the Health Board has generally good arrangements to support the effective conduct of Board business, but as we identified last year, it still needs to strengthen its policy management arrangements.**
- 21 The Health Board's Standing Orders, Scheme of Reservation and Delegation of Powers, and Standing Finance Instructions (SFIs) are up to date and reviewed annually with amendments or updates routinely reported to both the A&R Committee and Board.
- 22 The A&R Committee maintains appropriate oversight of compliance with the Scheme of Reservation and Delegation in relation to procurement matters, declaration of interests, standings orders, and SFIs. Both the August and October 2024 Procurement and Scheme of Delegation updates to the committee highlight high numbers of invoices on hold (due to no purchase order) compared to the all-Wales Health Board average. This has prompted communication to Health Board staff and an update to the Purchase Order Policy.
- 23 Declarations of Interest are taken at the start of every Board and committee meeting. There are also appropriate arrangements for declaring, handling, and recording and reporting declarations of interest from Board members and staff in Band 8d posts and above.
- 24 The Health Board continues to include key policies and procedures on its website. However, the Incident Management Framework, Handling Concerns Policy, Raising Concerns Policy, and Environmental Policy remain out of date (see **Appendix 2 – 2023 Recommendation 5**).
- 25 Arrangements for monitoring, tracking, and reviewing wider Health Board policies still require strengthening. The Health Board is currently exploring how it can achieve this using the Audit Management and Tracking (AMaT)² or SharePoint systems. Subsequently there is limited assurance provided to the relevant Committee on policy management. **(Recommendation 1, 2024)**

Effectiveness of Board and committee meetings

- 26 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:
- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
 - Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;

² AMaT is an audit management and tracking tool, which utilises dashboards to give intelligence, and enables staff to update progress in real time reducing the burden on governance teams as it automates many of the processes, such as asking for progress updates.

- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge;
 - committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board;
 - clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.
- 27 We found that **the Board and its committees continue to operate generally effectively, with planned changes to the committee structure focussed on strengthening oversight of strategic matters and building on current good arrangements.**
- 28 The Board and its committee continue to operate generally effectively. We found:
- up-to-date terms of reference, annual cycles of business and forward work plans in place for the Board and committees that broadly cover the breadth of the Health Boards business;
 - that committee chairs are actively involved in meeting agenda setting, with evidence of the Board Assurance Framework (BAF) being used to shape Board and committee business (see **paragraph 49**);
 - appropriate use being made of the consent agenda for routine business;
 - well-chaired meetings enabling contributions from all members on key issues;
 - good meeting etiquette being observed, with appropriate scrutiny and challenge. However, there were a small number of instances where discussions appeared to stray slightly too much into operational detail;
 - a well-established and effective approach for referring matters between committees and challenging the robustness of assurances provided (see **Appendix 2 – 2022 Recommendations 10c**); and
 - an effective approach to escalating issues to the Board with an identification of actions in response to risks.
- 29 The Planning, Performance & Finance (PP&F) Committee became responsible for oversight of the Health Board's estate last year. Our work this year indicates that the committee received an update on Estates performance at its meeting in February 2024. However, the recent critical incident at the Princess of Wales Hospital³, while unforeseen, re-enforces the strategic importance of effective Board oversight of the Health Board's estate, as well as the importance of developing an Estates strategy to accompany the Acute Clinical Services Plan. (see **Appendix 2 – 2022 Recommendation 10a**).

³ During October 2024, the Health Board declared a critical incident at its Princess of Wales Hospital site revealing serious deterioration to the building's roof that will require a substantial programme of replacement.

- 30 In general, the quality of information presented to Board and committees is improving. The Corporate Governance Team quality assures all papers before publishing. The recently introduced report writing training should also further improve report consistency and quality. However, while papers are generally clear and well-written, occasionally they can be overly long and detailed. The new committee arrangements (see **paragraph 32**), which will have a greater focus on strategic matters, may also help report authors focus on key matters, reducing the overall volume of meeting papers.
- 31 Cover reports follow a standard format and impact assessments are routinely completed covering a wide range of criteria⁴. Cover reports for presentations continue to be in a different format and do not capture the key risks and issues associated with the presentations (see **Appendix 2 - 2022 Recommendation 1d**).
- 32 In September 2024, the Board approved the following changes to the Health Board's governance and management arrangements:
- the number of formal committees will be reduced from nine to seven⁵;
 - the frequency of the Audit, Risk and Assurance committee meeting will change from bi-monthly to quarterly;
 - the introduction of a new Strategic Development Committee to provide oversight of strategic planning and programme delivery;
 - the introduction of a new Operational Delivery Committee to provide oversight of operational planning, performance, finance, digital and information governance;
 - the introduction of a new Executive Management Board to oversee day to day operational and corporate Health Board functions and maintain focus and oversight of long-term strategy, plans and programmes.
- 33 The Health Board anticipates that the new arrangements will ensure more efficient and effective management of Board and committee business and provide greater strategic oversight of the organisation. Board members support the new arrangements, however, there are potential risks around committee workload and flows of assurance given the proposed frequency of some committee meetings. Therefore, agenda setting under the new arrangements will be critical to ensuring that Board and committees are strategically focussed and seek the correct level of assurance. The Health Board intends to formally review the new committee structure once the arrangements embed. However, to support continuous

⁴ Impact Assessment criteria include Health Board strategic objectives, Wellbeing of Future Generations (Wales) Act 2015, domains and enablers of quality, environmental sustainability, equality and Welsh Language

⁵ The People and Culture (P&C), Planning, Performance & Finance (PP&F), Population Health & Partnerships (PH&P) and Digital and Data (D&D) Committees will be removed from the structure with their responsibilities transferred to other committees.

improvement, Board and committee members should regularly reflect on the effectiveness of the new arrangements.

Board commitment to hearing from patients/service users and staff

- 34 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:
- The Board using a range of suitable approaches to hear from a diversity of patients/service users, the public and staff.
- 35 We found that **the Health Board remains committed to hearing from patients, service users and staff, but opportunities exist to better identify and monitor the actions arising from listening and learning stories.**
- 36 The Health Board continues to engage effectively with staff and patients. The Board, Q&S, and P&C Committees receive a shared listening and learning story⁶ and spotlight presentation⁷. Our observations found a balance of both positive and negative stories. The Board also uses stories to follow-up on investment decisions. For example, in June 2023, the Board approved a business case to implement robotic assisted surgery. At its meeting in September 2024, the listening and learning item subsequently focussed on the positive outcomes of this decision, including both staff and patient perspectives. However, there is scope to introduce more systematic arrangements for identifying and monitoring actions arising from listening and learning stories (**Recommendation 2, 2024**). Following the committee re-structure (see **paragraph 32**), the Health Board will need to ensure that staff stories continue to inform Board members on staff experience.
- 37 The Health Board continues to have good arrangements to support Board walkarounds, allowing both Executive Directors and Independent Members to engage directly with patients and staff and triangulate performance information and assurances from management. Routine Q&S Committee updates provide an overview of good practice, areas of concern and issues and actions agreed for all the visits completed. Progress on these actions is monitored by Care Group Quality, Safety, and Patient Experience Groups. The Board Development Session scheduled for December 2024, is due to consider a review on the effectiveness and impact of the IM Walk-arounds.

⁶ Patient and staff stories describing their experiences.

⁷ Deep dive presentation on a specific service.

Board cohesiveness and commitment to continuous improvement

- 38 We considered whether the Board is stable and cohesive, and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:
- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
 - the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
 - a relevant programme of Board development, support, and training in place.
- 39 We found that **the Board continues to be cohesive and committed to continuous improvement.**
- 40 The Health Board has a cohesive and stable Board. All members of the Executive Team are in permanent positions and the Health Board has managed changes amongst its Independent Member cadre well. During the year, it successfully filled four vacant Independent Member positions⁸ with one vacancy remaining (Corporate Business). There will be a further change in 2025 when the Independent Member (Digital) reaches the end of his final term.
- 41 Board members have a broad mix of knowledge and experience. However, a recent skills review identified gaps around commercial contracting, procurement, estates, and property. Furthermore, the Board has lost one Welsh speaking Independent Member. The Board is using this information alongside its diversity profile⁹ to shape the role and inform recruitment for the Independent Member vacancy mentioned above.
- 42 The Board and its committees continue to review their effectiveness annually. During the year, the Health Board also completed a broader review of Board business and structures (see **paragraph 32**), the use of Board development and briefing sessions (see **paragraph 43**), and the approach to agenda planning sessions. A Board development session held in September 2024 reflected on the learning from this work and identification of areas of focus. The Corporate Governance Team is progressing actions as part of its work plan.
- 43 The Board development and briefing programme covers a variety of topic areas, such as future models of primary care, community engagement, research and development, and digital transformation. In addition, they are used to consider and inform the development of corporate strategies and plans. The Board and

⁸ The Health Board appointed a Vice Chair, and Independent Members for Community, Trade Union, and Legal

⁹ A Board diversity profile is a collection of goals and actions to ensure the Board is made up of a diverse group of people.

Corporate Governance Team are reviewing the programme for 2025 to ensure it provides a clearer focus on key strategic items.

Corporate systems of assurance

- 44 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.
- 45 We found that **the Health Board's systems of assurance are operating generally effectively, but opportunities remain to strengthen arrangements further and to take urgent action to address overdue recommendations and improvement actions.**

Corporate approach to overseeing strategic and corporate risks

- 46 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic and corporate risks were specifically looking for evidence of:
- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
 - the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.
 - an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities; and
 - the Board providing effective oversight and scrutiny of the effectiveness of the risk management system and corporate risks.
- 47 We found that **whilst the Health Board has generally effective corporate arrangements for managing risks, there is scope to strengthen reporting on the impact of actions taken to mitigate strategic risks.**
- 48 The Health Board maintains a detailed and comprehensive BAF, which the Board reviews at each meeting. The BAF is owned by the Board, who use it to oversee, scrutinise and manage strategic risks. The BAF reflects the Health Board's long-term strategic goals and captures the strategic risks it is currently facing and the associated impact on the organisation. It also provides appropriate information on risk scores, key controls, assurances, gaps in controls and assurance, and mitigating actions. However, the Health Board could strengthen its approach by clearly reporting the impact of actions that it is taking to mitigate its strategic risks. **(Recommendation 3, 2024)**
- 49 The Health Board continues to use the BAF to shape and inform its committee business. BAF and committee assigned risks are discussed at all agenda planning meetings and considered when shaping committee cycles of business.

Organisational risk register reports to committee identify both the strategic and organisational risks assigned to committees. The Board reviews its risk appetite position annually and has adopted either a cautious, open, or averse risk tolerance¹⁰ across its risk domains.

50 The Health Board continues to have effective risk management arrangements. We found evidence of:

- clear policies, procedures, and training;
- clear articulation of the organisation's highest scoring operational risks, existing controls, and actions to mitigate them within the organisational risk register;
- effective committee oversight of organisational risks during public and private meetings, with good scrutiny, questioning and discussion; and
- clear organisational risk register reports to committees.

51 While the Internal Audit Service's review of risk management arrangements provided reasonable assurance, it also identified weaknesses around Datix¹¹ record keeping, risk escalation, risk management training uptake and risk monitoring arrangements. The Health Board reports that it has addressed all but one of the recommendations to date.

Corporate approach to overseeing organisational performance

52 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

53 We found that **whilst the Health Board's performance management arrangements are generally effective, it needs to fully update its performance framework, ensure sufficient focus on impact of improvement actions, and ensure that the consequences of the critical incident at the Princess of Wales Hospital are effectively managed.**

54 Last year, we reported that the Health Board needed to update its draft performance management framework. This work is still underway and will need to be completed to ensure that roles, responsibilities, and performance review and

¹⁰ The Health Board's risk appetite matrix identifies several approaches to risk tolerance, i.e. averse, minimalist, cautious, open and eager.

¹¹ Datix is a web-based system used by NHS healthcare providers to report incidents and manage risk.

reporting arrangements are clearly understood at both service and management levels (see **Appendix 2 – 2023 Recommendation 6**).

- 55 Despite this, the Health Board continues to have appropriate Board-level arrangements to oversee and scrutinise organisational performance. Performance is reported to the Board, and PP&F Committee via the Integrated Performance Dashboard, which provides a detailed overview of the Health Board's performance against national delivery measures, and a small number of local measures. The report also includes a useful 'one-page' summary of the Health Board's highest profile national measures and 'direction of travel'. Detailed performance is presented within the report by Care Group (including priority areas such as Unscheduled Care and Planned Care), Corporate Directorate, or specific areas of focus and is supported by data, narrative explanation, and use of benchmarking performance data where appropriate (see **Appendix 2 – 2022 Recommendation 3**). However, while it identifies actions to improve underperformance, it does not clearly articulate whether those actions are achieving the intended impact (**Recommendation 4, 2024**).
- 56 Executive Directors share collective ownership for organisational performance. There is a collaborative approach at Board meetings, with each Executive Director presenting performance for their areas of responsibility. This includes good explanations of underperformance and actions taken to resolve issues. Scrutiny of the information is generally effective with Independent Members pursuing knowledgeable and insightful lines of questioning. Despite these arrangements, the recent unforeseen critical incident at the Princess of Wales Hospital is likely to have a notable and ongoing effect on operational performance. While the incident was beyond the Health Board's control, it has responded with a range of actions to mitigate its impact. It is crucial that the Health Board continues to ensure that these mitigating actions achieve their intended impact to secure recovery in this area.

Corporate approach to overseeing the quality and safety of services

- 57 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:
- the Board providing effective oversight and scrutiny of the effectiveness of the quality governance framework
 - clear organisational structures and lines of accountability in place for clinical/quality governance; and
 - the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.
- 58 We found that **the Health Board has generally effective arrangements for overseeing the quality and safety of services. However, it needs to fully**

embed its quality governance arrangements across the organisation and strengthen reporting on the Duty of Quality and Candour.

- 59 The Health Board continues to make good progress in addressing the outstanding areas highlighted in our 2023 Joint Review Follow-up of Quality Governance Arrangements. In August 2024, we followed up this work and found that the Health Board has addressed our original areas of concern. However, it needs to ensure continued improvement in relation to the Annual Quality Work Plan, Clinical Audit, and organisational culture and behaviours.
- 60 The Health Board's 2022-25 Quality Strategy and Quality and Patient Safety Framework, which the Board approved in early 2023, sets out its vision and strategic approach to quality and the underpinning quality assurance and management systems. The Health Board intends to update the framework by early 2025.
- 61 The Q&S Committee maintains good oversight of quality and safety and routinely considers Care Group's updates, the Patient Safety and Quality Dashboard, and People Experience Team update reports. The Board's Integrated Performance Dashboard also provides an overview of quality measures. These include metrics on healthcare acquired infections, never-events, nationally reportable incidents, Putting Things Right, and mortality rates. The Board also receives annual reports on Putting Things Right and the Duty of Quality during the year.
- 62 In September 2024, Internal Audit's review on the Health Board's Quality and Patient Safety Framework gave a reasonable assurance rating but also identified several areas where further improvements are required to strengthen 'floor to board' quality and safety assurance. These areas include Quality, Patient Safety and Experience meeting arrangements, Care Group assurance framework structures, and Care Groups and Clinical Service Groups annual quality work plans.
- 63 The Health Board continues to embed the Health and Social Care (Quality and Engagement) Act 2020. The Board considered the first Duty of Quality Report at its meeting in July 2024. This set out progress and plans for implementing and embedding the duty. The report highlights positive achievements, however, the Health Board needs to be clearer around the challenges it faces when introducing the required changes. Furthermore, while the report highlights several priorities for the coming year, it does not include milestones or targets to help the reader understand when it aims to achieve them. **(Recommendation 5, 2024)**

Corporate approach to tracking recommendations

- 64 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

- 65 We found that **the Health Board's progress in strengthening its recommendation tracking systems remains slow and urgent action is required to address overdue recommendations.**
- 66 The Health Board continues to develop its arrangements for tracking Internal and External Audit recommendations and Health Inspectorate Wales improvement actions, (see **Appendix 2 – 2018 Recommendation 6**). It is currently transitioning to the 'AMaT' system although this is taking longer than anticipated. This system will allow the Health Board to improve its approach for analysing progress by providing a dashboard to inform recommendation monitoring reports to the A&R and Q&S Committees. Whilst the quality of committee recommendation/action monitoring reports is improving, there currently is a considerable amount of manual intervention required to produce the reports.
- 67 More work is required to address overdue recommendations. The October 2024 update to the A&R Committee noted that a total of 111 Internal Audit, 21 Audit Wales and 71 HIW recommendations / improvement actions were overdue. The Corporate Governance Team and Executive Team are commencing a focussed programme of work to address this and will report progress to future A&R Committee meetings. Nevertheless, the Health Board should strengthen ownership and accountability amongst Executive Directors to secure sustained improvements in this area. **(Recommendation 6, 2024)**

Corporate approach to planning

- 68 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.
- 69 We found that **while the Health Board has an effective approach to developing corporate strategies and plans, it is experiencing challenges in progressing key elements of its long-term strategy. It also needs to strengthen its approach to monitoring and reporting strategy delivery and impact.**

Corporate approach to producing strategies and plans

- 70 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:
- a clear Board approved vision, appropriate objectives and a long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
 - the long-term strategy underpinned by an appropriate Board approved long-term clinical strategy;

- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

71 We found that **the Health Board has a generally effective corporate approach to producing strategies and plans and has produced a Welsh Government approved IMTP. However, its focus on addressing ongoing financial challenges in the short-term is impacting its ability to progress some strategic objectives.**

72 The Health Board continues to work towards delivering its long-term strategy – CTM 2030. During 2023-24, the Health Board progressed work on many key areas of the strategy including the development of the Llantrisant Health Park¹² and Maesteg Community Hospital¹³. However, the Board's steer and focus on achieving its target control total for 2023-24 (see **paragraph 90**), and addressing ongoing financial challenges during 2024-25 appears to be having some impact on the pace of delivering other key strategic objectives, such as providing the resources required to develop the Acute Clinical Services Plan. The new Strategy Development Committee will be critical in providing robust scrutiny and oversight of the Health Board's progress in developing and delivering its strategic plans.

73 The Health Board continues to have effective arrangements for preparing its 2024-27 Integrated Medium-Term Plan (IMTP). It uses a combined top-down and bottom-up approach where Care Groups and Corporate Directorates develop individual service plans aligned to the organisation's strategic objectives and policy / legislative requirements. The Health Board set up an Executive Steering Group to provide support and challenge to each Care Group during the development of their respective plans as part of preparation of its IMTP. The PP&F Committee and Board were fully involved in plan development, culminating in the Health Board producing a Welsh Government approved IMTP.

74 The process for developing wider corporate strategies and plans, such as the Strategic Equality Plan and Infection Prevention and Control Strategy 2024-27, is effective. Corporate strategies and plans are shared with Independent Members to provide feedback or are collectively discussed as part of Board Development sessions, or at various committees prior to receiving formal approval at public Board meetings. They are also discussed and shared with internal and external stakeholders to maximise input.

¹² The Llantrisant Health Park Programme aims to deliver a cutting-edge diagnostics and treatment centre.

¹³ Maesteg Community Hospital is being re-developed into a health, care and wellbeing hub.

Corporate approach to setting well-being objectives

- 75 We considered whether the Health Board has a sound corporate approach to setting its well-being objectives in accordance with the sustainable development principle¹⁴. We were specifically looking for evidence of:
- appropriate arrangements in place for setting well-being objectives which are underpinned by the sustainable development principle;
 - appropriate consideration given to how the organisation will ensure delivery of its well-being objectives; and
 - appropriate arrangements in place to monitor progress and improve how the organisation applies the sustainable development principle.
- 76 We found that **the Health Board has an appropriate corporate approach to setting well-being objectives. However, they need to be better aligned to national well-being goals and the well-being objectives of partners.**
- 77 CTM 2030 sets out the Health Board's long-term strategic objectives which are also its wellbeing objectives under the Well-being of Future Generations (Wales) Act 2015. The strategic / well-being objectives were shaped in line with the sustainable development principle and clearly articulate the Health Board's vision to become a population health organisation and 'anchor institution'¹⁵. They were developed and agreed by the Board following detailed research into population health and inequality and informed by extensive clinical and community exercises. Due consideration was also given to wider national policy such as 'a Healthier Wales', Values-Based Healthcare, and carbon net zero reduction.
- 78 The strategic / well-being objectives are cross cutting, future focussed and underpinned by the five ways of working. For example, the strategic / well-being objectives focussing on 'sustaining our future' and 'creating health', are underpinned by clear priorities for the Health Board. However, while CTM 2030 demonstrates alignment to the 'five ways of working', the Health Board's strategic / well-being goals have not been aligned to the seven national well-being goals or the well-being objectives of its partners. **(Recommendation 7, 2024)**
- 79 In paragraphs **72 and 82**, we comment on the Health Board's progress and arrangements for monitoring and overseeing delivery of CTM 2030 in the context of its more immediate challenges and priorities.

¹⁴ Under The Well-being of Future Generations (Wales) Act 2015, the Health Board is required to set and publish well-being objectives that are designed to maximise its contribution to achieving each of the well-being goals. Further information is available [here](#).

¹⁵ Anchor institutions are large organisations that are connected to their local communities and have a significant impact on their health and wellbeing. They are typically non-profit, public-sector organisations that are unlikely to relocate.

Corporate approach to overseeing the delivery of strategies and plans

- 80 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:
- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART¹⁶ milestones, targets, and outcomes that aid monitoring and reporting; and
 - the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.
- 81 We found that **whilst there are arrangements in place to enable the Board to oversee implementation and delivery of corporate plans, these could be strengthened further by developing clear outcomes measures for its key strategies and improving reporting on impact.**
- 82 While the Board receives routine updates on aspects of strategy delivery, the development of clear actions and outcomes measures for its high-level strategic objectives remains in progress. This work needs to be completed urgently to enable the Board to understand progress and clearly demonstrate delivery of CTM 2030 (see **Appendix 2 – 2022 Recommendation 4**).
- 83 The 2024-27 IMTP is appropriately aligned to CTM 2030 and sets out how the Health Board's strategy groups are used to deliver the key priority areas. While the 2024-27 IMTP delivery requirements are generally clear for year 1, milestones and targets for years 2 and 3 are less clear. The Health Board has also not formally set out Executive Director lead responsibilities for deliverables, which may limit appropriate accountability (see **Appendix 2 – 2022 Recommendations 5a and 5b**).
- 84 Quarterly IMTP progress reports are presented to the Board and PP&F Committee. The updates focus on the delivery of Care Group 'plans on a page' and the five Welsh Government ministerial priorities. Cover reports are narrative in nature and highlight progress and challenges, but are supported by detailed appendices setting out actions, and milestones for delivery. While there is reference to the Integrated Performance Dashboard in the report, there continues to be an opportunity to clearly link progress in delivering priorities to the Health Board's performance (see **Appendix 2- 2022 Recommendation 5c**). The Health Board also needs to develop an appropriate suite of population outcome measures to demonstrate the impact of its strategy delivery. (**Recommendation 8, 2024**)
- 85 During the year, the Board and committees received routine updates on wider corporate strategy and plan delivery such as the Strategic Workforce Planning and Mental Health and Learning Disabilities Strategic Work Programme. While these

¹⁶ Specific, measurable, achievable, relevant, and time-bound

provide sufficient information to demonstrate progress, they do not clearly articulate where delivery is off-track, mitigating actions, and revised delivery timescales. **(Recommendation 9, 2024)**

Corporate approach to managing financial resources

- 86 We considered whether the Health Board has a sound corporate approach to managing its financial resources.
- 87 We found that **financial planning, management, monitoring, and reporting arrangements are generally effective, but the organisation's focus on addressing its immediate financial challenges is presenting risks to the delivery of longer-term solutions to achieving financial sustainability.**

Financial objectives

- 88 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:
- the organisation meeting its financial objectives and duties for 2023-24, and the rolling three-year period of 2021-22 to 2023-24; and
 - the organisation being on course to meet its objectives and duties in 2024-25.
- 89 We found that **while the Health Board achieved its target control total in 2023-24 financial objectives, it faces risks to achieving its forecast breakeven position for 2024-25.**
- 90 The Health Board met its financial objectives for both revenue and capital expenditure in 2023-24, with additional in-year financial support from Welsh Government (some of which was conditionally recurrent and some of which was non-recurrent), which was provided to all health boards in Wales. However, because of a £24.5 million deficit in 2022-23, it did not meet its statutory financial duty to breakeven against its revenue resource limit over a three-year rolling period. Nevertheless, the Health Board's 2023-24 financial position represents a significant achievement and provides increasing confidence in its strategic financial management. This is likely to be a key factor that informed Welsh Government approval of the Health Board's 2024-27 IMTP. We note that the Health Board was the only health board in Wales to submit a balanced IMTP for 2024-27 that was subsequently approved by Welsh Government.
- 91 The Health Board forecasts a breakeven year-end position for 2024-25. However, the Month 6 2024-25 Finance update to the PP&F Committee in November 2024 highlighted a £3.3 million year-to-date deficit and significant risk that the forecast could deteriorate in the forthcoming months.

Corporate approach to financial planning

- 92 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:
- clear and robust corporate financial planning arrangements in place;
 - the Board appropriately scrutinising financial plans prior to their approval;
 - sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
 - the Board appropriately scrutinising savings and cost improvement plans prior to their approval.
- 93 We found that **the Health Board has a generally effective approach to financial planning in the short- to medium-term. However, the focus on achieving its financial objectives in the short-term poses risks to longer-term investment in sustainable services and models of care.**
- 94 The Health Board has a clear framework for developing its Financial Plan for 2024-27. Care Groups and Corporate Directorates, with the support of Finance Business Partners, submitted assessments of their underlying financial position and key investments, cost pressures, and savings opportunities. Initial submissions were scrutinised by Executive Directors, with further review undertaken by the Finance Team and Chief Operating Officer's Team. The Board approved the Financial Plan in March 2024 as part of the 2024-27 IMTP approval process.
- 95 The Health Board's ambition to continue to deliver a balanced financial position has led the Board to make difficult investment decisions. For example, it has been unable to invest in Stroke Services, which is encountering significant performance challenges. As mentioned in **paragraph 72**, addressing the financial position is also causing delays with the development of the Acute Clinical Services Plan, which is key to creating more sustainable models of care. While the Health Board has signalled potential opportunities for lower savings targets and higher levels of discretionary investment in years 2 and 3 of its 2024-27 IMTP, it will need to closely monitor and manage any immediate quality, performance, and longer-term financial sustainability risks that may arise. **(Recommendation 10, 2024)**
- 96 In 2023-24, the Health Board achieved its £27.4 million savings target. Despite this, our 2024 Review of Cost Savings Arrangements found that the Health Board now needs to initiate a more future orientated approach by focussing on service transformation to maintain its long-term financial sustainability. As at Month 6 2024-25, the Health Board reported achievement of £5.1 million savings which is £8.3 million below the year-to-date target of £13.2 million. Performance against savings targets continues to be scrutinised at the PP&F Committee and Board.

Corporate approach to financial management

- 97 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:
- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
 - the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
 - effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
 - the organisation's financial statements for 2023-24 were submitted on time, contained no material misstatements, and received a clean audit opinion.
- 98 We found that **the Health Board continues to have generally effective arrangements for overseeing and scrutinising financial management.**
- 99 The Health Board has a generally effective approach to overseeing and scrutinising financial management. The A&R Committee continues to receive good quality procurement and scheme of delegation reports which provide an overview of procurement matters (see **paragraph 22**). The reports also provide an update on changes to the Scheme of Delegation and Financial Control Procedures. The latest update to the A&R Committee in October 2024, indicated that there were still several Financial Control Procedures that are over their review date, and will be updated by the end of December 2024 (see **Appendix 2 - 2022 Recommendation 7c**). An Internal Audit review on Medical Variable Pay Agency Costs reported in September 2024 gave a reasonable assurance rating.
- 100 The Health Board continues to have good counter fraud arrangements. There is an agreed annual workplan and routine reports to the A&R Committee showing delivery against the plan.
- 101 The Health Board continues to have a good understanding of its cost drivers. The Financial Plan highlights risks including service and demand pressures, pharmacy costs, increasing commissioned activity, local investments, continuing healthcare, growth in staffing costs, and the Welsh Risk Pool. In addition, it acknowledges the wider contextual challenges facing the organisation including supply chain delays, and inflationary pressures. The Health Board continues to issue accountability letters to Executive Directors which set out requirements to manage the Health Board's financial position.
- 102 The Health Board submitted its draft 2023-24 Annual Report and Accounts within the required timescales. We issued an unqualified true and fair audit opinion, and a qualified regulatory opinion because the Health Board did not meet its revenue resource allocation over the three-year period.

Board oversight of financial performance

- 103 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:
- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
 - the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.
- 104 We found that **financial reports provide sufficient information to enable effective scrutiny and challenge and are clear on the impact of action taken to improve the financial position.**
- 105 The Health Board continues to have effective arrangements for reporting financial performance to the Board and PP&F Committee. Finance reports are tailored for both and provide sufficient information to enable scrutiny and challenge. Reports continue to highlight key financial risks and potential opportunities that may impact on the financial position and the impact of mitigating actions is reflected in the forecast position. (see **Appendix 2 - 2022 Recommendation 8a**).
- 106 Our observations found effective scrutiny and challenge from Independent Members on the Health Board's financial performance. We also note scrutiny and challenge on financial matters as part of wider Health Board business. For example, the spotlight presentation at the Q&S Committee meeting in September 2024 included questions around funding of the Rapid Assessment and Prevention Occupational Therapy service¹⁷.

¹⁷ The Rapid Assessment and Prevention Occupational Therapy Service is provided by a team that includes occupational therapists and other professional to assess and treat patients in the community, rather than in a hospital.

Appendix 1

Audit methods

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

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Public Board • Audit and Risk Committee; and • Quality and Safety Committee.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews

We interviewed the following Senior Officers and Independent Members:

- Chief Executive Officer;
- Chair of the Health Board;
- Vice Chair of the Board;
- Chair of the Audit and Risk and Planning, Performance and Finance Committees;
- Chair of the Quality and Safety Committee
- Director of Corporate Governance (Board Secretary)
- Assistant Director of Governance and Risk
- Executive Director of Finance
- Executive Director of Nursing, Midwifery and Patient Care
- Executive Director of Strategy and Transformation
- Executive Director of Public Health

Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports.

Recommendation	Description of progress
2018 Recommendation 6 The audit recommendation tracker should be expanded to include the recommendations of other external agencies e.g., Healthcare Inspectorate Wales and the Delivery Unit.	Complete – see paragraph 66
2022 Recommendation 1 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:	

Recommendation	Description of progress
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; d) update presentation cover sheets to enable authors to summarise the information sufficiently and capture the relevant risks and issues.	Complete – see paragraph 9 In progress – see paragraph 8 No progress – see paragraph 12
2022 Recommendation 3 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.	Complete – see paragraph 55
2022 Recommendation 4 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	In progress – see paragraph 82

Recommendation	Description of progress
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.	
2022 Recommendation 5 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.	No progress – see paragraph 83 No progress – see paragraph 83 In progress – see paragraph 84

Recommendation	Description of progress
2022 Recommendation 7 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: c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions.	In progress – see paragraph 99
2022 Recommendation 8 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.	Complete – see paragraph 105
2022 Recommendation 9 There is limited capacity within the Health Board to fully deliver its digital transformation agenda. The Health Board, therefore, should seek to set out in its refreshed Digital Strategy how it intends to overcome staffing and funding challenges to fully exploit the benefits offered by digital technologies and solutions.	We will undertake an assessment of the Health Board progress against this recommendation as part of our digital deep dive in 2025.

Recommendation	Description of progress
2022 Recommendation 10 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; 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.	Complete – see paragraph 29 Complete – see paragraph 28
2023 Recommendation 1 Whilst the Health Board meets in public, it is not clear how members of the public can request to attend these meetings in person. The Health Board, therefore, should provide clear guidance on how members of the public can request to observe public Board meetings in person.	Complete – see paragraph 13
2023 Recommendation 2 The Health Board makes good use of videos in committee meetings to present patient and staff stories. However, they are not subsequently made available on the Health Board's website. The Health Board, therefore, should ensure that any videos shown during committee	In progress – see paragraph 15

Recommendation	Description of progress
meetings are made available on its website for completeness with agreement of the contributors.	
2023 Recommendation 3 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.	No progress – see paragraph 17
2023 Recommendation 4 Whilst the Board and committees review and confirm the minutes of previous meetings, they are not always uploaded to the Health Board's website in a timely manner. The Health Board, therefore, should ensure that all confirmed minutes are uploaded to the relevant section of its website in a timely manner to ensure the public have full access to the approved records of meetings.	In progress – see paragraph 17

Recommendation	Description of progress
2023 Recommendation 5 Whilst the Health Board has a dedicated area on its website for policies and procedures, some of them are out of date. The Health Board, therefore, should ensure that all policies and procedures on its website are up-to-date and, if not, put a clear plan in place to revise and approve them.	No progress – see paragraph 24
2023 Recommendation 6 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.	No progress – see paragraph 54

Appendix 3

Management response to audit recommendations

Exhibit 4: Cwm Taf Morgannwg University Health Board response to our audit recommendations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)



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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response form



Report title: 2024 Structured Assessment

Completion date: 23rd January 2025

Document reference: 4579A2024

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should strengthen arrangements for monitoring, reviewing and updating Health Board policies and routinely report progress to the relevant Committee of the Board.	A detailed Project Initiation Document for a review of Non-Clinical Policy Management process has been developed. The project objectives are: 1. To establish a baseline compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined i.e. policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage.	31 December 2025 <i>It is anticipated that this programme of work will commence in January 2025 and conclude at the end of the calendar year</i>	Director of Corporate Governance / Board Secretary.

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		4. To review the policy pages on the internal and external websites to ensure ease of access for users when searching for documents. 5. To review the “Policy on Policies” and develop a simplified document supported with clear process maps. Progress on the Project will be monitored via the Executive Leadership Group. Once completed this will generate improved monitoring through the appropriate Board Committees.		
R2	The Health Board should introduce arrangements for identifying and monitoring actions arising from its listening and learning stories.	Any actions from Listening & Learning stories shared at Board & Committee meetings should be identified, monitored and completed prior to the Listening & Learning story being shared presented however, monitoring of any actions following the presentation of Listening & Learning	31 st March 2025	Executive Director of Nursing, Midwifery & Patient

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		stories at Board & Committee will be presented through the Care Groups QSRE groups and/ or the Patient Experience forum. The governance process for any actions arising from the presentation of these stories is currently being worked through. As this will be a new revised arrangement, with this work being in its infancy, a full review of the required governance arrangements will be undertaken for assurance. The Health Board will ensure that staff stories to inform Board members on Staff Experiences are included within the library of Listening & Learning stories being built up for wider sharing, this work will be monitored through the Patient experience Forum.		Care/Deputy CEO
R3	The Health Board should strengthen the Board Assurance Framework (BAF) by clearly reporting the impact of actions that	In order to clearly articulate the impact of actions an additional section will be added to the	31 March 2025.	Director of Corporate

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	the Health Board is taking to mitigate its strategic risks.	mitigating action of the Board Assurance Framework to clearly capture the impact.	<i>As the January iteration is already in the process of being updated this will take effect for the March iteration.</i>	Governance / Board Secretary.
R4	The Health Board should strengthen its Integrated Performance Dashboard by clearly articulating whether actions to improve underperformance are achieving their intended impact.	The performance report narrative will be stripped back to focus on remedial action and their impact, then updates on impact.	31st March 2025	Executive Director of Strategy and Transformation
R5	The Health Board should strengthen its reporting on the Duty of Quality and Candour by: R5.1 ensuring that future annual reports are clearer around the challenges it is	5.1 Future Annual Reports will include details in respect of the health board reporting mechanisms and in particular include clear narrative around the challenges experienced in embedding the requirements.	31 st May 2025 (to align with the required publication of the Quality & Safety Annual Report)	Executive Director of Nursing, Midwifery & Patient Care/Deputy CEO

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	experiencing in embedding the requirements; and R5.2 including appropriate milestones and targets to help the reader understand when it is aiming to achieve priorities.	5.2 Appropriate milestones will be included following the clarification of the required targets to help the reader understand the aim of the priorities.		
R6	The Health Board should: R6.1 ensure that it rapidly completes its work to strengthen the audit recommendations tracker; and R6.2 strengthen ownership and accountability for delivery of audit recommendations.	R6.1 The process for updating audit recommendations will fully transition to the automated system, AMaT, by the end of March 2025. There remain system enhancements and automated report improvements that the Quality Assurance & Compliance Team are linked in with the software provider on to take forward, however it is anticipated this activity may not be completed until the end of July 2025.	31 March 2025 Circa 31 July 2025, this date has interdependencies with the software provider so is subject to change.	Director of Corporate Governance / Board Secretary.

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		Audit Handbook also being developed to support colleagues with their understanding of the audit process and various stages that require compliance. R6.2 The following processes have been implemented to strengthen ownership and accountability of audit recommendations to support the proactive management and closure of actions: • Regular meetings established with Business Managers to discuss progress against recommendation actions. • Performance is reported to the Executive Leadership Group in terms of compliance with timescales for returning management responses and action completion dates. • Director of Corporate Governance / Board Secretary is reviewing the audit tracker and meeting with Executive Leads to ensure all actions remain current and accurate and will	28 February 2025 Complete. This is now implemented as business as usual activity so it is suggested that this recommendation is complete as it will be ongoing action. Improvement will be monitored via the Audit, Risk & Assurance Committee and through future Structured Assessment reviews.	

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		liaise with audit colleagues should there be any challenge to continued applicability. • The Corporate Governance Dashboard received at the weekly Executive Leadership Groups has specific items on Audit reviews to flag where any management responses have been issued and identifies any areas of concern. • Performance dashboard now included in the Audit Tracker report to the Audit & Risk Committee that identifies the areas of concern and limited progress. This report is also received at the Executive Leadership Group.		
R7	The Health Board should set out how each individual well-being objective aligns to the national well-being objectives and well-being objectives of its partners.	The wellbeing objectives are currently embedded throughout the CTM 2030 strategy as cross cutting themes in each programme. However we acknowledge that it would be beneficial to clearly set these out separately.	December 2025	Executive Director of Public Health

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		In order to demonstrate how the wellbeing objectives map across to the national objectives and those of our partners, a task and finish group will be established in March to develop this work. A report will be produced that sets out our wellbeing objectives and our progress against them, from which we can monitor progress annually. This will be reflected in a written output which will allows stakeholders to access current information.		
R8	The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	As part of the work overseen by the Creating Health Programme Board, the development of a data dashboard to monitor and report on population outcome measures is underway. To make this reporting meaningful however, both strategic and operational data sets will need to be developed using data from a number of different internal and external resources.	Initial meeting with PHW and CTMUHB to discuss the options around accessing the required data is planned for 10/01/25. After this a draft timeline for options and	Executive Director of Public Health

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		In addition to this, CTMUHB are working with the PSB to develop a data dashboard with Data Cymru and close collaboration with Swansea and NPT PSBs. Once developed, this will provide an up to date dataset across the well-being themes with around 150 indicators	system development can be produced. Timelines for PSB dataset to be confirmed	
R9	The Health Board should strengthen Board and committee corporate strategy and plan reporting by clearly articulating where delivery is off-track, mitigating actions, and revised delivery timescales.	There are three components to CTM 2030: -Building Healthier Communities – this reports in to the new Strategic Development Committee (SDC) and activities will be clearly set out with timelines and outputs (many of the outcomes of this work is expressed in decades) -Integrated community and primary care – a specific plan that will report to Operational Deliver Committee (ODC) with clear timelines and performance metrics.	30 April 2025 30 April 2025	Executive Director of Strategy and Transformation

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		-Acute Clinical Services Plan – the detail of this will be developed over the next 18 months through a process of systematic public engagement.	30 September 2026 <i>This will take time to develop and we also need to be mindful of the May 2026 Senedd election and the period leading up to that election.</i>	
R10	The Health Board should: R10.1 monitor and manage any immediate quality and performance risks that may arise as a result of limited or no investment in services as it seeks to achieve financial balance in the short-term; and	The Quality Governance Team will review the Quality Impact Assessment (QIA), learning from its recent use in the response to the POWH Critical Incident, to ensure that any improvements are addressed and that QIA's are routinely completed where there is a risk to quality and performance where investment in services is impacted. Consideration will also be given to how such instances routinely escalate through the appropriate stages of the Quality Governance Framework.	30 June 2025	Executive Director of Nursing / Deputy Chief Executive Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	R10.2 develop a long-term financial plan, beyond its 2024-27 Integrated Medium-Term Plan, aligned to its organisational strategy in order to achieve financial sustainability.	The health Board recognises the need to develop a long-term plan, aligned to our organisational strategy, and underpinned by a long-term financial model.	30 September 2026 <i>Developing the long-term financial plan cannot be done in isolation and needs to be properly aligned to other aspects</i>	Executive Director of Finance

Cwm Taf Morgannwg University Health Board

Outline Audit Plan 2025

Audit year: 2024-25

Date issued: January 2025

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

About Audit Wales

Our aims:

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

Our ambitions:



Fully exploit
our unique
perspective,
expertise and
depth of insight



Strengthen our
position as an
authoritative,
trusted and
independent
voice



Increase our
visibility,
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Be a model
organisation for
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Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend to share a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends to undertake to address the audit risks identified and other key areas of audit focus during 2025.



Adrian Crompton
Auditor General for
Wales

My audit responsibilities

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 will be reported to you in my Detailed Audit 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 Whole of Government Accounts.

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.

Fees and audit team

In January 2025, I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates. My fee rates for 2025-26 have increased by an average of 1.7% because of unavoidable inflationary pressures.

I will provide an estimate of your fee in my Detailed Audit Plan in May 2025, following completion of my detailed risk assessment.

Your engagement team:

Dave Thomas	Engagement Director & Audit Director (Performance Audit)
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We confirm that our audit team members are all independent of the Health Board and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

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- Structured Assessment, incorporating a deeper dive into estates management.
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- In terms of local project work, my early planning work suggests there would be value in following-up the recommendations I made in my 2011 and 2016 Review of Consultant Job Planning. However, my planning work might also highlight other areas worthy of review. Therefore, the exact focus of my local project work will be confirmed in my detailed Audit Plan in May 2025.

Timescales for individual projects will be discussed with you and detailed within the specific project briefs produced for each study.

Audit quality

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I 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.

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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

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- EQCRs
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Agenda Item

6.1.3

Unapproved / Minutes of the Audit & Risk Committee

Date and Time of Meeting	Tuesday 17 December 2024 at 10:00 am
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member (Chair)
	Kath Palmer	Health Board Vice Chair/Independent Member
	Ian Wells	Independent Member
In Attendance	Geraint Hopkins	Independent Member (in-part)
	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
	Nathan Couch	Audit Wales
	Mark Jones	Audit Wales
	David Murphy	Audit Wales (in part)
	Eifion Jones	NWSSP
	Owen James	Head of Corporate Finance
	Matthew Evans	Local Counter Fraud Officer (in-part)
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Emma Walters	
	Kathrine Davies	Corporate Governance Manager/Meeting Secretariat
Meeting Observers	Kelly Eddington	Quality Assurance & Compliance Officer
	Claire Brown	Head of Quality Assurance & Compliance
	Donna White	Senior Finance Manager, Planned & Unscheduled Care

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were



	also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how the meeting went.
1.2	Apologies for Absence
	Apologies were received from: • Dom Hurford – Executive Medical Director (Sallie Davies, Deputising) • Steve Sark – Audit Wales
1.3	Declarations of Interest
	No declarations were identified.
2.	CONSENT AGENDA BUSINESS
2.1	Items for Approval
2.1.1	Unconfirmed Minutes of the meeting held on 17 October 2024
Resolution	The minutes were APPROVED as an accurate record.
2.1.2	Unconfirmed Minutes of the In Committee meeting held on 17 October 2024
Resolution	The In Committee minutes were APPROVED as an accurate record.
2.1.3	Ratification of Chairs Urgent Action - Charitable Fund Financial Control Procedure (FPC) and Update of the Scheme of Delegation
Resolution:	The Chairs Urgent Action was RATIFIED by the Committee.
2.2	ITEMS FOR NOTING
2.2.1	Audit & Risk Committee Annual Cycle of Business 2024-25
Resolution	The Annual cycle of Business was NOTED .
2.2.2	Audit & Risk Committee Forward Work Programme
Resolution	The forward work programme was NOTED
2.2.3	Declarations of Interest and Gifts & Hospitality Report
Resolution	The Report was NOTED .



2.2.4	IA Report - PCH Management Actions Follow Up
Resolution	The Report was NOTED .
3.	MAIN AGENDA
3.1	GOVERNANCE
3.1	Audit & Risk Committee Action Log G. Watts presented the Action Log and provided an update on the following: - Action 2.1 – Business Sensitive Risks – G. Watts advised that the Chair had raised a query at the last meeting in relation to the scoring of those risks and advised that he had met with the Assistant Director of Governance and Risk who has reminded colleagues to ensure that they provide appropriate supporting narratives to explain any changes to risk scores. In relation to the Digital & Data risks G. Watts advised that the Assistant Director for Digital Delivery was currently undertaking a review of all risks in that area so the focus and detail of those risks would also be likely to be updated in the coming months. - With regard the Actions 3.1 and 6.1 in relation to the Committee Referral to the People & Culture Committee that item was on the CLOSED In Committee agenda to be discussed today. G. Watts advised that the risk 5.2 in relation to the Audit Tracker would be discussed under the Audit Tracker item on the agenda. Resolution The Committee DISCUSSED and NOTED the action log.
3.2	Matters Arising not contained within the Action Log
Resolution	There were no matters raised.
4.	SUSTAINING OUR FUTURE
4.1	Local Counter Fraud Report M. Evans presented the report that provided detail on tasks and actions undertaken with the four strategic counter fraud work areas. M. Evans drew the Committee's attention to one of the closed cases that related to a dispensing practice that had been reassessed following a recent referral and advised that he would keep the Committee sited on this case and suggested that he bring an update report back to a future meeting of the Committee. K. Palmer thanked M. Evans for his report which was clear and easy to understand and provided assurance. K. Palmer commented that she was pleased to hear about the awareness and targeting staff and that it would be good to have an update on that at some point in the future. K. Palmer suggested that it would helpful if these key matters could be put into the risk section of the report so that Members were aware prior to the meeting.



	The Chair referred to the cases status and rates on page 2 that had changed from last month and suggested that it would be helpful if they could have the previous month's figure in brackets to compare the changes and see the movement of the rate. The Chair referred to the open cases and suggested that any new update could be flagged by a different colour so that they would only need to read the new narrative. The Chair advised that the Outcome of the Committee Referral to People & Culture Committee arising from the previous Counter Fraud report would be received at the Closed In Committee session.
Resolution	The report was NOTED .
Action	To bring an update to a future meeting of the Committee on the long standing case with regard to the dispensing practice.
Action	To add any key items to flag to the risk section of the report so that members are aware prior to the meeting.
Action	To flag any changes to the open cases with a different colour so that Members can easily see the changes.
4.2	Losses and Special Payments Report S. May presented the report that provided the Committee with an update on the losses and special payments made by the University Health Board (UHB) for the three-month period from 1 July 2024 to 30 September 2024, as required by the Standing Financial Instructions. S. May drew the Committee's attention that any potential overspend by the Welsh Risk Pool would need to be shared amongst NHS organisations and could present a financial risk. However, at the time of reporting they were projecting the value to be on budget for 2024-25 so not flagging as a financial risk into the financial position currently but would continue to monitor this. The Chair commented that the report was getting more detailed which was helpful and particularly the red, amber and green boxes in relation to the Welsh Risk Pool submission.
Resolution	The Committee NOTED the losses and special payments made for the period 1 July 2024 – 30 September 2024.
4.2	Procurements and Scheme of Delegation Report O. James presented the report and highlighted the position on procurement matters for the period 1st August – 30 November 2024. K. Palmer referred to the outstanding invoices on hold and raised concern that this could impact on other businesses as well as cash flow and advised that these needed to be monitored closely and perhaps flagged up with the Executive



Team to raise awareness. S. May advised that the re-issuing of PO's was not working as smoothly as it could be and something that needed to be looked at from a procurement perspective.

O. James advised that there were elements from all sides to get it right in that requisitions, approvals and receipting were undertaken in a timelier manner and procurement sorting out issues when they are raised more quickly and challenging invoices on hold. O. James added that he had raised these matters with the procurement team and there had been improvement on an all-Wales position since January. There were five supplier that were holding up the No PO No Pay and they would be working with those suppliers to clear the invoices off.

Regarding the outstanding invoices on hold, O. James advised that they do meet the PSP target of 95% volume of invoices paid to suppliers and, a number of them were probably being dealt with in another way so there was a bit of a cleansing exercise to be undertaken. O. James advised that the volume of the invoices paid each month ran into the thousands.

S. May, in response, advised that many of the invoices tend to be low value such as the water coolers and there was work ongoing with that regard with procurement and the transition team and also messaging out to ensure that requisitions and POs were paid promptly. S. May added that she was not seeing so many issues where individuals were trying to raise requisitions on other people's budgets and that position had improved.

O. James informed the Committee that the team would be sending out a targeted approach on the requisitions and POs to get the top worst offenders and their managers advising that they are experiencing issues and offering them further training with Oracle and receipting. This would also be reiterated within the staff newsletter in January.

The Chair referred to the No PO no Pay and queried whether those organisations were contacted. O. James confirmed that they were informed and a notification would go out automatically to them reiterating the policy.

The Chair referred to the waivers and reasons being follow up work and compatibility and queried at what point does the follow up cease to become a waiver and a line drawn between.

S. May confirmed that in terms of 1,2 and 3 which were all strategy and planning and ADHD post autism diagnosis work that work that was first initiated in the previous financial year, the reasons were queried heavily and assurance was received that should be any future funds they would be undertaking an appropriate exercise to secure a longer-term partner. S. May advised that this would change once the new procurement regulations come into force from the end of February 2025.

S. May advised that with regards the maintenance contracts, that had been an issue as they had called for expressions of interest in the community as part of the Princess of Wales Hospital (PoW) roof change and emergency decant and



	this was the only provider who had responded at that point. The Chair, in response, advised that she fully anticipated the table to increase in size due to the PoW issues but it was just about the line on what is follow up and what is not.
Resolution	The Committee; APPROVED the updated FCPs • NOTED the position on procurement matters for the period 01.08.2024 to 30.11.2024; • NOTED the update regarding Purchase to Pay and achievement of PSPP target up to Month 7 of 2024/25;
5.	IMPROVING CARE
5.1	Organisational Risk Register G. Watts presented the Report report and highlighted key updates to members. G. Watts advised that ongoing training had been extended to the NHS Wales Joint Commissioning Committee (JCC) colleagues and ongoing conversations were being held with Care Group leaders, training them in risk which was continuing to see improvements with quality and consistency. G. Watts advised that this was the November iteration of the Risk Register with the next iteration being January 2025. I Wells referred to risk 5417 in regards to paediatric dentistry which was concerning and sought an update on this. G. Watts advised that he would pick this up with the Chief Operating Officer outside of the meeting and provide an up-to-date position. K. Palmer, in response, commented that she was going to raise the same concern and that the risk had been increased which showed that it had been reviewed. She added that it had been an issue prior to the Princess of Wales Hospital (PoW) problems and it would be helpful to see some timescales and a plan of action due to the volume of children waiting. The Chair referred to the corporate governance risk on sustained effective policy management and process that had been escalated and queried whether there was a policy register in place within CTM. G. Watts advised that there currently not anything substantial in place and it had been recognised by the team that this was something that required further discipline with version control on policies coming up for review, however, the team have very limited resources currently in terms of capacity but would be looking to review this in the near future. G. Watts advised that he would bring an update back to the Committee on how they were managing and addressing this and was hopeful that they would have the Committee's support in taking forward this significant piece of work.
Resolution:	The Committee NOTED the report.



Action:	To request an update on risk 5417 outside of the meeting and provide an update.
Action:	To bring an update back to the Committee on the corporate governance risk in respect of policy management.
5.2	Audit Recommendations Tracker G. Watts presented the report to the Committee which outlined the progress of implementing audit report recommendations and actions in the revised format following transition to an automated system using the Audit Management and Tracking (AMaT) inspection module. G. Watts extended his thanks to C. Brown and K. Eddington in the Quality Compliance and Assurance Team for the huge amount of work they were undertaking in developing the tracker and the transition to the new AMaT system. G. Watts advised that there were lots of data and graphics within the report which was difficult to read in terms of the amount of work they were managing. G. Watts added that the work was very much underway but would take some time before they realise the benefits. G. Watts advised that the team were working with the Chief Operating Officer (COO) on the outstanding recommendations for the directorate that he was responsible for and that included the 57 overdue internal audit recommendations which he had reviewing. G. Watts added that it was a lengthy but important process and he would be meeting with the COO and his Business Manager again in the new year so that they could support him with their views and to make a sense check of the recommendations and he was confident that some of those recommendations could then be removed. G. Watts advised that he would also be working closely with internal audit colleagues on this also. G. Watts added that he hoped that the Committee would have a more positive report when they meet in February. K. Palmer advised that she could see the huge amount of progress and queried whether they prioritised the overdue actions and that it would be helpful if they could see some narrative on those so that they could get some assurance that good progress was being made. K. Palmer welcomed the joint working with internal audit colleagues and their support in getting to a manageable and reasonable position. I Wells referred to previous iterations where the tracker would have an up-front visual on who was accountable and where those actions derived from and he asked if they could be put back in. G. Watts advised that they had sanitised the tracker due to the size of it, however, once the tracker becomes more manageable, they would be able to provide this detail.



	The Chair raised a minor concern in that she was unable to read this unless she enlarged it, but then lost the left-hand column and queried whether this could be looked at. The Chair referred to the actions that were waiting for approval and queried whether this was internal or for the Audit and Risk Committee to approve. G. Watts clarified that it was for the Executive and Management to approve and for the Committee to take assurance of and pose any questions that they may have.
Resolution	The Committee NOTED the Report and AGREED the assurances provided.
Action	To include the feedback received for the next iteration of the Tracker
	INTERNAL AUDIT
5.3	Internal Audit Progress Report P. Dalton presented the progress report that provided the Audit & Risk Committee with the current position of the work undertaken by Internal Audit. K. Palmer commented that it was helpful to hear about the new standards and she queried whether they were proposing to have an action plan on the changes for the Committee to have more clarity. P. Dalton advised that they had been looking at this to see what the changes were. The key things were in relation to reporting and material areas of change. He added that most of the other changes they were already doing and were more prescriptive in nature. K. Palmer, in response, suggested that an update at the next meeting would be helpful, particularly with regards to audit and strategy. P. Dalton advised that the new standards come into force from the 1st January 2025, the guidance and practice notes for organisations were issued last Friday and they would be working through that in time for the next meeting. The Chair advised that the she had commented in the Hosted Bodies meeting that the format of the report was much clearer. P. Dalton referred to section 4 and the performance measures and metrics which were all showing as green which was positive. However, table 4 was reflecting that work was quite slow currently, due to engagement and the planning stages. P. Dalton advised that they were working with the Corporate Governance team and the COO, holding monthly meetings with his senior team. The Chair advised that this had been discussed in the private meeting with the Auditors held earlier where it had been stated that there clearly was a problem in gathering information which was disrupting the workflow of audit, not around the accounts but the internal audit and audit Wales work. The Chair added that once the Director of Corporate Governance was no longer involved, they would need to find a way of unblocking the delays and ensuring that responses are made in a timely manner rather than continually pushing things back and clearly something that would need to be managed robustly.



	K. Palmer commented that on reading through the internal audit papers she had picked up on the delays and wondered how this was cascaded down through the teams to support the external and internal audit work. G. Watts, advised that as P. Dalton had alluded to, they had seen progress in getting responses back and he also raised this at Executive Leadership Group each Monday through the Corporate Governance Dashboard. G. Watts added that once they were in a better position with the outstanding recommendations they would have a complete reset, working with internal audit. The Chair suggested that it would be helpful if internal audit could keep a diary of what has and hasn't been chased so that there are real examples of what could be used to expedite. K. Palmer sought clarity on whether there was a risk of not achieving the internal audit programme for the year if they did not see any measured progress in engagement and the Executive Team should be made aware of this if there was. In response, P. Dalton advised that they did have a communications process that they were logging and raising with the Director of Corporate Governance. Looking at the year-end as it stood currently, they were hopeful that they would achieve the internal audit programme, so there were no concerns but this was with a caveat that they did need that engagement and momentum to deliver. I Wells referred to the clinical coding review where it had stated that Digital Health Care Wales (DHCW) had undertaken work in this area. E. Samways advised that when they undertook the planning for this year's programme and started to scope the work it had been established that DHCW had already completed an annual review on the accuracy of the clinical coding data so they had felt that they would only have repeated DHCW's work in this area. E. Samways confirmed that they have put it to defer and would be having a discussion with the Director of Digital to see if there was something they could do as part of the 2025-26 internal audit plan.
Resolution:	The report was NOTED
5.3.1	IA Review – Energy Management E. Jones presented the report which has been given a 'Reasonable' Assurance rating. The Chair queried whether this fed into the year-end report that all Health Boards and Trusts were required to do on energy usage and waste. E. Jones confirmed that it was contained within the estates and facilities performance management system (EFPMS) report that provides assurance that this is being captured and fed back as accurate on an all-Wales basis.
Resolution:	The Committee NOTED the report.



5.3.2	IA Review – Additional Medical Pay E. Samways presented the report which has been given a 'Limited' Assurance rating. S. Davies extended her thanks to the team who had undertaken a lot of work over the last 18 months in terms of medical additional pay and work was underway putting in those procedures to rectify the situation. The Chair commented that there was a huge amount of work to complete by February 2025 given the winter pressures and the issues at PoW and queried whether they would end up on the Audit Tracker as missed dates. S. Davies advised that a lot of the work had already commenced before the audit and some of this was falling on colleagues within the People Directorate, she confirmed that she would have a further discussion with them as to whether or not it was realistically achievable and would feedback to the Committee following this. S. May commented that whilst she agreed that they need to be realistic about implementation dates there should also be some learning and recognising that some of this should have been in place when they implemented the system, particularly around 'Patchwork' as there were some significant weaknesses associated with the way things were implemented and addressing this was quite urgent not only from a financial perspective but from a control perspective.
Resolution:	The Committee NOTED the report.
Action	To discuss the February 2025 timescales with colleagues from the People Directorate and update the Committee following this.
5.3.3	IA Review – Charitable Funds E. Samways presented the report that had received a 'Reasonable' Assurance rating. I Wells commented that this was a good audit report and pleasing to see the plan and strategy to the investments in Objective 4.
Resolution:	The Report was NOTED .
5.3.4	IA Report – Estates Verbal Update The Chair advised that she had received a briefing from the Director of Corporate Governance on the long outstanding Estates internal audit report and sought an update from internal audit colleagues to provide some background to the report, what the issues were and when would they be likely to see and finalise this piece of work. E. Jones confirmed that they had undertaken the estates conditional review in the summer of 2023 which was part of a wider piece of work where they were undertaking an audit across NHS Wales. The draft report was issued in October 2023 where the findings were similar to the work undertaken across NHS Wales. However, in concluding the report they were not able to reach agreement on



	the recommendations and this was down to some factual accuracy on the scope. E. Jones advised that to date they have had some information through but were waiting for a more comprehensive response. With regard to the disagreement on the recommendations they were happy to consider any suggestions and amend the report, if appropriate. S. May, in response, advised that the original scope agreed for the audit had differed and had been queried due to the fact that they had not been aware that they were going to have same audit across all the Health Boards and that there was an issue with the recommendation that stated there was 'Limited' assurance because they would not have enough funding to cover the backlog as it currently stood at £108m and there was also an issue with the suggestion that they were required to undertake very expensive facet surveys. S. May advised that the revised report was currently with the Assistant Director of Assistant Director of Planning, Capital and Estates who is currently very stretched with the PoW issues. S. May confirmed that they would have a final round of what they can agree but she was not sure if this was a valuable audit in her view due to them not having the £108m required. The Chair commented that it was important that the Committee had been made aware of the situation and would look forward to receiving the update when ready and in the meantime if they could look at the scope to ensure that the recommendations were in line that would also be helpful.
Resolution	The Committee NOTED the verbal update and discussion.
5.4	Audit Wales - Audit & Risk Committee Update M. Jones presented the report. M. Jones advised that the work on the Charitable Accounts for 2023-24 was currently ongoing and on track to be completed by the end of this week and would be presented to the Board on the 30th January 2025 with certification by the Auditor General Wales on the 31st January and then sent to the Charity Commission. M. Jones advised that he wanted to flag that with regard the 2024-25 Annual Report and Accounts of the Health Board, the deadline for certification was being brought forward by two weeks to the 30th June 2025 rather than the 15th July, however, the timetable for preparation of the accounts was unchanged. M. Jones advised that he would write to the Corporate Governance outlining this. G. Watts referred to the audit of the accounts and advised that he had received correspondence from Welsh Government with regards the Joint Commissioning Committee (JCC) and the fact that there was now an Accountable Officer for propriety and regularity and what it might mean for the accounts and whether Audit Wales were engaged in those discussions and aware in relation to the governance statement. M. Jones advised that they had met with the JCC, CTM and O. James, Head of Corporate Finance, discussing the arrangements that



	were specific to CTM and it had been agreed that the template account would be effectively the same as last year with some additional columns in some of the primary statements but with an additional memorandum which would provide more information on the JCC balances. S. May advised that there was a requirement to be clear within the accounts in discharging that Accountable Officer responsibility and that this would need to be raised with Welsh Government for guidance. M. Jones advised that the JCC Accountable Officer letter had been issued within the last month and signed by the Chief Commissioner. M. Jones added that CTM had asked for clarity in relation to the Accountable Officer within the accounts in relation to what sat with the JCC or CTM. G. Watts, in response, advised that they would require clarity in regard to the Governance Statement and whether there would be any implications in terms of having an Accountable Officer letter and it was the expectation of CTM that there would be a more detailed segmentation report.
Resolution:	The Report was NOTED .
Action:	No action was identified
5.4.1	Audit Wales Report - Primary Care Follow Up Review N. Couch presented the report that provided an overview of the review following the previous 2018 review. G. Hughes commented that in the main it was a positive report, they had put significant investment around the transfer of the resource with the CTM Hospital at Home Service and had established a Primary Care Transformation Committee which was Chaired by the Chief Executive and were also targeting the shift in relation to activity. G. Hughes also added that in terms of the new primary care structure and the new posts put into place, the benefits of this were now being felt within the team.
Resolution:	The report was NOTED .
5.4.2	Audit Wales Report - Review of Cost Savings Arrangements - Final Management Response D. Murphy presented the report. The Chair referred to the long-term savings and advised that it was important that they were undertaking the service changes not just to save money but for the clinical benefit and clinical changes within the Plan which ultimately will be more efficient from a financial perspective.
Resolution	The report was NOTED .
6.	CLOSE OF BUSINESS
6.1	Any Other Urgent Business There was no urgent business to report.



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

Agenda Item

6.1.2

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

Date and Time of Meeting	Tuesday 17 th December 2024 @ 13:00pm
Venue	Virtual via MS Teams

Members Present	Patsy Roseblade	Independent Member (Committee Chair)
	Kath Palmer	Vice Chair of CTMUHB
	Ian Wells	Independent Member
In Attendance	Gareth Watts	Director of Corporate Governance / Board Secretary
	Sally May	Executive Director of Finance
	Matthew Evans	Local Counter Fraud Specialist
	Sallie Davies	Deputy Executive Medical Director
	Donna White	Senior Finance Manager - Planned & Unscheduled Care
	Paul Dalton	Head of Internal Audit
	Emma Samways	Deputy Head of Internal Audit
	Mark Jones	Audit Wales – Finance Audit Lead
	Nathan Couch	Audit Wales – Performance Audit Lead
	Cally Hamblyn	Assistant Director of Governance & Risk (Meeting Secretariat)
Meeting Observers	None	

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions P. Roseblade, Committee Chair welcomed everyone to the meeting.
1.2	Apologies for Absence Apologies for absence were received from: Geraint Hopkins, Independent Member (Local Authority)
1.3	Declarations of Interest There were none to declare.



2. MAIN AGENDA	
2.1	Organisational Risk Register (Business Sensitive Risks) G Watts presented the Organisational Risk Register noting that there were no substantive changes to the business sensitive risks captured in the report. The Committee were advised that the Digital & Data Directorate are currently reviewing their risks and are linked in with the Assistant Director of Governance Risk as appropriate for any guidance or support. Resolution: The Organisational Risk Register was DISCUSSED and NOTED. Action: None identified.
2.2	Financial Controls Procedure - Medical Variable Pay – Summary of Authorised Breaches S Davies presented the report which provided a summary of all approved rates up to and above 10% of the Additional Duty Hours (ADHs) and agency rate cards for each Care Group relating to, 1st August 2024 to 31st October 2024. S Davies assured the Committee that there is a Financial Control Procedure (FCP) which sets out a clear authorisation process where there is a request for any rates up to and over 10% outside the ADH and agency rate cards. She further noted that there is a 'Medical Workforce Productivity Programme: Performance and Escalation Group' (MWPP: PEG) which scrutinises the metrics and explores the rationale for any overpayments within Care Groups and considers mitigation and longer-term resolutions. In concluding this item, the Committee explored whether further reports of this nature require visibility by the Committee or whether it is appropriate for scrutiny to be managed solely by the MWPP: PEG. Following advice from S May, S Davies advised that she revisit the FCP and consider what is appropriate from an assurance perspective and revert to the Committee with a recommendation. Resolution: The report was NOTED. Action: S Davies to revisit the FCP and consider what is appropriate from an assurance perspective as to the continuing visibility of this activity at the Audit & Risk Committee.
2.3	Outcome of the Committee Referral to People & Culture Committee – Recruitment Process Assurance M Evans presented the report noting that the review of the specific fraud case and associated recruitment processes did not identify any significant process failures or key risks. He further noted that the finding of the Health Board's



	internal review has been shared with the NWSSP Recruitment Team for any joint learning and a fraud risk assessment is being developed with engagement from all key stakeholders. This outcome was also shared at the recent People & Culture Committee. Whilst the Committee welcomed the assurance provided on the specific fraud case considered, further assurance was sought in relation to the thematic review which was being undertaken to mitigate future risks. M Evans advised the Committee that a holistic approach to this matter is being undertaken focussing upon substantive, temporary and agency recruitment. He noted that the report on nurse agency recruitment will be shared at the next Committee meeting. M Evans stressed the challenges in fully mitigating this risk where individuals are determined to act fraudulently, however, he confirmed that there is a robust foundation in place, with a balanced and pragmatic approach being taken. The Committee were pleased to note that there was a notable increase in staff feeling confident to escalate concerns of fraud. It was also noted that systems will be tested through the routine Counter Fraud and Audit Reviews undertaken in these areas which will provide a further measure of assurance to the Committee. In concluding the matter, the Committee thanked M Evans for the clear overview and looked forward to receiving the outcomes of the thematic reviews at future meetings.
Resolution:	The Report was NOTED .
Action:	M Evans to share Nurse Agency report to the next Committee meeting.
3.	ANY OTHER BUSINESS
	There was no urgent business to report on this occasion.
4.	DATE AND TIME OF NEXT MEETING:
	The next Committee meeting is scheduled for the 13 th February 2025.



Agenda Item

6.1.3

Audit, Risk & Assurance Committee

ANNUAL REPORT TIMETABLE 2024-2025

Dyddiad y Cyfarfod / Date of Meeting	13/02/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Forum Individuals	Date	Outcome
Executive Leadership Group	20/01/2025	APPROVED

Acronyms / Glossary of Terms	

1. Situation / Background

- 1.1 In recent weeks the final iteration of the Manual for Accounts has been received confirming the deadlines for submission of documents to Welsh Government and Audit Wales. The Annual Report encompassing the required reporting elements set out in the Manual for Accounts will be presented at the Health Board's Annual General Meeting on 31 July 2025. As in previous years, the suite of Annual Report documents will be presented electronically at the Annual General Meeting.

2. Specific Matters for Consideration

- 2.1 There is a timetable enclosed at **Appendix 1**, supporting the development of the Annual Report led by the Assistant Director of Governance & Risk and Head of Corporate Governance & Board Business. The timetable highlights the final deadline dates to deliver the Annual Report and Financial Statements for the year 2024/25.
- 2.2 Submissions are being sought from Executive Directors during January/February 2025 and the content is being worked through. Those which are outstanding will be followed up in order that we are able to complete the complex task of drafting the Annual Report element and these are being processed for the initial review by ELG.
- 2.3 Audit Wales and Internal Audit colleagues have received a copy of the timetable and concur that they will be able to meet the scheduled dates.

3. Key Risks / Matters for Escalation

- 3.1 As is the case each year, the production of these annual reporting documents takes place alongside the delivery of normal business. This task is therefore a significant challenge for all those involved.

4. Assessment

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



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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i>	Yes: ☐	No: ☒
Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Outcome:	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i>	Yes: ☐	No: ☒
Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable 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) /	There is no direct impact on resources as a result of the activity outlined in this report.
Resource Impact (People / Financial)	

5. Recommendation

- 5.1 The Committee is asked to **NOTE** the final timescales in place in respect of the delivery of the Annual Report process for 2024-2025

Annual Report and Accounts Timetable – 2024-2025

N/B Timescales are subject to change as the final version of the MfA is awaited.

Main Tasks	Executive Lead	February 2025	March 2025	April 2024	May 2025	June 2025	July 2025
Introductory Pages Foreword CEO and Chair About CTMUHB CTM2030 Issues of Particular Note Performance and Delivery Report (within Annual Report) - Performance Overview - Delivery and Performance Analysis - Wellbeing of Future Generations (Wales) Act 2015 - Welsh Language - Sustainability Report Accountability Report - Corporate Governance Report - Statement of Accountable Officer and Directors Responsibilities - Governance Statement - Remuneration and Staff Report - Modern Slavery Act 2015	Various – Please refer to content requirements spreadsheet	Drafting	Content / Narrative Submissions to Corporate Governance by 7th March 2025. 1st March 2025 - Issue Governance Compliance Statement to NIAW for signing on the 31st March 2025.	Draft to Executive Leadership Group for comment 7th April 2025 at the latest. Submit to Operational Delivery Committee members on the 29th April 2025, to gain endorsement for submission of first draft to WG. Joint Commissioning Committe will complete a full Governance Statement to provide assurance on the Chief Commissioner’s Accountable Officer (AO) status for the propriety and regularity for public finances delegated to them by Welsh Government, Health Boards and the JCC. Draft AGS to JCC meeting in March 2025. Submit to CTM before 1 May 2025. NIAW Compliance Statement signed and received.	Annual Governance Statement JCC due in on the 1st May 2025. By the 5th May 2025 Internal Audit provide their draft opinion (but not full draft annual report) to allow inclusion in version being prepared for WG submission Draft to Welsh Government/ Audit Wales by 9th May 2025 (<i>request comments within a fortnight</i>). Following any necessary amendments draft prepared (with inclusion of complete internal audit draft annual report submission) for consideration at existing meeting of Audit, Risk & Assurance committee on 22nd May 2025.	Final Draft to Extra-ordinary Audit, Risk & Assurance Committee to endorse for Board Approval 25th June 2025. Final Draft received at Extra-ordinary Public Board held in public 26th June 2025 for approval. Final version to Welsh Government via Auditor Wales by Close of play 26th June 2025. Auditor General Certification – 27th June 2025. Audit Wales to Submit to WG – noon 30th June 2025. Initiate Welsh Language Translation.	Welsh Language Translation. Annual General Meeting 31st July 2025.
Audited Financial Accounts and Statements Pooled Budgets and All FRs including FR6, (except FR10) MS A to C and F-H inclusive	Sally May, Executive Director of Finance	Drafting	Drafting	Drafting	Unaudited Accounts to be submitted by CTMUHB to Audit Wales & Welsh Government by 2nd May 2025. Draft Accounts to the Audit, Risk & Assurance committee on 22nd May 2025.	Audited Accounts Final Draft to Extra-ordinary Audit, Risk & Assurance Committee to endorse for Board Approval 25th June 2025. Final Draft received at Extra-ordinary Public Board held in public 26th June 2025 for approval. Final version (Signed and Unsigned) to be sent to Audit Wales by Close of play 26th June 2025. Auditor General Certification – 27th June 2025. Audit Wales to Submit to WG – noon 30th June 2025.	Annual General Meeting 31st July 2025.



Agenda Item

6.1.4a

Audit Risk & Assurance Committee

Committee Annual Cycle of Business 2025

Dyddiad y Cyfarfod / Date of Meeting	13/02/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

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

Acronyms / Glossary of Terms	



1. Situation /Background

- 1.1 The Audit Risk & Assurance 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 2025 to 31 December 2025.

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 & Assurance Committee Cycle of Business for further detail.

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:
	No - Not Applicable



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

5. Recommendation

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

6. Next Steps

6.1 There are no next steps required.

Audit & Risk Assurance Committee – Annual Cycle of Committee Business

(1st January 2025 to the 31st December 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: [Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](#)

The Audit & Risk Assurance Committee meets at **least 4 times per annum**. It is anticipated that an extra-ordinary Committee will need to be established in circa June / July to meet Annual Report requirements.

Committee Chair: Patsy Roseblade, IM Audit & Finance	Committee Vice Chair: Ian Wells, IM Digital & Data	Executive Leads for Agenda Planning Sally May, Executive Director of Finance Gareth Watts, Director of Corporate Governance/Board Secretary
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CTMUHB Committee Business:

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Committee Governance Arrangements																
1. Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings		R			R			R			R		R If all actions are complete	R If there are actions in progress / overdue actions
2. Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings		R			R			R			R		R	X
3. Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings		R			R			R			R		R	X
4. Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings		R Annual Review			R			R			R		R Except for the annual review in February	R Annual Review only
5. Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually					R								X	R
6. Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually								R					X	R

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Committee Governance Arrangements CONTD																
7. Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually											R		X	R
Corporate Governance & Risk Management Activity																
8. Declarations of Interest and Gifts, Hospitality & Sponsorship Report	Director of Corporate Governance / Board Secretary	Twice per annum					R						R		X	R
9. Standing Orders – Annual Review	Director of Corporate Governance / Board Secretary	Annually								R					R	X
10. Standing Orders – Variation or Breach Report	Director of Corporate Governance / Board Secretary	All regular meetings if required		R			R			R			R		R	X
11. Annual Accountability Report (Governance Statement)	Director of Corporate Governance / Board Secretary	Annually						R An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts							X	R
12. Approval of the Annual Review of the Risk Management Framework / Board Assurance Framework	Director of Corporate Governance / Board Secretary	Annually					R								X	R
13. Organisational Risk Register	Director of Corporate Governance / Board Secretary	All regular meetings		R			R			R			R		X	R
14. Data Lapses /Data Loss Updates / Reports	Director of Digital	All regular meetings (if required)		R			R			R			R		X	R
15. Annual SIRO Report	Director of Digital	Annually					R								X	R
16. Annual DPO Report – Timing TBC	Data Protection Officer	Annually													X	R

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Audit Reviews & Assurance Activity																
17. Clinical Audit Annual Plan	Executive Director of Nursing / Deputy CEO	Annually					R								R	X
18. Clinical Audit Annual Report	Executive Director of Nursing / Deputy CEO	Annually					R								R	X
19. Audit Recommendation Tracker (AW, IA and HIW)	Director of Corporate Governance / Board Secretary	All regular meetings		R			R			R			R		X	R
20. NWSSP Internal Audit Services – Progress Report	Head of Internal Audit	All regular meetings		R			R			R			R		X	R
21. NWSSP Internal Audit Services – Annual Audit Plan	Head of Internal Audit	Annually		R											X	R
22. NWSSP Internal Audit Review Reports	Head of Internal Audit	All Regular Meetings		R			R			R			R		X	R
23. NWSSP Internal Audit Services – Head of Internal Audit Opinion	Head of Internal Audit	Annually					R								X	R
24. Audit Wales Progress Update	Audit Wales - Performance Audit Lead	All Regular Meetings		R			R			R			R		X	R
25. Audit Wales – Audit Review Reports	Audit Wales - Performance Audit Lead	All Regular where applicable		R			R			R			R		X	R
26. Audit Wales Annual Audit Report	Audit Wales - Performance Audit Lead	Annually					R								X	R
27. Audit Wales Structured Assessment Report	Audit Wales - Performance Audit Lead	Annually											R		X	R
28. Audit Wales – Audit of the Financial Statement (ISA 260, Letter of Representation and Audit Opinion)	Audit Wales - Financial Audit Lead	Annually							R An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts						X	R
29. Audit Wales - Audit of Financial Statements Addendum Report	Audit Wales - Financial Audit Lead	Twice per annum (if required)								R			R		X	R

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Financial Governance Activity																
30. Annual Financial Accounts	Executive Director of Finance	Annually						An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts							X	
31. Losses and Special Payments Report	Executive Director of Finance	All Regular Meetings													X	
32. Procurement & Scheme of Delegation Report	Executive Director of Finance	All Regular Meetings													X	
33. Post Payment Verification Mid-Year and Annual Report	Executive Director of Finance	Twice a Year											Mid-Year		X	
Counter Fraud Activity																
34. Local Counter Fraud Report	Local Counter Fraud Specialist	All Regular Meetings													X	
35. Counter Fraud Annual Report	Local Counter Fraud Specialist	Annually													X	
36. Counter Fraud Annual Self-Assessment	Local Counter Fraud Specialist	Annually													X	
37. Counter Fraud Draft Work Plan	Local Counter Fraud Specialist	Annually													X	
38. National Fraud Initiatives Progress and Outcomes	Local Counter Fraud Specialist	Twice Per Annum													X	
CTMUHB Hosted Bodies Audit & Risk Committee																
39. Joint Commissioning Committee Audit Recommendations Tracker	Director of Corporate Governance (JCC)	All Regular Meetings													X	

CTMUHB Hosted Bodies Audit & Risk Committee																
40. Joint Commissioning Committee Corporate Risk Assurance Framework	Director of Corporate Governance (JCC)	All Regular Meetings		R			R			R			R		X	R
41. National Imaging Academy Risk Register	Director of the National Imaging Academy	All Regular Meetings		R			R			R			R		X	R
42. Hosted Organisation - Annual Governance Statement & Accounts	Director of Corporate Governance /Director of the National Imaging Academy	Annually						R An extra-ordinary meeting will be scheduled in June (Draft) and July (Final) as required in the Manual for Accounts							X	R
43. Hosted Organisation External / Internal Audit Reports	Director of Corporate Governance /Director of the National Imaging Academy	All Regular Meetings if a report is received.		R			R			R			R		X	R

Audit Risk & Assurance Committee – Non-Routine Committee Business Forward Plan

(1st January 2025 to the 31st December 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Medical Job Planning	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – PCH Supply Chain Partner Management	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Regional Integration Fund	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Vaccination Policy Implementation	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Service Level Agreements – Follow Up	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting.
Email from Audit Wales	Audit Risk & Assurance Committee	Audit Wales	Audit Wales Annual Report	Requested via Email from Audit Wales	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
Email from Audit Wales	Audit Risk & Assurance Committee	Audit Wales	Audit Wales Report – Structured Assessment	Requested via Email from Audit Wales	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
Email from Audit Wales	Audit Risk & Assurance Committee	Audit Wales	Audit Wales 2025 Outline Plan	Requested via Email from Audit Wales	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
Requested via email	Audit Risk & Assurance Committee	Gareth Watts, Director of Corporate Governance/Board Secretary	Annual Report Timetable 2025	Requested via Email	Emma Walters, Head of Corporate Governance & Board Business	Gareth Watts, Director of Governance/Board Secretary	13 February 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Estates Assurance Condition	Deferred from February meeting.	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Capital Systems	Deferred from last meeting	Internal Audit	Gareth Watts, Director of	15 May 2025	This item is on the agenda for the

						Governance/Board Secretary		February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Duty of Candour	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Follow Up – Performance Management 4 Hour Target	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the February 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Digital Transformation National Review	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Continuing Health Care	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Discharge Planning	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Digital Benefits Realisation	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Primary Care	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Service User Experience	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Welsh Risk Pool	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Risk Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	15 May 2025	This item is on the agenda for the May 2025 meeting

COMPLETED ITEMS:

Action from October 24 meeting CLOSED In Committee Meeting	Additional Item Audit & Risk Committee	Audit & Risk Committee	Outcome of Committee Referral to People & Culture Committee –	Action arising from the October 2024 Audit & Risk Committee	Assistant Director of People Policy and Compliance/Local	Executive Director for People	17 December 2024	Received at the December 2024 meeting - Closed
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			Recruitment Process Risk Assurance Report		Counter Fraud Officer			
December 2024	Audit & Risk Committee	Internal Audit	IA Review – PCH Management Actions – Follow Up	Requested via Internal Audit	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	17 December 2024	Received at the December 24 meeting - Closed
December 2024	Audit & risk Committee	Internal Audit	IA Review – PCH Redevelopment of Management Actions Final	Requested via Internal Audit	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	17 December 2024	Received at the December 24 meeting - Closed
October 2024	Charitable Funds Committee	Gareth Watts, Director of Corporate Governance/Board Secretary	Ratification of Chairs Urgent Action – Charitable Fund Financial Control Procedure & Update of the Scheme of Delegation	A request seeking urgent support for approval of the Charitable Funds FCP and Scheme of Delegation was circulated on the 23 rd October 2024 following agreement with the Audit & Risk Committee Chair	Head of Corporate Finance and Head of Charity and Income Generation	Gareth Watts, Director of Governance/Board Secretary	17 December 2025	Received at the December 2024 meeting - Closed
December 2024	Audit & risk Committee	Internal Audit	IA Review – Energy Management	Requested via Internal Audit	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	17 December 2024	Received at the December 24 meeting - Closed
December 2024	Audit & risk Committee	Internal Audit	IA Review – Additional Medical Pay	Requested via Internal Audit	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	17 December 2024	Received at the December 24 meeting - Closed
December 2024	Audit & risk Committee	Internal Audit	IA Review – Charitable Funds	Requested via Internal Audit	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	17 December 2024	Received at the December 24 meeting - Closed
December 2024	Audit & risk Committee	Audit Wales	Audit Wales Report – Primary Care – Follow Up Review	Requested via Audit Wales	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	17 December 2024	Received at the December 24 meeting - Closed
December 2024	Audit & risk Committee	Audit Wales	Audit Wales Report – Review of Cost Saving Arrangements – Final Management Response	Requested via Audit Wales	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	17 December 2024	Received at the December 24 meeting - Closed