

Agenda

10:30 - 10:35
5 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Patsy Roseblade, Committee Chair

1.2. Apologies for Absence

Information Patsy Roseblade, Committee Chair

1.3. Declarations of Interest

Information Patsy Roseblade, Committee Chair

10:35 - 10:40
5 min

2. CONSENT AGENDA BUSINESS

Patsy Roseblade, Committee Chair

The Committee Chair will ask if there are any items from the Consent Agenda (item 8) 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, Committee Chair

 3.1 Action Log ARAC 14 August 2025 v1.pdf (3 pages)

3.2. Matters Arising not Captured on the Action Log

Discussion Patsy Roseblade, Committee Chair

10:45 - 11:15
30 min

4. COMMITTEE GOVERNANCE ARRANGEMENTS

4.1. Organisational Risk Register

Discussion Cally Hamblyn, Assistant Director of Governance & Risk

 4.1a Org RR July 2025 - ARAC CP.pdf (8 pages)

 4.1b App 1. Org RR July 2025 - ARAC.pdf (9 pages)

4.2. Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards

Decision Cally Hamblyn, Assistant Director of Governance & Risk

 4.2 Update to SFI Chapter 11 ARAC 14 August 2025.pdf (4 pages)

 4.2a Chapter 11 - Procurement and Contracting.pdf (19 pages)

11:15 - 11:35 **5. FINANCIAL GOVERNANCE ACTIVITY**
20 min

5.1. Losses and Special Payments Report

Discussion Sally May, Executive Director of Finance & Procurement

 5.1 Losses Special Payments ARAC 14 Aug 2025.pdf (9 pages)

5.2. Procurement and Scheme of Delegation Report

Discussion Sally May, Executive Director of Finance & Procurement

 5.2 Procurement & SoD ARAC 14 Aug 25.pdf (9 pages)

 5.2a FP1 Capital Monitoring amended.pdf (25 pages)

 5.2b FP6 Creditor payments.pdf (11 pages)

 5.2c FP8 Manual Payments.pdf (7 pages)

 5.2d FP11 Inventory of Non Capital Assets.pdf (5 pages)

5.3. Penalties for Late Submitted Evidence Update

Discussion Richard Hughes, Deputy Director of Nursing, Midwifery & Patient Care

 5.3 WRP Penalties Report ARAC 14 August 2025.pdf (8 pages)

11:35 - 11:45 **6. COUNTER FRAUD ACTIVITY**
10 min

6.1. Local Counter Fraud Report

Discussion Matthew Evans, Local Counter Fraud Officer

 6.1 Local Counter Fraud Update ARAC 14 Aug 25.pdf (3 pages)

 6.1a Local Counter Fraud Update ARAC 14 Aug 25.pdf (4 pages)

 6.1b Appendix 1 - Briefing Report.pdf (15 pages)

 6.1c Appendix 2 - Counter Fraud Investigations Update.pdf (11 pages)

11:45 - 12:45 **7. AUDIT REVIEWS AND ASSURANCE ACTIVITY**
60 min

7.1. Audit Recommendations Tracker

Discussion Cally Hamblyn, Assistant Director of Governance & Risk

 7.1a ARAC Audit Tracker - 14.8.25 - CP.docx (8 pages)

 7.1b App 1 - ARAC Audit Tracker OVERDUE AMaT Audit Recs-14.08.2025.xlsx (14 pages)

7.2. NWSSP Internal Audit Progress Report

Discussion Paul Dalton, Head of Internal Audit

 7.2 IA Progress Report ARAC 14 Aug 25.pdf (7 pages)

7.3. NWSSP Internal Audit Review Reports

Discussion Paul Dalton, Head of Internal Audit

7.3.1. IA Review - End of Life Care Management - Final

Discussion Emma Samways, Internal Audit

 7.3.1 IA End of Life Care Mgt Review.pdf (10 pages)

7.3.2. IA Review - Welsh Risk Pool

Discussion Emma Samways, Internal Audit

 7.3.2 IA Report WRP - Final.pdf (13 pages)

7.3.3. IA Review - Audit Recommendations Tracker Review

Discussion Emma Samways, Internal Audit

 7.3.3 Audit Recommendations Tracker Final.pdf (9 pages)

7.3.4. IA Report - Decarbonisation - Follow Up

Discussion Emma Samways, Internal Audit

 7.3.4 Decarbonisation Follow up - Final.pdf (6 pages)

7.3.5. IA Review - Financial Systems

Discussion Emma Samways, Internal Audit

 7.3.5 Financial Systems Final Report.pdf (8 pages)

7.3.6. IA Review - Access to Diagnostics Criteria

Discussion Emma Samways, Internal Audit

 7.3.6 Access to Diagnostics ARAC 14 Aug 25.pdf (12 pages)

7.4. Audit Wales - Audit Risk and Assurance Committee Update

Discussion Nathan Couch, Audit Wales

 7.4 AW Audit Update ARAC 14 Aug 25.pdf (14 pages)

7.5. Audit Wales - Audit Review - Tackling the Planned Care Challenges

Discussion Sara Utley, Audit Wales

 7.5 Tackling the Planned Care Challenges July 2025.pdf (44 pages)

7.6. Audit Wales - Audit of Accounts Report Addendum

Discussion Mark Jones, Audit Wales

 7.6 Audit of Accounts Report Addendum CTMUHB 2024-25.pdf (23 pages)

12:45 - 12:55
10 min

8. CONSENT AGENDA

8.1. For Approval

8.1.1. Unconfirmed Minutes of the Meeting held on 22 May 2025

Decision Cally Hamblyn, Assistant Director of Governance & Risk

 8.1.1 Unconfirmed Minutes 22.05.25 ARAC 14 Aug 25.pdf (13 pages)

8.1.2. Unconfirmed In Committee Minutes of the Meeting held on 22 May 2025

Decision Cally Hamblyn, Assistant Director of Governance & Risk

 8.1.2 Unconfirmed IC Minutes 22.5.25 ARAC 14 Aug 25.pdf (4 pages)

8.1.3. Unconfirmed Minutes of the Extra Ordinary Meeting held on 25 June 2025

Decision Cally Hamblyn, Assistant Director of Governance & Risk

 8.1.3 Unconfirmed EO Minutes 25.6.25 ARAC 14 Aug 25.pdf (4 pages)

8.1.4. Draft Committee Annual Report 2024-25

Decision Cally Hamblyn, Assistant Director of Governance & Risk

-  8.1.4a Committee Annual Report 2024-25 ARAC 14 Aug 25.pdf (3 pages)
-  8.1.4b Draft Annual Report 2024-25 ARAC 14 Aug 25v2.pdf (14 pages)

8.2. For Noting

8.2.1. Committee Annual Cycle of Business 2025

Information Cally Hamblyn, Assistant Director of Governance & Risk

-  8.2.1a Annual Cycle of Business ARAC 14 Aug 2025.pdf (3 pages)
-  8.2.1b Annual Cycle of Business ARAC 14 Aug 2025.pdf (5 pages)

8.2.2. Committee Forward Work Plan

Information Cally Hamblyn, Assistant Director of Governance & Risk

-  8.2.2 Forward Work Plan ARAC 14 August 2025.pdf (5 pages)

8.2.3. Standing Orders - Variation or Breach Report

Information Cally Hamblyn, Assistant Director of Governance & Risk

-  8.2.3 Breaches to Standing Orders ARAC 14 August 2025.pdf (3 pages)

8.2.4. Outcome of the Committee Self Effectiveness Survey & Improvement Plan

Information Cally Hamblyn, Assistant Director of Governance & Risk

-  8.2.4 Cmt Self-Effectiveness Survey ARAC 14 Aug 25.pdf (4 pages)

12:55 - 13:00 9. CLOSE OF BUSINESS

5 min

9.1. Any Other Urgent Business

Discussion Patsy Roseblade, Committee Chair

9.2. Committee Highlight Report to Board

Discussion Patsy Roseblade, Committee Chair

9.3. How did we do in this meeting

Discussion Patsy Roseblade, Committee Chair

13:00 - 13:00 10. PRIVATE IN COMMITTEE SESSION

0 min

Information Patsy Roseblade, Committee Chair

1. Organisational Risk Register - Business Sensitive Risks
2. Medical Variable Pay - Summary of Authorised Breaches

13:00 - 13:00 11. DATE AND TIME OF NEXT MEETING

0 min

Information Patsy Roseblade, Committee Chair

13th November 2025 at 10:30 am

Audit Risk & Assurance Committee - Action Log (as at 30.07.25)

Name of Meeting: Audit Risk & Assurance Committee									
Committee Chair: Patsy Roseblade									
Date of meeting the action originated from	Minute Item reference	Minute 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 & Assurance Committee - May 2025	3.1	3	Action Log	Risk relating to Paediatric Dentistry - a report had been received by Quality, Safety & Experience Committee and it was suggested that this report could be share as a cross report between the two Committees	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	Aug-25	Propose to close	Report was shared via email to the Committee on the 30.7.25
Audit, Risk & Assurance Committee - May 2025	4.3	4	Organisational Risk Register	To provide further assurance on clarity and mitigations of risk 5671 - Cross Health Board Data Sharing	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	Aug-25	Propose to close	Update was shared via email to the Committee 23.05.25
Audit, Risk & Assurance Committee - May 2025	5.1	5	Losses and Special Payments Report	To receive an update on penalties for late submitted evidence	Deputy Director of Nursing & Midwifery	Director of Nursing & Midwifery	Aug-25	Propose to close	Penalties for Late Submitted Evidence Update report scheduled for the August meeting at agenda item 5.3.
Audit, Risk & Assurance Committee - May 2025	7.3	8	NWSSP Internal Audit Services Annual Audit Plan 2025-26	To review the Executive Lead for the Medical Annual Leave and Rostering	Head of Internal Audit	Head of Internal Audit	Aug-25	Propose to close	Report was reviewed outside of meeting and amended to reflect the Executive Leads as the Medical Director & Executive Director for People
Audit Risk & Assurance Committee - February 2025	4.2	4	Losses and Special Payments Report	To implement a cross Committee Referral to Quality, Safety & Experience Committee on the concern raised regarding the increases in medical negligence claims	Head of Corporate Governance & Board Business	Director of Corporate Governance/ Board Secretary	May-25	Open - <i>scheduled for November 2025 Committee</i>	A verbal update was provided to Quality Safety & Experience Committee at its meeting on the 22 July 25 where it was noted that a written update would be presented to the September Quality, Safety & Experience Committee. This item has now been deferred to the November ARAC meeting to await the outcome.
Audit Risk & Assurance Committee - February 2025	5.3.2	8	IA Review - Medical Job Planning	To bring further detail on the job planning work back to a future meeting of the Committee.	Medical Director	Medical Director	Aug-25	Propose to close	Included as an update in the In Committee session on the 14 August at Agenda item 2.2.
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	Latest update captured on the Organisational Risk Register for July 2025. See agenda item 4.1b. This risk is monitored via the following assuring Committees - Operational Delivery Committee and Quality, Safety & Experience Committee.
PREVIOUSLY CLOSED ACTIONS									

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	Closed	The actions from the last meeting will be built into the improvement programme for the development of the Audit Tracker
Audit Risk & Assurance Committee - February 2025	5.3.5	9	IA Review - Vaccination Policy Implementation	To consider where the reporting of the Vaccination Policy Implementation should sit.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/Board Secretary	May-25	Closed	This will be reported via the Integrated Performance Dashboard to Operational Delivery Committee, but assurance will also be given to the Quality, Safety and Experience Committee at the appropriate given that Committee's legitimate interest in this area.
Audit Risk & Assurance Committee - February 2025	5.3.5	9	IA Review - Vaccination Policy Implementation	To consider where the reporting of the Vaccination Policy Implementation should sit.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/Board Secretary	May-25	Propose to close	This will be reported via the Integrated Performance Dashboard to Operational Delivery Committee, but assurance will also be given to the Quality, Safety and Experience Committee at the appropriate given that Committee's legitimate interest in this area.
Audit Risk & Assurance Committee - February 2025	5.4.2	11-Dec	Audit Wales Report - Structured Assessment	To further discuss the content of the report offline prior to it being presented to board.	Audit Wales	Director of Corporate Governance/Board Secretary	May-25	Closed	Received at the Health Board Meeting 27.03.25
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	Closed	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 & Assurance Committee - February 2025	4.1	3	Local Counter Fraud Report	To highlight any new updates in the Cases Report in a different colour so these can be flagged for the Committee's attention.	Local Counter Fraud Officer	Executive Director of Finance & Procurement	May-25	Closed	Report to be brought to May 2025 meeting to include coloured text to highlight last updates.
Audit Risk & Assurance Committee - February 2025	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	Executive Director of Finance & Procurement	May-25	Closed	Primary Care review in progress. Update to be brought to May 2025 meeting as part of the Local Counter Fraud Report
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	Dec-24	Closed	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	Closed	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 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	Closed	Table has an additional column to highlight actions since last report. Happy to review formatting for future meetings if Committee would prefer different style.

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	Dec-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	Dec-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

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	14 August 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

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	June / July 2025	RISKS REVIEWED
Executive Leadership Group	14 July 2025	REVIEWED AND MANAGEMENT SIGN OFF RECEIVED
Quality, Safety & Experience Committee	22 July 2025	ASSIGNED RISKS REVIEWED
Operational Delivery Committee	29 July 2025	ASSIGNED RISKS REVIEWED

Acronyms / Glossary of Terms

1. Situation /Background

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

2. Specific Matters for Consideration

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.
- 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 4 July 2025.

Training

- 2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.
- 2.7 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:
- Risk Management Approach
 - Practical Approach to Managing Risk
 - Risk Assessment and Scoring
 - Datix Risk Management Module
- 2.8 To date **792** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2.
- 2.9 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.

- 2.10 109 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 4.80 out of a maximum score of 5.
- 2.11 100% of the 109 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.
- 2.12 98% of the 109 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.
- 2.13 Some of the recent comments from the session, received through evaluation, have been included below:
- *"I feel confident in doing a risk management review but still need some more guidance in doing it. Familiarity with the Datix system for risk will improve much of our knowledge on how to do a report".*
 - *"I found it very useful to see the practical demonstration of the Datix system. The presenter was very knowledgeable and explained things really well have a much better understanding of the difference between the BAF and Organisational Risk Register. Finally makes sense!"*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Patient Care and Safety Directorate

- Datix Risk ID 6228 - Effective and efficient management of requests from the HM Coroner. New risk escalated with a risk score of 16.
- Datix Risk ID 6229 - Timely development of, management and response to Learning from Event Reports (LFERs). New risk escalated with a risk score of 16.
- Datix Risk ID 6230 - Proactive management and compliance with Medical Negligence or Personal Injury claims at Pre-Action Protocol stages. New risk escalated with a risk score of 16.
- Datix Risk ID 6231 - Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. New risk escalated with a risk score of 16.
- Datix Risk ID 6232 - Stability of the Legal Services Function. New risk escalated with a risk score of 15.

Estates Directorate

- Datix Risk ID 6234 - National skills shortage in Estates Roles (Private sector salaries are impacting the CTMUHB's ability to be competitive in the recruitment market) resulting in recruitment and retention challenges throughout the department. New risk escalated with a risk score of 16.

- Datix Risk ID 6235 - Insufficient funding to address backlog maintenance across the estate. New risk escalated with a risk score of 16

Finance Directorate

- Datix Risk ID 6239 - Failure to reduce the £7.8m recurrent deficit at the start of 25/26 down to the planned £1.7m recurrent surplus at the end of 2025-2026. New risk escalated with a score of 20.
- Datix Risk ID 6240 - Failure to achieve the planned break-even position in 2025-2026. New risk escalated with a score of 20.

Diagnostics, Therapies, Pharmacy & Sciences Care Group

- Datix Risk ID 5304 - The Air Handling Unit (AHU) for the pharmacy aseptic production suite. New risk escalated with a risk score of 16.

Children & Family Care Group

- Datix Risk ID 6217 - A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity. New risk escalated with a score of 15.

3.2 CHANGES TO RISKS

Risk Score Increased

Children and Family Care Group

- Datix Risk ID 5753 – Inadequate Special School Nurse Provision. The risk score increased from a 16 to a 20 in July 2025 due to ongoing capacity challenges.

Risk Score Decreased

No risks were decreased in terms of risk score in the July 2025 iteration of the Organisational Risk Register.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Children and Family Care Group

- Datix Risk ID 5903 - Unfunded Continuing Care Packages / unfilled packages. This risk was closed in July 2025 due to improvements in workforce provision. Care Group have advised that this risk can now be closed as following review of continuing care new staff training and packages then within the next 6 weeks (from 1 July) the service will be totally removing New Cross agency from the remaining package, the service have put in place regular oversight during this period from the CCN key workers.

Capital and Estates Directorate

- Datix Risk ID 5932 - 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. This risk has been removed as the roof and battens have been completed above patient areas in Phase 1, only plant rooms remain.

- Datix Risk ID 5961 - Remedial roof works to resolve the water ingress at POWH. this risk has been removed as has been significantly reduced for the Phase 1 roof that this refers to as the roof has been replaced as in risk 5932 above. Risk likelihood score reduced as only leak on Phase 1 recently was above ITU and the flashing was identified as the problem and subsequently corrected so this should not reoccur.

Digital & Data Directorate

- Datix Risk ID 5669 - Increased cost of Citrix Subscription. The procurement activity has been completed and a new 3-year contract with Citrix has been negotiated. The new contract, effective from 14th December 2025 will provide a saving of ~£226,000 p.a. (~73%) compared to the current price. Work will continue to reduce our thin client estate. This risk is now closed.
- Datix Risk ID 4337 - Integrating Patient Records across the Health Board. Whilst the PAS disaggregation has completed, Care Groups now need to work with operational managers and clinicians to access Health Board wide ways of working and Standard Operating Procedures to manage patient pathways in a consistent way across CTMUHB. This risk, associated with the migration, can now be closed. Improvements post migration will be tracked in risk 6102.

Patient Care and Safety Directorate

- Datix Risk ID 4908 - Failure to manage Legal cases efficiently and effectively. This risk has been closed as it has been superseded by the new risks under the Patient Care and Safety Directorate identified on page 3 of this report.

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

Consequence	5			3337 6217	4664 5276 6053 6102	
	4			5820	4417 5374 4671 4885 6039 5576 5821 6229 6228 6230 5304 6235	5646 5579 5761 5691 2795 5793 5045 4973 3567 6231 6234
	3					4491 3826 4632 5417 6111 6179 5753 6239 6240
	2					4672 4691 5040 6232
	1					
	CxL	1	2	3	4	5
					Likelihood	

3.5 EMERGING RISKS

Identified in the May 2025 Organisational Risk Register Cover Report:

3.5.1 The Diagnostics, Therapies, Pharmacy and Sciences Care Group are reviewing the following risk for escalation to the Organisational Risk Register in July 2025:

- Datix Risk ID 5304 – Air Handling Unit for the Pharmacy Aseptic Production Suite – Medicines Management.

This risk has now been escalated in the July 2025 iteration of the Organisational Risk Register as identified in section 3.1.

3.5.2 The Primary, Care & Community Care Group are assessing a risk in relation to the Welsh General Optometry Service (WGOS), with a few to escalating to the Organisational Risk Register in July 2025. Any escalation has been deferred as discussions are underway in July and August with Welsh Government. A more robust update as to whether this is a risk that requires escalation to the Organisational Risk Register will be shared in the next iteration of the Organisational Risk Register in September 2025.

3.5.3 Finance Directorate – following closure of Risk ID 5765, captured in section 3.3, a new risk for the financial year 2025-2026 was being developed with a view to escalating to the Organisational Risk Register in July 2025. Two new financial risks have now been escalated in the July iteration of the Organisational Risk Register as identified in section 3.1.

Emerging risks identified whilst drafting the July 2025 iteration of the Organisational Risk Register are identified below:

3.5.4 Children & Family Care Group are considering the escalation of a risk regarding the extensive wait times for paediatric patients to have an Electroencephalogram (EEG) investigations (Datix Risk ID 6187) once a review of the demand management plan has been further considered with the Chief Operating Officer.

3.5.5 Primary Care & Community Care Group – are considering the escalation of a risk around the Lymphoedema Service (Datix Risk ID 6107) once the service review plan with district nursing has further been considered with the Chief Operating Officer.

3.5.6 Unscheduled Care – Care Group – are currently reviewing the mitigation relating to the “Lack of Resuscitaire in Princess of Wales Hospital Emergency Department” (Datix Risk ID 6152). This risk at the time of finalising the Organisational Risk Register was scoring at a risk score of 20, however, the current control measure is that there is an interim measure to enable access to a Resuscitaire when required as the Emergency Department will be able to access the Resuscitaire located in



paediatrics for neonatal patients who come into Emergency Department. Furthermore, agreement and approval to purchase Resuscitaire for the Emergency Department has been agreed and an order placed for delivery. As a result of these mitigations the risk score is under review and therefore at the time of submitting this report it is uncertain whether it will still require escalation to the Organisational Risk Register, however it has been referenced here to ensure visibility.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUEB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUEB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient 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 (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (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	Yes: ☐	No: ☒



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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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
1	6239	Executive Director of Finance	Finance Directorate	Deputy Director of Finance	Sustaining Our Future	Financial Risk	Failure to reduce the £7.8m recurrent deficit at the start of 25/26 down to the planned £1.7m recurrent surplus at the end of 25/26 IF: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding for 2025/26. THEN: The Health Board may not be able to deliver a break-even financial position for 2026/27. 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 26/27 • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 26/27. • Potential cash shortfalls in 26/27.	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and Directors. • Regular reporting to the Executive Leadership Group, the Operational Delivery Committee and the Board.	• June 2025 update: The H3 YTD position is a £4.7m deficit and this position presents a risk to both the 1n year forecast and the recurrent forecast. The forecast recurrent position at the end of 25/26 will be reviewed after Q1. • The main action is to develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 26/27 as well as schemes in delivery for 25/26.	Operational Delivery Committee	20	C4xL5	12 C4xL3	New risk escalated to Organisational Risk Register in July 2025	30.06.2025	30.06.2025	30.09.2025
2	6240	Executive Director of Finance	Finance Directorate	Executive Director of Finance	Sustaining Our Future	Financial Risk	Failure to achieve the planned break-even position in 2025/26. IF: The Health Board is not able to plan and deliver expenditure run rates that align with the available funding for 2025/26. THEN: The Health Board will not be able to deliver the planned break-even financial position for 2025/26. RESULTING IN : • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • Failure to deliver the financial 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 the latter months of 25/26	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and Directors. • Regular reporting to the Executive Leadership Group, the Operational Delivery Committee and the Board.	• Context: The Health Board has submitted a balanced financial plan for 25/26 but this plan includes significant risks, including the delivery of £31.3m of efficiency savings. The savings plans at the 31 March 25 total £14.8m with a RAG rating of £9.2m Green, £5.2m Amber and £1.4m Red. • June 2025 update: The H3 YTD position is a £4.8m deficit, which includes a £5.0m shortfall in savings delivery. The Health Board is continuing to forecast a break even position for 25/26. The key risks to the forecast are estimated at £35.3m and the main risks are savings delivery shortfall of £13.9m and anticipated allocations from WG of £14.3m. The following actions are to support savings plan identification, development and delivery: • Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 26/27 as well as schemes in delivery for 25/26. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Develop the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.	Operational Delivery Committee	20	C4xL5	12 C4xL3	New risk escalated to Organisational Risk Register in July 2025	30.06.2025	30.06.2025	30.09.2025
3	6179	Executive Director of Public Health	Public Health - Health Protection	Executive Director of Public Health	Creating Health & Improving Care	Quality / Complaints / Assurance / Patient Outcomes Impact on the safety - Physical and/or Psychological harm	High and increasing prevalence of overweight and obesity in children and adults. IF there is insufficient preventative activity to reduce rates of overweight and obesity Then rates of obesity will remain high in CTM . Resulting in increased activity/acute/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents.	A range of work is currently under way in response to high levels of obesity in CTM including: 1) Great funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment 2) Adult Weight Management Service - the scale of this is vastly insufficient to make a difference to population level rates of obesity 3) Children and Young People's weight management service - current time-limited funding for Pypn, preventative family based intervention, ongoing development work to maximise population impact, scale remains small. Proposed future development of a service in line with level 3 of the All-Wales Weight Management Pathway. 4) Healthy pre- and health schools programmes - working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: healthy environments healthy settings, healthy people, leadership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	The Healthy Weight Steering Group is currently developing a healthy weight road map for CTMUHB, outlining actions and strategic direction over the short, medium and long term. This will be in line with Healthy Weight: Healthy Wales, and take into consideration health board actions under the new national action plan. The Healthy Weight roadmap is under development and due at Board for approval in November 2025 There is a business case in place for sustainability and increased capacity for Pypn (level 1+), and a CYP level 3 weight management service. A level 3 weight management service will help improve outcomes for some of our most disadvantaged children. Update 7.7.2025 - Confirmation being sought as to whether this was approved as part of the DHPF process - update from finance awaited.	Quality, Safety & Experience Committee. Strategic Development Committee.	20	C4xL5	9 C3xL3	↔	06.05.2025	09.05.2025	08.07.2025
4	6111	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety	Medical Examiner Delays IF: there continues to be delays in length of time for scrutiny of deaths by the Medical Examiner Service Then death certification will not be completed in a timely manner and so increasing the length of stay of the deceased Resulting in: complaints from bereaved relatives due to delayed funerals, inability to view loved ones, and deterioration in condition due to delay and inability to comply with WG bereavement framework and mortuary capacity being overwhelmed	Bereavement database updated to track cases and ensure timely attendance by doctors following scrutiny. Bereavement teams to provide estimated timescales for scrutiny based on database. Daily monitoring of daily occupancy. Funeral directors to be contacted by mortuary teams. All contingency capacity WB wide activated in line with mortuary escalation action card. Use of contracted funeral director staircase if required. Use of medlink sessions to manage post mortem demand.	Plan to improve timely death certification by CTMUHB specific QR code to alert wider staff and reduce delays and education videos from HES to improve accuracy. Continue to improve on communications with families around delays and estimated timescales. Update End of June 2025 - Communications ongoing with ICT colleagues around a data sharing risk using MS Office. Current work ongoing to implement this. Current work-around is in place to take data into a spreadsheet then delete the forms after a certain period of time. Discussions with ICT also in place in terms of solution to implement QR Code.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C4xL5	12 (C4xL3)	↔	05.03.2025	30.06.2025	31.8.2025
5	6053	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Service / Business Interruption	Failure to secure an alternative Clinical System for GP practices on Vision IF: a new supplier is not secured. Then there will be a significant risk to the availability of a clinical system/solution to support General Practice service delivery for our GP practices yet to transfer to an alternative provide (EMIS). Resulting in GP service delivery and patient care being significantly impacted and further impacting on other healthcare services.	Digital Health Care Wales (DHCW) Task force with 4 workstreams set up to manage the project Comms & engagement. The company is currently seeking a buyer, process started on Friday, December 13th. DHCW will work with the administrator on the next steps, whatever the outcome of the marketing process. The administrator has advised they are planning to maintain a full service to minimise disruption to practices. Health Boards are working together with DHCW to produce business continuity plans for both HbIs and for practices.	Collaboration with DHCE and other Health Boards for Business Continuity Plans - timeframe 27.3.2025. Securing a new Clinical System Provider - timeframe 30.06.2025. Update May 2025 - Digital Health Care Wales (DHCW) are still in negotiations with interested / preferred buyer of the Cedemid clinical system. In the meantime HOPC/DHCW and Health Board Digital Leads working on mitigation and business continuity plans. Update 24 June 2025 - new provider secured and Nonation Agreement for the transfer of the contract has been received by CTM to sign. Returned to Digital HealthCare Wales. This will secure the clinical services for practice and part of the contract is to expedite the migration to EMIS earlier in 2025. Next review	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C5xL4	5 (C5xL1)	↔	15.01.2025	24.06.2025	1.8.2025
6	6102	Director of Digital	Central Corporate - Digital & Data	Head of Clinical Admin Transformation	Sustaining Our Future	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm Patient Pathways - Working in WPAS Instances. IF: A patient is moved between Swansea Bay University Health Board WPAS and Cwm Taf WPAS and their pathway is closed in one before it is opened in the other. Then: The pathway will not be automatically re-opened by the systems (this must be manually serviced) and the pathway will remain closed. Resulting in: The incorrect ending of the patient pathway, as they will not be visible on the system, which could lead to possible patient harm/ death.	Monitor records/ processes through agreed Standard Operating Procedure's and ensure corrective actions are taken until mitigation is successful. Flagging to users/ management where examples of this not being followed are identified.	Review current business processes and Standard Operating Procedures to clarify the importance of opening the CTM record before closing the Swansea Bay University Health Board record. This process prevents delays in urgent pathway management, as highlighted by flagged dermatology cancer referrals that were discharged on WPAS but not set up on another system at the time of checking. It is anticipated that the target score will not be achieved until CTMUHB have a fully migrated PAS systems and the whole organisation is using a singular PAS system for patient pathways. Update July 2025 - Whilst the PAS disintegration has completed, Care Groups now need to work with operational managers and clinicians to agree Health Board wide ways of working and Standard Operating Procedures to manage patient pathways in a consistent ways across CTMUHB.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C5xL4	5 (C5xL1)	↔	19.02.2025	3.7.2025	31.08.2025
7	6491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm Failure to meet the demand for patient care at all points of the patient journey IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - 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 available harm which will be reported and acted upon accordingly. • A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. • All unreported lists that appear to require reporting have been added to the RTT reported lists • All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 21:59 case load. • A Harm Review process is being piloted within Ophthalmology - it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. • The Health Board is exploring working with neighbouring HbIs in order to utilise their estate for operating.	Update July 2025 Unscheduled Care - Rapid Improvement Action Plan in development to achieve Ministerial Advisory Group target of 45 minutes for handover for Ambulance Internal action plan in development to achieve a reduction in 12 Hour Emergency Department performance. Formulations of ED Rapid Improvement Plan and Improvement Targets, including: • The above improvements will be aligned against the following assumptions: - Single Point of Access (scheduling, unscheduled care) - November 2025 - All GP / 111 / NHS24 calls to be triaged by the New Hub - Zero tolerance to any GP expected patients (off-pre-views) being seen first in ED - November 2025 • Ticket to ride for all WAST non-red Care Home attendances - implementation aligned with national work • Additional hospital at home (HbH) and clinically optimised for discharge (COPD) capacity within Primary and Community Care • 30 additional beds from August 2025 • Patients prioritised on clinical need using nationally defined categories • 40-minute specialty in reach - August 2025 • Sign off Internal Professional Standards Substantive consultant recruited June. Start date in Jan '26. 1 Stroke Consultant 6 month phased return. Single Point of Access Board to be established. Planned Care Update: • Progress made on >104 week • 4 theatres across CTMUHB remain closed • Endoscopy moved back to Princess of Wales Hospital in June 2025. • 2 mobile endoscopy treatment rooms opened 4th March 2025. • 4 Mobile theatres opened Mid-April • 2 Prince Charles Hospital (PCH) theatres opened end of April 2025 • 1 Theatre and Ward at PCH dedicated to Orthopaedic Inpatient surgery from May - July 2025	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 C4 x L3	↔	13.7.2023	01.07.2025	31.08.2025
8	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Impact on the safety - Physical and/or Psychological harm Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation) IF: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM THEN: avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care Resulting in: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • 1 JtL 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 briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update July 2025 - Consultant medical workforce remains fragile • Substantive consultant recruited June with an anticipated start date in January 2026. • 1 stroke consultant has XfW on phased return over a 6-month period. • 2 x agency locums remain in place and secured until December 2025	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4 x L3)	↔	11.05.2021	20.06.2025	31.07.2025
9	5276	Director of Digital	Central Support Function - Digital and Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Operation	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 impacts.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update May 2025 - Phase 1 UAT has now been completed by Digital Health Care Wales (DHCW). They are working with University Health Boards to understand any issues or critical blockers from testing. Replacing options are also being currently looked at e.g. should migration be based on individual specialities/discipline rather than at an individual University Health Board level. DHCW are currently undertaking a procurement activity reviewing the use of Citrix, which is used to deploy LIMS, so activity to explore the mitigation of a potential Citrix contract termination in December is underway. Update July 2025 - Rather than a whole Health Board migration approach, the national programme have proposed that individual pathology disciplines are migrated across Wales. Each University Health Board has been asked to approve that approach and any associated costs. Clarity is being sort on the appropriate governance to approve the additional costs.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	3.7.2025	31.08.2025
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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
4664	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Legal / Regulatory	Ransomware Attack resulting in loss of critical services and possible extortion	The detail of this risk is captured in the Closed Session due to business sensitivities.			Operational Delivery Committee	20	C5 x L4	15 (C5xL3)	↔	26.05.2021	3.7.2025	31.08.2025
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety	Emergency Department (ED) Overcrowding	If, as a result of wait back due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting In: Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filing assessment spaces compromised the ability to provide timely rapid assessment of major cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional respite 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 Meesteg community hospital. Daily site wide safety meeting to ensure flow and site safety is maintained. There is now a daily WAST test call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. Twice weekly meetings with B&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 rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update 20.08.2025 - The emergency departments across CTM remain overcrowded. There are many internal actions being undertaken within Care Group to reduce attendances, improve flow and reduce overcrowding - • CTM UML Development of Urgent & Emergency Care Rapid Improvement Plan (15 minute ambulance handover and 90-day ED performance) • TRUE Rapid Improvement Plan through 6 Goals Programme - SRO - Deputy Exec Med Director and Deputy COO • USC CG Formulas and sign off 30/60/90-day improvement plan • Acute Medicine Transformation Programme (STAMP) - POW - 2 workshops complete - 3 further planned June/early July • New investment agreed for x3 Consultant Acute Physician posts. Targeted recruitment drive currently underway. • Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established. • Targeted recruitment of Acute Medicine Consultants following new investment to provide 7/7	Quality, Safety & Experience Committee Operational Delivery Committee	20	C6xL5	12 (C4xL3)	↔	24.09.2019	20.06.2025	31.08.2025
5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Paediatric Dentistry - General Anaesthetic (GA) theatre list	If... Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. Then... the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in... 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction. 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 8 wks 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 600+ 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 May 2025 - Prince Charles Hospital (PCH) has confirmed a GA session will run every Friday, this will enable up to 7 patients to be seen p/w dependent on complexity. Still exploring possible use of Vanguard, waiting for the theatres to be utilized by adult patients from the 10 April to understand suitability if theatres are safe for Paediatric use. CDS have started to assess 30 patients p/w in readiness for the Saturday list however will pull down additional assessment clinics in the next few weeks if there is a delay in use of the Vanguard Theatres Confirmation is required as soon as possible due to children can only be assessed 9-10 weeks prior to treatment, additionally other CDS patient lists are currently being cancelled to ensure there is an appropriate cohort for treatment on the Vanguard lists. Currently waiting for secondary care staffing costs to be shared with Service Director to enable costs to be reviewed/signed off. Update July 2025 - Since the previous update, the service has been informed that the Vanguard theatres are unsuitable for the delivery of paediatric lists on the weekend. Therefore, the service will offer the opportunity to explore Saturday lists at Prince of Wales Hospital (POWH). However, other specialities have also been considering the use of POWH and as a result, CDS have been asked to scope Sunday availability of staff instead. In addition, the service has now also been informed that weekend lists could be run from the main site of Royal Glamorgan Hospital (RGH) on the weekend, using the Paediatrics Assessment Unit. This option will be explored over the coming weeks. Next review end of July 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C6xL5	9 (C3xL3)	↔	26.04.2023	25.06.2025	31.07.2025
5753	Executive Nurse Director / Deputy Chief Executive	Children & Family Care Group	Care Group Service Director	Improving Care	Workforce / Organisational Development / Staffing / Competence	Inadequate Special School Nurse Provision	If the Health offer towards the current Special Schools Nursing Model is not increased and Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools. Then the Community Children's Nursing (CCN) Service are unable to meet their obligations across the five special schools in CTM and be unable to fulfil their obligation to Rhonda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA. Resulting in: Dissatisfaction and fractured relationships within RCT and Merthyr LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), impact on Consultant Led clinics, inability of special school nurse to deliver on School Nursing Framework in Wales part 2 - Nursing in Special Schools and Healthy Child Wales (HCW) part 2, lack of access to continual professional development and peer support for the nurses based in Special Schools, continued issues with recruitment and retention of nursing staff into Special Schools.	Mitigation - reviewing SLA at pace with LA, high level meetings with EDOH, Nursing Director and Directors of education. Supporting staff, sharing risk across SSN schools. During periods of absence or vacancies, access to a school nurse will not be available in person 5 days per week. However, telephone advice and support will be available. These control measures do not meet expectations of Local Authority. Meetings have been held between Directors of education and Director and Executive Nurse. SBAR has been escalated to Care Group OMB but needs to be escalated to HB OMB (19/02/2025) Engagement between senior nurse and head teachers and support for special school nurses has been given.	Update May 2025 - Special school nursing team remains fragile, 1 LTS ongoing from September, 1 Maternity Leave unsuccessful backfill, 1 staff member just returned from LTS. Increasing demands from schools and uncertainty of agreed roles and responsibilities heighten this fragility. Discussion scheduled for May with Chief Operating Officer (COO) and Executive Director of Nursing and Care Group. Update July 2025 - Meeting held 3 June 2025 with Chief Operating Officer and Executive Director of Nursing / Deputy CEO to provide them with an update and risks raised and capacity challenges. As at 4 July 2025 there are two vacant posts now 'live' on the Trac recruitment system following notification of staff departures. At present risk score remains unchanged.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C6xL3	8 (C4xL2)	↑	16.04.2024	04.07.2025	31.07.2025
6228	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Effective and efficient management of requests from the HM Coroner	If the Health Board fails to effectively respond and manage requests from the HM Coroners Office in a timely manner. Then: there is a risk that the Health Board will breach The Coroners (Investigations) Regulations 2012 in failing to provide documentation on time and take required action in a timely manner to ensure lessons have been learned. Resulting in: poor experience and the wellbeing impact for the families and staff members involved in requests, reputational impact of the Health Board in terms of trust and confidence in the service, an increase in the number of Regulation 28 / 29 reports on actions to prevent future deaths, an increase in potential enactment of the Coroners powers, including under Schedule 5 - "Power to require evidence to be given or produced".	Review initiated to understand CTMNUH's position in terms of the number of requests underway and the response to requests. Review and re-map internal processes in the management of request cases within the organisation. Weekly coronal meetings with the Senior Coroner's Officer to discuss operational progress and individual cases. Weekly oversight meetings and briefings on cases of concern for discussion at ELG as well as performance review.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage requests effectively, if internal processes and systems need to be revisited to make changes underway and for further improvement. July 2025: cases reviewed in partnership with Senior Coroner's Officer, resulting in case reduction from >350 to 191 cases. Weekly panel meetings are now in place to review new request notifications, to align already received evidence, and to ensure appropriate allocation of care groups and witnesses. Organisational Change Process of Patient, Care & Safety team near completion ensuring appropriate allocation of resources.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
6229	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcomes	Timely development of management and responses to Learning From Event Reports (LFERs)	If the Health Board fails to achieve timely completion of LFERs, respond promptly to the questions from the Welsh Risk Pool Learning Advisory Panel and provide assurance that learning has been implemented and shared. Then: there is a risk that improvement to quality and safety in healthcare aligned to learning which flows from case investigations, and the LFER (Learning From Event Report) is not acted upon. Resulting in: reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned. Missed opportunities to improve patient care and safety following identification of areas for improvement. Financial penalties if the Welsh Risk Pool consider withholding reimbursements due to being dissatisfied with the learning and actions taken in a case.	Review initiated to understand CTMNUH's position in terms of the number of cases underway and the response to requests. Current controls: Incident Management Framework and Toolkit. Incident Investigation Training. Viability of data using the Data System. Learning and Learning Framework	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes underway and identify areas for further improvement. July 2025: Cases are reviewed in partnership with the Head of Safety at Welsh Risk Pool, with plans for approved extensions on current cases and WRP support on case management. Weekly data meetings are in place to review current cases, align already received evidence, and ensure appropriate allocation of care groups and teams. WRP to support on the development of an internal CTMNUH Learning From Events Report Panel. Organisational Change Process of Patient, Care & Safety team near completion ensuring appropriate allocation of resources.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
6230	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future??	Standard Duty, regulation, mandatory requirements.	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	If the Health Board fails to comply with the Personal Injury or Medical Negligence Pre Action Protocol stages of a case. Then: there is a risk of breaching practice direction / pre action conduct. Resulting in: avoidable delays to the litigation process being incurred including the wellbeing impact on family's and staff involved. Reputational impact in terms of compliance failings. The court initiating a range of penalties due to no compliance, proceedings being commenced unnecessarily or where additional costs have been incurred.	Review initiated to understand CTMNUH's position in terms of the number of cases underway and the response to requests. Current controls: Claims Management Procedure. Engagement with Legal & Risk Services. Experienced Claims Handlers in post.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes underway and identify areas for further improvement. July 2025: Cases are reviewed in partnership with the Assistant Director for Health & Safety, resulting in a review and streamlining of current case activity. Weekly data meetings are in place to review current cases, align already received evidence, and ensure appropriate case management. The Organisational Change Process of the Patient Care & Safety team is near completion, ensuring appropriate allocation of resources. The Deputy Executive Director of Nursing and the Assistant Director for Corporate Governance & Risk have met with Legal & Risk leads to review options on case management of current cases and substantive measures to streamline current processes.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025
6231	Executive Director of Nursing / Deputy CEO	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future??	Standard Duty, regulation, mandatory requirements.	Proactive management and compliance with cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	If the Health Board fails to comply and proactively manage cases that qualify for consideration under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Then: there will be a missed opportunity to deal with concerns under a single and consistent method for grading, investigating and to actively involve the person raising the concern in an open and engaged manner to put things right. Resulting in: Delays in improving patient safety and experience as a result of identifying how services may have improved as a result of concerns notified and dealt with under these arrangements. Early resolution of cases which provide an opportunity for closure for families and staff as well as effective and efficient learning to be implemented. Avoidable costs should a case proceed to litigation due to failure to comply proactively with the arrangements. Reputational impact of the Health Board in terms of trust and confidence in the service and assurance that lessons have been learned	Review initiated to understand CTMNUH's position in terms of the number of cases underway and the response to requests. Current controls: Putting Things Right - Handling Concerns Procedures. Engagement with Legal & Risk Services. Experienced Concerns Handlers in post.	Legal Services Recovery Plan in place which will consider if there is sufficient capacity to manage cases effectively, if internal processes and systems need to be revisited to make changes underway and identify areas for further improvement. July 2025: Performance reviewed on a twice weekly basis focusing on KPI/standards in responses within 30 working days, acknowledgement within 2 working days and overall management of early resolutions. Current performance indicates improvement with 30 working day target above 75% and acknowledgement standard at 64% compliance. Additional work in partnership with the CEO's team to review management of NPMS concerns has resulted in improved communication and streamlining of case management (under regular review).	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	C4xL2 = 8	New risk escalated to Organisational Risk Register in July 2025	3.7.2025	3.7.2025	31.8.2025

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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
1	6234	Executive Director of Finance (Executive Lead for Estates)	Central Directorate - Estates	Assistant Director - Capital Estates	Sustaining Our Future	Environmental / Estate / Infrastructure	National skills shortage in Estates Roles (Private sector salaries are impacting the CTMHB's ability to be competitive in the recruitment market) resulting in recruitment and retention challenges throughout the department. IF: A UK skills shortage coupled with the demand for labour in the private sector has caused recruitment and retention issues throughout the department, this has affected the ability to fill all WTE posts in a timely manner. THEN: The Health Board is at risk of being unable to complete all statutory, mandatory preventative maintenance tasks and help desk requests. There is also a risk of being unable to support the delivery of capital projects, and departmental vibrant works. RESULTING IN: Insufficient staff to deliver the service, significant delays in replacement of staff. Increased revenue costs for overtime and contractor costs to supplement shortfalls. Inability to complete all Statutory and mandatory maintenance activities which could potentially breach legislation requirements. Decrease in the maintenance performance figures. Failing estates affecting patient safety and service. Increased risk of claims. Reputational damage.	Performance levels monitored monthly at SMT and weekly at operational estate management level. Overtime worked and contractors employed when key risks identified.	Vacancies reviewed at Senior Management Team (SMT) meetings on a monthly basis. Age profile developed to manage succession planning.	Operational Delivery Committee	18	C4xL4	9 (C3xL3)	New risk escalated to Organisational Risk Register in July 2025	4.7.2025 - Opened on Datix	4.7.2025	31.08.2025
19	6235	Executive Director of Finance (Executive Lead for Estates)	Central Directorate - Estates	Assistant Director - Capital Estates	Sustaining Our Future	Environmental / Estate / Infrastructure	Insufficient funding to address backlog maintenance across the estate. Then: there is a risk that it may not be able to maintain an estates infrastructure that keeps services functioning, meets statutory compliance regulations and provide enhancements/ improvements for patient care and staff well being RESULTING IN: An inability to deliver its services efficiently and effectively. Poor environment and experience for patients, visitors and staff. Estate infrastructure problems. Unable to replace failing/ ageing plant and equipment. Poor estate regulatory compliance. High carbon footprint. Loss of service and productivity. Increased backlog maintenance IF: There is insufficient funding to address backlog maintenance across the estate. Then: there is a risk that it may not be able to maintain an estates infrastructure that keeps services functioning, meets statutory compliance regulations and provide enhancements/ improvements for patient care and staff well being RESULTING IN: An inability to deliver its services efficiently and effectively. Poor environment and experience for patients, visitors and staff. Estate infrastructure problems. Unable to replace failing/ ageing plant and equipment. Poor estate regulatory compliance. High carbon footprint. Loss of service and productivity. Increased backlog maintenance Internal - Regular Monitoring through CTMHB's Executive Capital Management Group. Capital Scheme Delivery Programme. Annual Estates and Energy Performance Report received at the Operational Delivery Committee (and planning, Performance and Estates Committee prior to that Committee being disbanded) Routine performance reports submitted quarterly to the Estates and Capital Governance Board and monthly at the Estates Operational Management Team meetings. Escalation of Risk through the Capital and Estates Risk Escalation Group. Comprehensive internal audit programme. External - NHS Shared Services Partnership-Specialist Estate Services (NWSSP-SES) have collected Estates and Performance Monitoring System data (EPFMS) on behalf of Welsh Government. ISO14001 Certification - Environmental Management Achieved. Regular Reporting and Monitoring with Welsh Government. Comprehensive external audit programme.	Prioritisation of Estate Activity based on risk-based decision making. Applications to the Targeted Estates Fund (TEF) to access funding under the infrastructure monies. Applications to the AllWalesCapital Programme on an annual basis. Discretionary Capital Maximise current revenue allocations, optimised for statutory compliance and risk priorities. Maintenance Programme established managed via the Plant Facilities Management System (planned and reactive maintenance jobs). In 2024-2025 the estates operational function was digitised, the estates operatives were provided with mobile devices so that they are now able to work in real time, this has helped to maintain performance despite the staff shortages. Internal - Regular Monitoring through CTMHB's Executive Capital Management Group. Capital Scheme Delivery Programme. Annual Estates and Energy Performance Report received at the Operational Delivery Committee (and planning, Performance and Estates Committee prior to that Committee being disbanded) Routine performance reports submitted quarterly to the Estates and Capital Governance Board and monthly at the Estates Operational Management Team meetings. Escalation of Risk through the Capital and Estates Risk Escalation Group. Comprehensive internal audit programme. External - NHS Shared Services Partnership-Specialist Estate Services (NWSSP-SES) have collected Estates and Performance Monitoring System data (EPFMS) on behalf of Welsh Government. ISO14001 Certification - Environmental Management Achieved. Regular Reporting and Monitoring with Welsh Government. Comprehensive external audit programme.	Lifecycle replacement programme in place to highlight risk and replacement of assets. This is utilised to secure funding from discretionary or Targeted estates funding to replace the highest priority replacement assets.	Operational Delivery Committee	16	C4xL4	9 (C3xL3)	New risk escalated to Organisational Risk Register in July 2025	4.7.2025 - Opened on Datix	4.7.2025	31.08.2025
20	5304	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Sustaining Our Future	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite The AHU at the Royal Glamorgan hospital (RGH) is 25 years old, therefore is at higher risk of failing to meet the required standards due to its age and design, with four recent incidents occurring. If the AHU is not maintained to the required standard this could then lead to further closures at short notice or production being halted. Resulting in: Patient Safety and Quality: Delays in supplying treatments, particularly for cancer patients, which could compromise patient outcomes. Reputation: There is also a risk of severe patient harm if regulatory compliance cannot be maintained. Complaints and Patient Experience: Increased waits to start treatment or delays in treatment, leading to poor patient satisfaction and an increased number of complaints. Regulatory Risk: Negative publicity due to increased waiting times for cancer treatments or the inability to provide certain treatments, resulting in reduced patient and clinician confidence. Financial Risk: Increased medicines expenditure and wastage from having to outsource aseptically prepared products from external suppliers. Research and Innovation: No opportunity to conduct clinical trials involving aseptically prepared products.	The output from the AHU is continuously monitored internally & externally The estates department maintain the AHU regularly here are contingency plans in place to outsource products from elsewhere.	Capital resource approved and the service is working with project manager on timelines which will then initiate a review of the risk to see if mitigations are successful and risk score can be reduced.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	4 (C4xL1)	New risk escalated to Organisational Risk Register in July 2025	29.11.2022	27.06.2025	30.09.2025
21	3567	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	Capacity of Cellular Pathology Service - Space If there is not enough laboratory and office space for Cellular Pathology to operate the core service safely or support increasing demand, service discontinuation and future Health board changes. Then: the service will be unable to work effectively and efficiently in line with Duty of Quality guidance and recognised Health board standards for IPC, H&S etc. Resulting in: Inability to meet increasing demand Increase in staff stress and compromised well being due to working in suboptimal conditions. Poor cancer performance and inability to meet expected turnaround times, impacting on Health Board cancer performance Poor quality patient care due to delays in diagnosis or misdiagnosis Increase in clinical incidents, complaints and potential for reputational damage. Inability to effectively disaggregate the current SLA with Swansea Bay and repatriate services from Bridgend impacting clinical services across CTM. Inability to support full digital rollout and support regional reporting in line with WG strategic direction Delayed development of advanced scientist dissection to support increasing reporting capacity and delivery of workforce modernisation Loss of tissue leading to Serious incidents and Regulatory non-compliance with HTA and potential compromise of HTA license. Financial risk of outsourcing Threat to strategic regionalisation project due to the scale of the lack of capacity in CTM	SGPs are in place to standardise practice and mitigate risk of variation in practice caused by limitations of the laboratory environment. Controls to reduce the use of reception/dissection as a thoroughfare including signage and demarcation belt. Workflows established to maximize efficiency of limited space. Risk and slide filing removed from laboratory area where possible. System of work including check established in dissection to minimize risk of error. IPC and H&S environment inspections undertaken to assess impact of laboratory environment on clinical effectiveness and risk to patients and staff.	Mitigating Action Plan includes: Engagement with estates to review small scale projects to increase laboratory space. Engagement and participation in Regional Scoping group to scope options including estates to look at long term solutions. Update July 2025 - Initial meeting held 10/06/25 to discuss options for progress. Follow up meeting scheduled to finalise what options meet future requirements and look to understand feasibility. Discussed plans with COO and Planned care colleagues around options within RGH. No change to risk at present.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	C3xL2 4	↔	28.05.2019	27.06.2025	31.07.2025
22	5045	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	Access to Neurology Inpatient and Outpatient Services for CTM Residents If there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of RTE; Then: existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue. Resulting in: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients.	An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint x1 consultant neurologists within CTM as part of the Neurology Liaison Plan. A locum consultant neurologist started in Royal Glamorgan Hospital (RGH) in December 24 and is currently providing inpatient support to RGH and 4 OP clinics per week. This is supporting reducing the OP backlog and improving inpatient support, however, as at end of March 25 there are 1782 patients waiting over 26 weeks for a first op appointment. MTP bid for neurology consultant posts submitted and awaiting a decision. Update July 2025 - Agreement to progress CTM Neurology Liaison service through support the recruitment of 2 x Consultant Neurologists posts. These posts are being advertised as part of a targeted recruitment campaign. Date to be confirmed.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	09.3.2022	20.06.2025	31.08.2025	
23	5576	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Palliative Medicine Staffing If the Health Board are unable to recruit to the vacant Palliative Medicine Consultant post in Ysbyr Cwm Cynon (YCC) for Merthyr/Cynon. Then: there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant complement. Resulting in: a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status.	Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant. Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards.	Update July 2025 - Care Group update as at 24.06.25 - meeting arranged with COO and CEO on 26.06.2025 to agree engagement plan as part of wider system changes with view to commence process. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	11.10.2023	25.06.2025	31.08.2025
24	4973	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	Clinical Medical Cover within CTM Adult Mental Health Services If: CTM Mental Health Service fails to implement adequate senior medical cover across adult in-patient and CHMT services Then: the Health Board's ability to provide quality care, a safe environment for patients and a good standard of training for junior doctors will be reduced and potentially compromise the safety of patients and staff Resulting in: sub-optimal care to patients, inability to discharge its legal duties under the Mental Health Act, due to insufficient numbers of suitably skilled and experienced Approved Clinicians. Junior doctor supervision will be reduced which may affect future recruitment, patient safety/experience compromised and staff well being will be poor.	Functional inpatient model in place with 3 consultants to cover. Redeployment out of the service and resignation has led to a further depleted workforce and cover will reduce to two consultants from January 2025 with additional middle grade support. Rehabilitation service is at a critically low level with urgent closure of one service needed. Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients. Difficulty recruiting to locum posts due to introduction of rate card and need to have Welsh AC approval. Permission to go out to non-DE has been provided. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements. Two PAs recruited to Rehab and IP in Jan/March 2025 which will free up senior time The Adult Directorate is managing medical staffing through "escalated action" procedures with daily scrutiny and communication pressures and counter measures. To release the Consultant body. Daily reviews with Retinue on the availability of staff	Substantive jobs which are new posts are being developed and advertised. Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025. Update July 2025 - The control measures in place are themselves fragile and the implications of them being ineffective are major. The control measures are having to be reviewed on a daily basis to ensure their remain effective. No change to risk at present.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4xL3)	↔	06.01.2022	25.06.2025	31.07.2025
25	5821	Executive Director of Strategy & Transformation	Central Directorate - Commissioning	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business Interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB). If: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GPs have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update 17.04.2025 - agreement with North Bristol NHS Trust extended to 30/4/25 to all North Bristol Trust to schedule all the new out patient appointments. Wash up meeting planned for May to discuss progress and whether it is something that could be repeated in 25/26 (subject to funding). Funding discussions ongoing. Welsh Government have commenced scoping exercise and has met with all University Health Board commissioning leads in March and will meet with clinical leads this month. Draft report to be submitted to Welsh Government by scoping lead in April. Update 26 June 2025 - wash up meeting between CTMHB and North Bristol Trust has been held. 59 urgent referrals were triaged and 45 of these were offered an outpatient appointment. Majority of those seen were discharged back to GP with management advice. Looking to secure funding to support an additional 40 urgent referrals but not yet confirmed. Meeting again in July to explore option of longer term solution. This cannot happen at the moment due to CTMHB awaiting the outcome of a Welsh Government scoping exercise.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL5	4 (C4xL1)	↔	08.07.2024	26.06.2025	29.08.2025
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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
2755	Director of Digital	Central Corporate - Digital & Data	Assistant Director for Digital Delivery	Sustaining Our Future	Statutory Duty, Regulation, Mandatory Requirements	EUC: Unsupported Windows 10 Desktop Operating Systems	IF: Unsupported Desktop 10 Operating Systems on the network are not upgraded / replaced THEN: the devices running these OS's, will remain unsupported by the vendor as well as being vulnerable to: 1. Virus infection. 2. Intrusion. 3. Denial of Service. 4. Support Issues. RESULTING IN: A lack of vendor support for any issues, and a potential loss of data, function or service, due to the increased risk of the above points. There is also an increased risk to the rest of the network as these devices could be used as a route in, before traversing the network with malicious intent.	1. Plan of Action to upgrade current operating systems. 2. Where equipment cannot be upgraded replacement stock available. 3. Rolling replacement programme includes replacement of remaining equipment. 4. Where operating system cannot be replaced there is a Risk Assessment document from OSSMB to mitigate the risks.	Update July 2025 - Currently CTNUHB have approx. 6200 devices that are still on Windows 10. Based on that figure the costs for a 1-year ESU extension would be ~£330,000. We have mobilised a task and finish group to speed up migration to Windows 11 and will report progress and potential financial impact to here. Progress across Wales in other Health Boards is being tracked and conversations are taking place about a co-ordinated national response to the challenge within Directors of Digital forum and National Service Management Board.	Operational Delivery Committee	16	C&L4	4 (C&L1)	↔	11.07.2017	1.7.2025	31.08.2025
6039	Director of Digital	Central Corporate - Digital & Data	Assistant Director for Digital Delivery	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service/business interruption	Increased cost of VMWare Licensing	IF the proposed increase in costs for providing a virtual server infrastructure (VMWare/ViXrail) is not affordable or fully funded within FY25/26 and FY26/27 THEN nearly every clinical service (e.g. Pathology, ICU) will be affected RESULTING IN the health board being unable to access local clinical systems	Identification of funding within discretionary capital allocations and opportunities in end of year slippage - estimates to replace all 35 VXiRail nodes is £3.5m (Feb 26 - 4 nodes go out of support, June 26 - 6 nodes go out of support, Jan 27 - 18 nodes. Estimate cost to replace each node is £100k).	The further mitigating action plan is that the Digital and Data Team are exploring alternative technologies with providers to ensure an effective and efficient service. Update July 2025 - Welsh Government have indicated that additional capital funding maybe made available earlier in the Financial Year - so plans for replacements for the 6 nodes that go out of support in June 2026 are being drawn up. Replacement options for the 18 nodes going out of support in January 2027 are being considered.	Operational Delivery Committee	16	C&L4	8 (C&L2)	↔	09.01.2025	1.7.2025	31.08.2025
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	IF: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation 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.	Update 12.6.2025 - Progress against the timeframes outlined in the Project Initiation Document for the Policy Review programme are being met. There are some delays in gathering the baseline information status for all Non Clinical Policies and Procedures, which at this stage this is not causing concern in terms of implementation date, however, this will be raised with the Executive Management Board via a progress update being shared with them on the 30 June 2025. At this stage the mitigating actions are yet to positively impact the risk so the risk score remains unchanged. Next risk review scheduled for end of August 2025	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 (C&L2)	↔	26.10.2021	12.06.2025	31.08.2025
5691	Chief Operating Officer Closed Session due to business sensitivities	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	The detail of this risk is captured in the Closed Session due to business sensitivities.				Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C&L4	C&L4 12	↔	31.01.2024	25.06.2025	31.08.2025
5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	Cross Health Board Data Sharing	IF: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMNUHB have asked for alternate options for a quicker solution and transparent, available data. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems - this has been an issue for some time. ABNUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pen-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. Update May 2025 - No change to risk score or mitigation this period. Executive Medical Director to raise risk again at next All Wales Medical Director meeting. Update 23 June 2025 - Still no movement here. Its within the discussion of Digital HealthCare Wales provider status and open sharing of data between Health Boards. The current proposal has not been agreed between ABNUHB and DHCW. CTMNUHB are raising and raising the concern, however, cannot directly resolve.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 C&L2	↔	26.04.2024	23.06.2025	01.09.2025
5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	The impact of "Right Care Right Person" (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 July 2025 - MHLD Care Group update 17.6.2025 - Risk reviewed, no change at present however in the Right Care Right Person meeting on 13/06/25 it was agreed to reduce the Likelihood from Highly likely to Likely which would reduce the over score from 16 to 12 and lead to a de-escalation from the Organisational Risk Register, however this decision needs to be ratified through the Care Group's internal Operational Management Board prior to taking effect.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	16	C&L4	12 (C3&L4)	↔	08.12.2023	17.06.2025	31.07.2025
5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes	IF there is no children and young person's weight management service Then the Health Board will be unable to support children and young people to manage their overweight and obesity Resulting in: non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PIPN continues to be delivered in Hentyrh (PHW funding until 26) and Taff Ely and Rhondda (Cluster funding until 26) 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3) Business case developed submitted and submitted for IMTP consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Finance dependant controls: 1) Set up service if funding identified via IMTP process.	Update July 2025 - Awaiting formal notification of IMTP investment which will reduce this risk.	Quality, Safety & Experience Committee Strategic Development Committee	16	C&L4	8 C&L2	↔	13.10.2023	20.06.2025	18.08.2025
5374	Executive Director of Strategy & Transformation	Central Function - Environmental Sustainability	Deputy Director of Strategy and Transformation	Sustaining Our Future	Environment / Estate/ Infrastructure	Fulfilling our environmental and social duties	IF: the health board's decisions fail to reflect our values or consider the long term environmental or social impact Then: we will not fulfil our socio-economic duty, our Wellbeing of Future Generations objectives or our value based healthcare principles Resulting In: negative environmental and social impacts and loss of trust and confidence among stakeholders	• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • CTM 2030 delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. • Decarbonisation Action Plan • Established a CTM Environmental Sustainability Group which will have oversight and delivery of CTM's decarbonisation agenda • CTM 2030 seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management - elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases • CTM representatives attend the Welsh Government Green meeting • Adaptation sub-group established and plan to be produced by March 2026 • OAP updated and signed off by Board March 2024 • Board and Committee cover papers also now include environmental impact against SIs. • Sustainability post appointed to, started July 2024 - Use of SimplyGo platform - Close working with Innovation Team and wider partners to deliver a number of sustainability projects - Solar panels being rolled out - LED lighting fitted in POW as part of roof programme	Update 26 June 2025 - Mitigating action continues to undertake work to assess the environmental impact of projects and programmes that are not classed as "sustainability" projects/programmes. Currently score remains unchanged.	Strategic Development Committee	16	C&L4	8 (C&L2)	↔	21.2.2023	26.06.2025	29.08.2025

	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
41	4691 Linked to RTE Risks 4803, 4795, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	IF: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update July 2025 – RHLD Care Group Director update 30.06.2025 - 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 now that the capital teams capacity has become available since the initial Princess of Wales Hospital critical incident. No change to risk score at this stage.	Quality, Safety & Experience Committee Operational Delivery Committee	13	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	30.06.2025	31.08.2025
42	5820	Executive Director of Public Health	Public Health – Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	IF as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. THEN there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIP. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. Resulting in avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with Cymru finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation N/B – Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update July 2025 – Local Public Health Team Strategic Development meeting are scheduled to meet on the 8th July 2025 to review the risk and consider if risk score can be reduced or whether it remains at a score of 12. Review date end of July.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	7.7.2025	11.07.2025
43																		

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
Nil											

	A	B	C	D	E	F	G	H	I	J	K
	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
1											
	5903	Chief Operating Officer	Improving Care	Statutory Duty, Regulation, Mandatory Requirements.	Unfunded Continuing Care Packages / unfilled packages	If the budget is not allocated, to employ additional staff within Children's Continuing Care Then agreed packages of care which have clearly identified an unmet need, will remain unfilled Resulting in impacts of child and family wellbeing, risk to the child, risk of the unmet need continuing, children with packages for school being prevented from attending. Not meeting health boards obligation against Welsh Government Continuing Care Guidance.	Recruitment activity underway. Temporary posts advertised for Health Care Support Worker - partially successful Risk remains high as staff need to be recruited, inducted and trained SBAR for permanent recruitment escalated to Operational Management Board - no decision to date.	Update May 2025 - Financial allocation being discussed with Care Group which is likely to reduce / remove this risk. Update July 2025 - 4 new starters will complete initial training by end of July to manage the package (2nd person) currently being managed by new cross agency, rotas from mid august move to health board staffing, therefore risk can be closed	Quality, Safety & Experience Committee Operational Delivery Committee	jul-25	Update July 2025 - Care Group have advised that this risk can now be closed as following review of continuing care new staff training and packages then within the next 6 weeks (from 1 July) the service will be totally removing New Cross agency from the remaining package, the service have put in place regular oversight during this period from the CCN key workers.
2											
	5932	Executive Director of Finance Executive Lead for Estates	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 clinical/non 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 July 2025 - This risk has been removed as the roof and battens have been competed above patient areas in Phase 1, only plant rooms remain. Risk score revised to a likelihood of 2 as it could be on a very small scale/localised area compared to the whole Phase 2 roof.	Operational Delivery Committee Quality, Safety & Experience Committee Health, Safety & Fire Sub Committee	jul-25	Capital & Estates Directorate have removed this risk as the roof and battens have been competed above patient areas in Phase 1, only plant rooms remain. Risk score revised to a likelihood of 2 as it could be on a very small scale/localised area compared to the whole Phase 2 roof. Target score of 10 was reached.
3											
	5961	Executive Director of Finance Executive Lead for Estates	Sustaining Our Future	Environmental / Estate / Infrastructure	Remedial roof works to resolve the water ingress at POWH.	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 areas at the 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 CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations to vacate 1st floor wards & depts. 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 July 2025 - risk of water ingress – this risk has been significantly reduced for the Phase 1 roof that this refers to as the roof has been replaced as in risk 5932 above. Risk likelihood score reduced as only leak on Phase 1 recently was above ITU and the flashing was identified as the problem and subsequently corrected so this should not reoccur.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	jul-25	Capital & Estates Directorate have removed this risk as it has been significantly reduced for the Phase 1 roof that this refers to as the roof has been replaced as in risk 5932 above. Risk likelihood score reduced as only leak on Phase 1 recently was above ITU and the flashing was identified as the problem and subsequently corrected so this should not reoccur. Target score reached.
4											

	A	B	C	D	E	F	G	H	I	J	K
	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
1											
5	5669	Director of Digital	Sustaining Our Future	Service / Business interruption	Increased cost of Citrix Subscription	If: the proposed increase in costs for providing thin client (Citrix) desktops to staff is not affordable or fully funded Then: Some or all of the staff that use Citrix will no longer be able to do so Resulting in: Staff being unable to access local and national systems Citrix is used by staff to access Virtual Desktops from IGEL thin client devices - 4000 across. These devices only work with Citrix. Staff who access systems using Windows Laptops and PC's will be affected less severely, although many do use Citrix for certain functions. Legacy Annual Budget - £284K Interim renewal offer - £416k (based on 12 month cost) Proposed Annual Cost - £1.44M Aside from the CTM Local use and costs for Citrix - National applications that are delivered via Citrix are also in scope of the cost increase, and DHCW have indicated that any costs associated with this are likely to be passed on directly to the organisations.	Renewal costs will increase. Work underway with NHS Wales and Citrix to arrive at the best value licensing on an all Wales basis. CTM Renewal is March 2024, although an interim offer has been made which will take the renewal to December 2024 - allowing all NHS Wales organisations to align their renewals and for negotiations around licensing levels and quantities to be fully understood. A task and finish group has been started to reduce Citrix use across CTM. Additional WG slippage money has been secured to replace a large percentage of our iGel estate, approx. ~2,500 devices, out of an iGel estate of ~3,500 devices.	Update July 2025 - The procurement activity has been completed and a new 3 year contract with Citrix has been negotiated. The new contract, effective from 14th December 2025 will provide a saving of ~£226,000 p.a. (~73%) compared to the current price. Work will continue to reduce our thin client estate. This risk can now be closed.	Operational Delivery Committee	Jul-25	Update July 2025 - The procurement activity has been completed and a new 3 year contract with Citrix has been negotiated. The new contract, effective from 14th December 2025 will provide a saving of ~£226,000 p.a. (~73%) compared to the current price. Work will continue to reduce our thin client estate. This risk is now closed.
6	4337	Director of Digital	Creating Health	Operational: - Core Business - Business Objectives - Environmental / Estates Impact - Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board	If: The Health board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers Then: The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	Key Controls 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan There is no data item integration with GP systems, the ABHB Clinical Workstation or Local Authority system Numerous delays in NHS Wales progressing open architectural approach which results in CTM UHB being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Update July 2025 - Whilst the PAS disaggregation has completed, Care Groups now need to work with operational managers and clinicians to access Health Board wide ways of working and Standard Operating Procedures to manage patient pathways in a consistent way across CTMUHB. This risk, associated with the migration, can now be closed. Improvements post migration will be tracked in risk 6102.	Operational Delivery Committee	Jul-25	Update July 2025 - Whilst the PAS disaggregation has completed, Care Groups now need to work with operational managers and clinicians to access Health Board wide ways of working and Standard Operating Procedures to manage patient pathways in a consistent way across CTMUHB. This risk, associated with the migration, can now be closed. Improvements post migration will be tracked in risk 6102.
7	4908	Executive Nurse Director / Deputy Chief Executive	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update July 2025 - this risk has been superceded by new risks	Quality, Safety & Experience Committee Operational Delivery Committee	Jul-25	Update July 2025 - this risk has been superceded by new risks



Agenda Item

4.2

Audit, Risk & Assurance Committee

Interim Amendments to the Model Standing Financial
Instructions Chapter 11 for Local Health Boards

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Gareth Watts, Director of Corporate Governance/Board Secretary
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Cally Hamblyn, Assistant Director Governance and Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

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	

1. Situation /Background

- 1.1 NHS bodies in Wales must agree Standing Orders (SOs). This, together with a set of Standing Financial Instructions (SFIs) and a scheme of decisions reserved to the Board, a scheme of delegations to officers and others, and a range of other framework documents, set out the arrangements within which the Board, it's Committees, Advisory Groups and NHS staff make decisions and carry out their activities.
- 1.2 Standing Orders and Standing Financial Instructions should be based upon the model determined by the Welsh Government.
- 1.3 All Health Board members and officers must be aware of the SOs and, where appropriate, should be familiar with their detailed content.

2. Specific Matters for Consideration

- 2.1 The Welsh Government has made amendments to the model documents issued in July 2023 to comply with the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and the Procurement Act 2023 (and associated subordinate instruments).
- 2.2 The relevant SFI chapter issued in 2023 will now be superseded by the following document:
 - Model Standing Financial Instructions - Local Health Boards - Chapter 11- Procurement and Contracting.

3. Key Risks / Matters for Escalation

- 3.1 Once endorsed by the Committee this update to the SFIs will be escalated to the Board for approval
- 3.2 Once approved, the relevant update will be uploaded to SharePoint and the Health Board's Internet site.

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	Choose an item.
	If more than one applies please list below:
	A Wales of Cohesive Communities



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>)	Choose an item. 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>)	Efficient 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: N/A this action is a requirement of Welsh Government
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):	If no, please include rationale below: N/a – Welsh version can be made available if 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>) /	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 **ENDORSE FOR BOARD APPROVAL** the amendments to Chapter 11 of the Health Board's SFIs.

6. Next Steps

- 6.1 The update will be taken to Board for formal approval and adoption.

11. PROCUREMENT AND CONTRACTING

Any instruction or summary of legislation in this chapter of the Local Health Board's (LHB's) SFIs is neither legal advice nor statutory guidance, is not intended to be exhaustive, nor an authoritative statement of the law, nor is it intended to override existing legal obligations applicable to the LHB. The law is subject to constant change and the LHB, should seek its own legal advice as appropriate as well as consult with NHS Wales Shared Services Partnership (NWSSP) Procurement Services.

In the event of any conflict between what is contained in legislation and the LHB's SFIs, the former shall prevail.

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement, the service is delivered by NHS Wales Shared Services Partnership (NWSSP) Procurement Services ("**Procurement Services**").

11.1.2 Procurement staff employed by NWSSP provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the LHB. Where the term 'procurement staff' or 'department' is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of Procurement Services, e.g.; 'Pharmacy' and 'Works', who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement, including tendering and contracting processes. The policies and procedures shall comply with these SFIs, the NWSSP Procurement Manual (existing and future revised), and the Revised General Consent to enter Individual Contracts [included as Schedule 1 of these SFIs].

11.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

Model Standing Orders, Reservation and Delegation of Powers for LHBs
Schedule 2.1: Standing Financial Instructions
Revised Chapter 11
May 2025

11.2.3 NWSSP's Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures are:

- kept up to date;
- conform to statutory requirements and regulations;
- adhere to guidance issued by the Welsh Ministers; and
- are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Legislation Governing Public Procurement

11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, the [Procurement Act 2023](#) and associated subordinate instruments (together “**the 2023 Act**”) and the [Health Services \(Provider Selection Regime\) \(Wales\) Regulations 2025](#) and associated subordinate instruments (together “**the PSR Wales Regulations**”) are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services (“**In-Scope Health Services**”) and further detail these can be found in the Welsh Government's statutory guidance titled “[Health service procurement: statutory guidance](#)”. Goods and services which are not In-Scope Health Services (“**Goods and Non-Health Services**”) fall within the scope of the 2023 Act. `

11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words ‘**In-Scope Health Services Only**’ will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the Act, the words ‘**Goods and Non-Health Services Only**’ will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability.

11.3.3 ‘**Goods and Non-Health Services Only**’ The Act governs the procurement of Goods and Non-Health Services. The Welsh Government's Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the LHBs SFIs. **In the event of any conflict between what is contained in the 2023 Act and the LHB's SFIs, the former shall prevail.**

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11.3.4 **‘In Scope Health Services Only’** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the LHB to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB’s SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the LHB’s SFIs, the former shall prevail.**

11.3.5 All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices and all associated subordinate instruments are the model upon which all procurement exercises should be based.

11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the LHB and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:

- Social Partnership and Public Procurement (Wales) Act 2023
- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government’s Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government ‘Towards zero waste: our waste strategy’
- The Welsh Government Procurement Policy Framework, including:
 - Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)

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- The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023)

11.4 Procurement Principles and Objectives

11.4.1. The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.4.2 **‘Goods and Non-Health Services Only’** The legal and governing principles guiding ‘covered procurement’ under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:

- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority’s procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs.
- Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 **‘In Scope Health Services Only’** The legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the LHB doing the following:

- Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;
- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government’s Health Service Procurement: Statutory Guidance; and
- Having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

11.5 Procurement Procedures

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11.5.1 To help towards ensuring that the LHB is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the LHB shall, through Procurement Services, ensure that it shall have procedures that set out:

- a) requirements for, and exceptions to, formal competitive tendering ('**Goods and Non-Health Services Only**');
- b) tendering processes including post tender discussions;
- c) requirements and exceptions to obtaining quotations ('**Goods and Non-Health Services Only**');
- d) evaluation and scoring methodologies; and
- e) approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the LHB delegation arrangements and approval processes.

11.6 Notification to Welsh Government and consent from the Welsh Ministers

11.6.1 **Schedule 1** details the requirement and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for the LHB to comply with Standing Orders, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy and in support of social, environmental, economic and cultural goals in Wales, the LHB must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible and within the legislative framework. The principles of the [Well-being of Future Generations \(Wales\) Act 2015](#) ("**the WBFG Act 2015**") should be adopted at the earliest stage of procurement planning.

11.7.2 For example, the WBFG Act 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a shared purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well-being of Wales.

11.7.3 The seven well-being goals are:

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- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

11.7.4 The WBFG Act 2015 puts in place a “sustainable development principle” which tells relevant public bodies how to go about meeting their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of brief summary are as follows:

- **Collaboration:** acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives;
- **Integration:** considering how the public body’s well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies;
- **Involvement:** the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves;
- **Long term:** the importance of balancing short-term needs with the need to safeguard the long-term needs; and
- **Prevention:** how acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The LHB is required to consider the [Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains](#) and the [Code of Practice](#) on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of actions designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The LHB shall make use of the tools developed by Welsh Government Commercial Delivery team in implementing the principles of the WBFG Act 2015. The LHB shall benchmark its performance against the WBFG Act 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, LHBs are required to take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the [Sustainable Risk Assessment Template](#) (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with the ‘covered procurement’ objectives in the 2023 Act, Welsh Government’s commitments are set out in Welsh Government’s ‘technical guidance for covered procurement’ and the current and subsequent versions of the Wales Procurement Policy Statement (WPPS). The LHB shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

11.9 Planning Procurements

11.9.1 The LHB must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and an appropriate representative from the service and other appropriate stakeholders, (depending on the value, risk and complexity of the procurement). The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost;
- the likely ‘route to market’ which will consider the legislative and policy framework set out above;
- the availability of funding to be able to award a contract following a successful procurement process; and
- that the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the four principles of prudent healthcare:

- equal partners through co-production;
- care for those with the greatest health need first;
- do only what is needed; and
- reduce inappropriate variation.

For ‘**Goods and Non-Health Services Only**’ Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. For ‘**In Scope Health Services Only**’ Value Based Healthcare should be considered under the Key Criteria ‘Value’ where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

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11.9.4 Where free of charge services are made available to the LHB, 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 LHB does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the LHB should be submitted by the LHB Board Secretary to the Audit Committee.

11.9.5 The LHB is required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government's Health and Social Care Finance Department, and the opinions of Procurement Services and NWSSP Legal and Risk prior to external opinion being sought, where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the LHB's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government's Commercial Delivery team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by public sector bodies located outside of Wales.

11.10.2 **'Goods and Non-Health Services Only'** - In the absence of an existing suitable procurement framework to source the required item, a competition must be operated in accordance with the 2023 Act and the table below. The LHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations.

TABLE ‘Goods and Non-Health Services Only’

Goods/Services/Works Whole Life Cost Contract value (figures excl. VAT)	Minimum competition (1)	Form of Contract
Below £5,000	Evidence of value for money has been achieved	Purchase Order
£5,000 - £24,999	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
£25,000 plus to the prevailing Procurement Act 2023 threshold (2)	Advertised open call for competition. Minimum of 4 tenders received if available	Formal contract and Purchase Order
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required (3)	Formal contract and Purchase Order

(1) Subject to the existence of suitable suppliers

(2) The Procurement Act 2023 - [Schedule 1 – threshold amounts](#)

(3) In accordance with the requirements set out in Schedule 1.

11.10.3 ‘In Scope Health Services Only’ - In the absence of an existing suitable procurement framework to source the required item, the LHB is required to follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations and the [health service procurement: statutory guidance](#). The LHB should note that one of the key objectives of the PSR Wales Regulations are to provide more flexibility when selecting providers for health services with competitive tendering being one tool for the LHB to use when it is of benefit; alongside other routes that may be more proportionate, with a view to enabling the development of stable supplier partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB’s SFIs.

11.10.4 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 **‘Goods and Non-Health Services Only’** The LHB must consider the minimum financial thresholds for quotes and competitive tendering arrangements when undertaking a procurement. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in [Schedule 1 of the 2023 Act](#).

11.11.2 **‘Goods and Non-Health Services Only’** Advice from Procurement Services must be sought for all requirements in excess of £5,000 (excluding VAT).

11.11.3 **‘Goods and Non-Health Services Only’** The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 **‘Goods and Non-Health Services Only’** Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000 (excluding VAT), must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 (excluding VAT) and require competition.

11.11.5 **‘In Scope Health Services Only’** There is no minimum financial threshold for application of the PSR Wales Regulations.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- required timescales are achievable.
- specifications are drafted which:
 - are fit for inclusion in competition documents;
 - are drafted in a manner encouraging innovation by the market;
 - are capable of being responded to and do not narrow competition;
 - deliver in line with legislative and policy frameworks;
 - include robust performance measures to effectively measure and manage supplier performance; and
 - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities. **‘Goods and Non-Health Services Only’**, under

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the 2023 Act there is a requirement to set and publish at least 3 Key Performance Indicators (KPI's) for contracts above £5m, and to publish a notice on these at least annually during the term of the contract (note: this does not apply to 'light touch regime' contracts) and in circumstances where the LHB considers that the supplier's performance under the contract could not appropriately be assessed by reference to key performance indicators (s.52(2) of the 2023 Act)).

11.12.3 'Goods and Non-Health Services Only' Criteria for selecting suppliers and achieving an award recommendation must be evaluated on the basis of the "Most Advantageous Tender", which provides contracting authorities with greater flexibility to take into account wider social and environmental issues where that is decided to be relevant for the best solution. Such criteria must:

- be appropriately weighted;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life costs, including (where appropriate) the cost of change and / or end of life costs.

11.12.4 'In-Scope Health Services Only' Criteria for selecting suppliers and achieving an award recommendation must follow (where applicable) the provisions in the PSR Wales Regulations, regarding:

- Key Criteria (regulation 6);
- Basic Selection Criteria (regulation 22); and
- Exclusions (regulations 25 and 26)

The LHB is required to ensure the appropriate criteria is set with regards the selected procurement process, as set out under the PSR Wales Regulations and [Health service procurement: statutory guidance](#)".

11.13 Single Quotation Application (SQA) or Single Tender Application (STA) - 'Goods and Non-Health Services Only'

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- a technical compatibility issue which needs to be met e.g., specific equipment required, or compliance with a warranty cover clause;

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- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- when joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/national strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through a Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- robust justification is provided;
- a value for money test has been undertaken;
- no bias towards a particular supplier;
- future competitive processes are not adversely affected;
- no distortion of the market is intended;
- an acceptable level of assurance is available before presentation for approval in line with the LHB's Scheme of Delegation; and
- an "or equivalent" test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the LHB has already entered into an arrangement directly.

11.13.5 As a SQA or STA are only used in exceptional circumstances the LHB, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent repeated inappropriate use of a SQA or a STA by the LHB.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- instruct a representative of the LHB to attend Audit Committee;
- escalate to the Board;
- request an internal Audit Review;

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- request further training; or
- take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. The NWSSP Procurement Manual details the schedule of departures from a SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, Procurement Services will retain a central register of all such activity including SQA/STA's not endorsed by Procurement Services or any exceptional matters.

11.14 Disposals - 'Goods and Non-Health Services Only'

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g., Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the LHB making use of any agreements covering the disposal of such items.

11.14.3 The LHB must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the LHB. Evaluation teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include:

- retaining accurate records;
- monitoring contract performance measures;
- engaging suppliers to ensure performance delivery;
- implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by Procurement Services.

11.16.3 Advice on Contract Management best practice is available from Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 ‘Goods and Non-Health Services Only’

11.17.1.1 Extending, modifying, or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g., scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.1.2 If there is no such provision, the 2023 Act defines such limitations. Further information on contract modifications can be found in [sections 74-77 of the 2023 Act](#) and in [Guidance: Contract Modifications](#).

11.17.2 ‘In-Scope Health Services Only’

11.17.2.1 Modification of the scope of an existing contract is possible if:

11.17.2.1.1 the modification is clearly and unambiguously provided for in the original contract or framework agreement documents, or

11.11.2.1.2 the original contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character.

11.17.2.2 If provisions set out in 11.17.2.1.1 are not met, the PSR Wales Regulations define limitations concerning modifications of contracts as being, the modification must be:

- solely a change in the identity of the provider however continues to meet the basic selection criteria, and there are no other considerable changes to the contract; or
- made in response to external factors beyond the control of the 'relevant authority' (as defined under section 10A of the National Health Service (Wales) 2006), and the provider, for example changes in patient or service user volume; changes in prices in accordance with a formula provided for in the contract documents and neither of these modifications render the contract or framework agreement materially different in character; or
- made at the discretion of the relevant authority and does not render the contract or framework agreement materially different in character and the cumulative change in the estimated lifetime value of the contract or framework agreement is under £500,000 or is under 25% of the estimated lifetime value.

11.17.3 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.4 If there was no provision to extend, further approvals are required from the LHB budget holder and the LHB Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.5 This ensures an appropriate identification and assessment of potential risks to the LHB's compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.6 The budget holder must seek advice from Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

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11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB. The budget holder will source those goods (**‘Goods and Non-Health Services Only’**) or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract frameworks, such as those managed by Welsh Government’s Commercial Delivery team, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the Procurement Services to undertake quotation / tendering exercises (**‘Goods and Non-Health Services Only’**) on their behalf in line with SFI 11.11 thresholds (**‘Goods and Non-Health Services Only’**).

11.18.3 All orders for goods (**‘Goods and Non-Health Services Only’**) and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The LHB will ensure compliance with the ‘No Purchase Order, No Pay’ policy, the All-Wales policy which was introduced to ensure that Procure to Pay continues to provide high-class services on a ‘Once for Wales’ basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

- a) Be consecutively numbered;
- b) State the LHB’s terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the LHB by Procurement Services.

SCHEDULE 1

GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as “General Consent to enter individual contracts” replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI’s) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

“(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2) In particular it may—

- (a) acquire and dispose of property,*
- (b) enter into contracts,*
- (c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the Local Health Board or for any purposes relating to the health service).*

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case).”

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 (“**the Investment Guidance**”) includes the following in relation to Local Health Boards:

“Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular WHC(2015)031. Organisations should ensure

Model Standing Orders, Reservation and Delegation of Powers for LHBs
Schedule 2.1: Standing Financial Instructions
Revised Chapter 11
May 2025

that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.”

This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC’s mentioned above were issued.

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

“Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.”

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process).

That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.

Entering into contracts

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care’s consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;
- All eligible LHB and HEIW and DHCW contracts >£1m in total to be submitted to the Director General HSCEY for consent prior to award;

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Revised Chapter 11
May 2025

- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

- i) Contracts of employment between LHBs, HEIW, or DHCW and their staff;
- ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW;
- iii) Out of Hours contracts;
- iv) All NHS contracts; that is where one health services body contracts with another health service body;
- (v) Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g. annual education and training commissioning also do not require further Ministerial notification or consent; and
- (vi) Contracts between £500k - £1 million (for noting) and £1 million + (for approval).
 - a) Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.
 - b) Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales



Agenda Item

5.1

Audit, Risk & Assurance Committee

Losses and Special Payments 01.04.25 to 30.06.25

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
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

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

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

1. Situation /Background

- 1.1 This report advises the Audit & Risk Committee on the losses and special payments made by the University Health Board (UHB) for the 3-month period from 1 April 2025 to 30 June 2025, as required by the 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 £3,052k, 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 £606k, giving a net cash out position for the period of £2,446k.
- 2.6 The losses and special payments are available in detail on request from the Head of Corporate Finance if required and are summarised in the table below.



	01.04.25 - 30.06.25 £000	Previous Periods	Total 25-26 £000
Medical Negligence Claims	1,732	0	1,732
Medical Negligence Costs	688	0	688
Medical Negligence Defence Fees	497	0	497
Medical Negligence Totals	2,917	0	2,917
Redress Medical Negligence Claims	3	0	3
Redress Medical Negligence Costs	6	0	6
Redress Medical Negligence Defence Fees	3	0	3
Redress Medical Negligence Totals	12	0	12
GP Indemnity Claims	0	0	0
GP Indemnity Costs	36	0	36
GP Indemnity Defence Fees	15	0	15
GP Indemnity Totals	51	0	51
Personal Injury Claims	11	0	11
Personal Injury Costs	38	0	38
Personal Injury Defence Fees	3	0	3
Personal Injury Totals	52	0	52
Permanent Injury Benefit	0	0	0
Permanent Injury Benefit Totals	0	0	0
Other:			
Ex-Gratia	18	0	18
Debt Write Off	0	0	0
WRP Penalty Charge	0	0	0
Ombudsman	2	0	2
Employment Matter/Other	0	0	0
Other Totals	20	0	20
TOTAL	3,052	0	3,052
Recovered from Welsh Risk Pool	(606)	0	(606)
Net Cash Write-Off/(Recovery)	2,446	0	2,446

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 £606k of claims (11 claims), this was paid in June. 3 further claims reviewed by the committee were deferred, and another 17 claims were deferred until further information was received.

b) Provision as at 30 June 2025

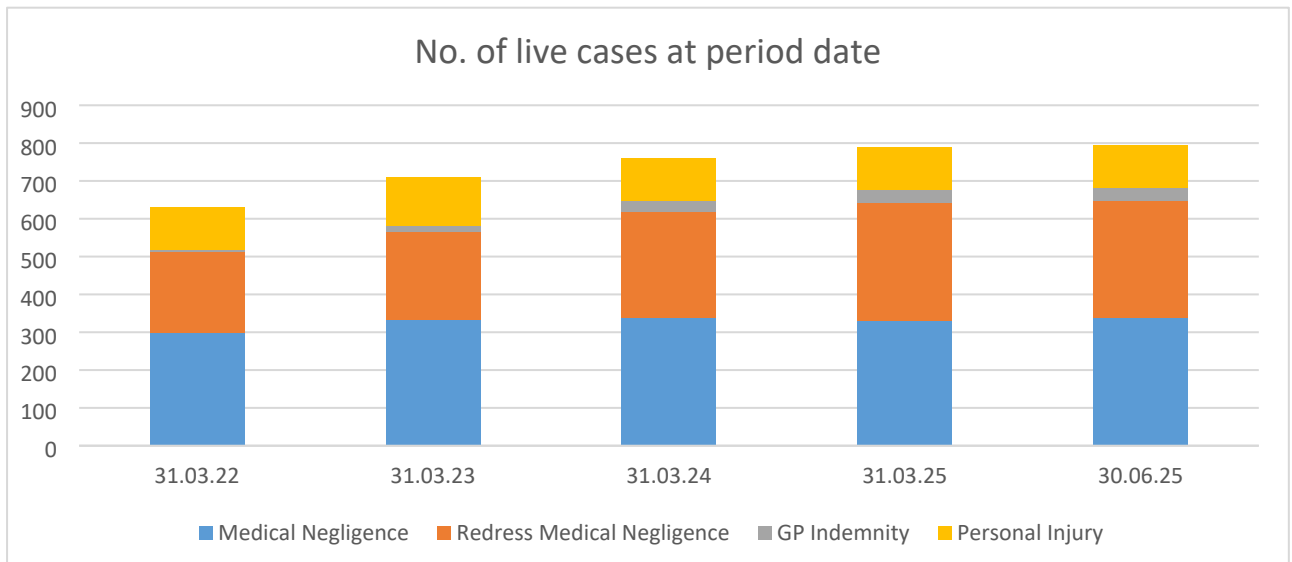
- 2.9 A provision reflecting the estimated value of the claim will be made on the balance sheet as a claim is deemed probable. There will also be an estimate for the value recoverable from Welsh Risk Pool, leading to a net provision value on the balance sheet.
- 2.10 The table below shows the provision 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 decreased by £5,980k since 31st March 2025, this is mainly due to a decrease in value of medical negligence claims.
- 2.12 The net provision at the end of 30th June 2025 was £14,092k which is £2,188k higher than the previous reported period.



	30.06.25	31.03.25	31.03.24	31.03.23	31.03.22
	£000	£000	£000	£000	£000
	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
Medical Negligence claims/costs	130,715	136,729	94,478	72,198	65,127
Redress Medical Negligence claims/costs	482	490	372	385	235
GP Indemnity (Note 1)	1,744	1,670	612	0	0
Personal Injury claims/costs	1,702	1,734	917	701	611
TOTAL CLAIMS/COSTS PROVISION	134,643	140,623	96,379	73,284	65,973
Recoverable from Welsh Risk Pool	(152,467)	(156,234)	(106,450)	(83,623)	(93,074)
NET CLAIMS / COSTS PROVISION	(17,824)	(15,611)	(10,071)	(10,339)	(27,101)
Permanent Injury Benefit	3,732	3,707	3,755	4,077	6,201
NET PROVISION inc Perm Injury Ben.	(14,092)	(11,904)	(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
	30.06.25
	£000
Medical Negligence claims/costs	(3,097)
Redress Medical Negligence claims/costs	2
GP Indemnity	126
Personal Injury claims/costs	20
Recoverable from Welsh Risk Pool	3,161
Net claim expenditure (Note 1)	212
Permanent Injury Benefit	25
Other	20
Total Net expenditure	257

Note 1: The annual budget for net claim expenditure for 2025-26 is £2,019k, with a year-to-date budget of £168k, actual expenditure for the year is £168k, therefore showing a balanced position to June 2025. It is important to note that these costs can fluctuate during the year and we are very early in the year.

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 For 2025/26 WRP are reporting a risk of overspend of £42m, based on the risk sharing agreement, this would equate to an overspend risk for CTM of £6.5m. This is currently included as a risk within our reported position at Month 3.

3. Key Risks / Matters for Escalation

Net provision increase

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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims)	If no, please include rationale below:



	Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee	
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome: Completed as part of the Financial Control Procedures for Losses & Special Payments (FP 15)	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim	
Enw da / Reputational	Yes (Include further detail below)	
	As noted within Quality Impact Assessment section above, reputational risk is managed via the reporting hierarchy.	
Effaith Adnoddau <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 April 2025 to 30 June 2025.
- **NOTE** the risk of overspend on the WRP risk sharing agreement of £6.5m.
- **NOTE** the key risks for escalation on the increasing net provision value and the penalties imposed for overdue deferred learning.

6. Next Steps

6.1 The Audit, Risk & Assurance 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

5.2

Audit, Risk & Assurance Committee

Procurement & Scheme of Delegation Update

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
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

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



1. Situation /Background

1.1 Procurement Matters

The following areas within the Scheme of Delegation (SoD) are reported to the Audit, Risk & Assurance 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 01.04.25 to 30.06.25

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 2025-26.

1.3 Scheme of Delegation and Financial Control Procedures

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

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

2. Specific Matters for Consideration

2.1 Procurement Matters

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

There were no engagements or contracts entered into during the period 01.04.25 to 30.06.25.

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.

In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition;
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

Tables A and B below provides details of such actions during the period 01.05.25 to 30.06.25.

Table A – Single Tender Actions 01.05.25 to 30.06.25

There are none for this period.

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

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

Reference	Title	Supplier	Value	Date Awarded
CTM-DCO-154	Outsourcing Surgical Procedures	Practice Plus	£1,875,432	07/05/25

d) Summary of contracts awarded over £500,000

Health Boards must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. There are none for this period.

e) Free of Charge Services

Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer-term commitment. Below is a summary of free of charge services that have been provided between 01.04.25 to 30.06.25

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 Orders	Comment
Blue Arrow	533928_RGH CAT STORE	155	Agency Staffing
	544063_LLW DOM TOP B		
	533914_RGH PORTERS		
Arjo UK Ltd	555003_Clinical Engineering (EBME)	125	Beds
BOC Ltd	533002_RESPIRATORY & SLEEP PHYSIOLOGY	68	Medical Gas
	533041_DENTAL SURGERY YNYSHIR		
	555100_PCH PHARMACY		

Top 3 Receipting Areas	Total
533168 Dewi Sant Restaurant	152
533701_DS EST DEPT	111
533323_TAITH NEWYDD DOMESTICS	102

g) Consultancy Contracts

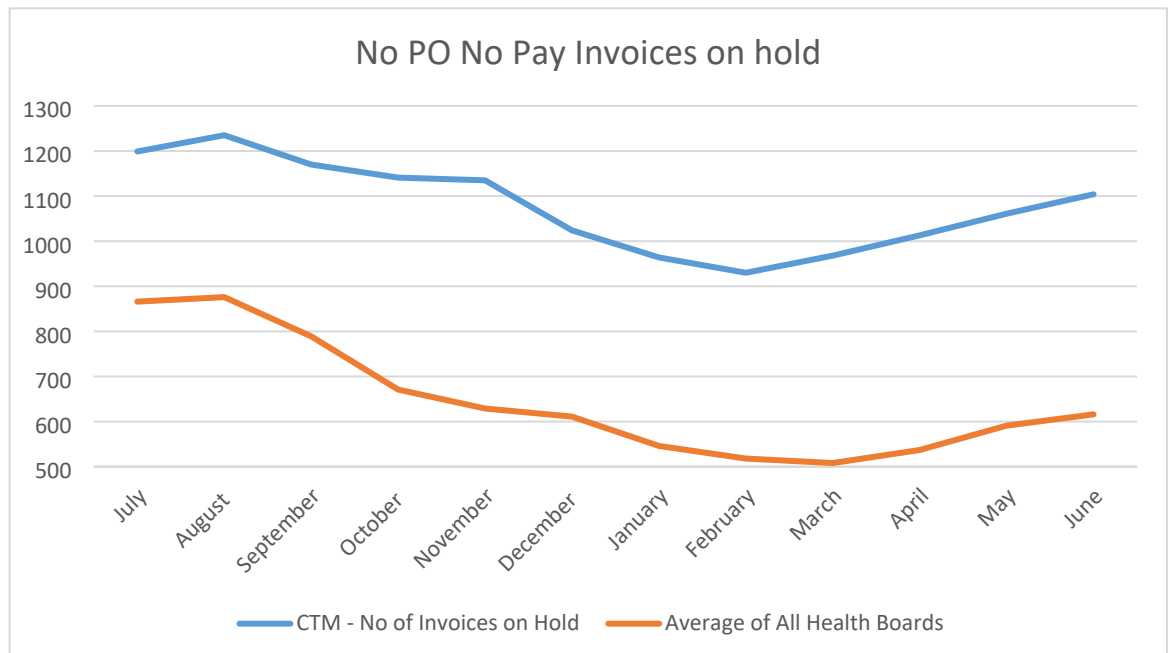
Below is a table detailing consultancy contracts that have been awarded between 01.04.25 to 30.06.25

Reference	Title	Supplier	Value	Date Awarded
CTM-DCO-142	Consultancy and Advisory Services for Health	Tektology	£379,080.00	30/05/25

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.
- Improvements at the back end of the calendar year have seen a slight dip in recent months.
- The largest organisation with No PO No Pay holds has been in advanced discussion with the Procurement team on clearing outstanding invoices.
- There has recently been a clear steer on how these can be cleared, this will clear around 400 invoices on No PO No Pay holds, which will take CTM closer to the average across Wales. We are awaiting a consolidated invoice which will clear this down when paid.
- 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 the end of 30th June 2025.

The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 3 2025-26 achieving 96.0% (value 94.0%). This means the Health Board achieved the target of 95% for the year to date.



	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-25	23,349	48,613,792	24,243	52,792,910	96.31%	92.08%
May-25	21,336	48,846,593	22,188	50,835,517	96.16%	96.09%
Jun-25	20,173	46,562,058	21,139	49,596,993	95.43%	93.88%
Jul-25						
Aug-25						
Sep-25						
Oct-25						
Nov-25						
Dec-25						
Jan-26						
Feb-26						
Mar-26						
YTD	64,858	144,022,443	67,570	153,225,419	96.0%	94.0%

The NHS invoice position continues to be challenging and shows a position of 82.5% (number) and 95.0% (value) of invoices were paid within 30 days to Month 3 2025-25. Velindre NHS Trust have recently piloted an Invoice Exception Approval workflow where invoices which are on the No PO No Pay exception list such as NHS Wales invoices can be approved in line with the approval hierarchy directly to the approver without need for PO. This could be an option to approve NHS Wales invoices in a timely manner. The Head of Corporate Finance is currently reviewing the process and engaging with appropriate stakeholders to understand whether this could be a viable option to implement in CTM. This could improve the timely payment of NHS Wales invoices going forward.

2.3 Scheme of Delegation and Financial Control Procedures (FCPs)

There are a number of updates to FCPs for this report which have been considered either by the Finance Senior Management Team or relevant subject expert leads. The FCPs being updated are as listed below and are included in the appendices to this report.



- FP 1 Capital Monitoring
- FP 6 Creditor Payments
- FP 8 Manual Payments
- FP 11 Inventory of Non Capital Assets

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

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



<i>Have you undertaken a Quality Impact Assessment Screening?</i>		
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 applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 **NOTE** the position on procurement matters for the period 01.04.2025 to 30.06.2025;

NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 3 of 2025/26;

APPROVE the updated FCPs.

Financial Control Procedure: Capital Monitoring (FP1)

Document Type:	Non Clinical Organisational Wide Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Head of Corporate Finance
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	Audit, Risk & Assurance Committee
Approval / Effective Date:	14/08/2025
Review Date:	14/08/2028
Version:	v.2

Target Audience:

People who need to know about this document in detail	Executive Directors Assistant Directors Care Group Managers
People who need to have a broad understanding of this document	Budget Holders
People who need to know that this document exists	

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: Outcome:
Welsh Language Standard	No
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Ensure sustainability in all that we do, economically, environmentally and socially



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

10. Equality Impact Assessment

11. Appendices

1. INTRODUCTION

- 1.1. This procedure aims to ensure that the University Health Board has robust controls to monitor and report on the timing and level of expenditure on capital schemes in the acute, community and primary care settings, by setting out the responsibilities of officers in relation to the appropriate use of capital funding. This procedure is applicable to both Cwm Taf Morgannwg University Health Board and the hosted service of Joint Commissioning Committee (JCC).
- 1.2. Where the term University Health Board is used this applies equally, unless otherwise specified, to (JCC).
- 1.3. This procedure should be read in conjunction with the University Health Board's Standing Financial Instructions and other Financial Control Procedures.
- 1.4. The Director of Finance shall establish the capital resources available to the University Health Board in any given year and provide guidance as to the level of commitment that should be made against that funding.
- 1.5. The Director of Finance shall be responsible for all accounting arrangements around the capital programme. Compliance is required with the Capital section in the Manual of Accounts. The Director of Finance shall sign off all expenditure returns submitted to WG.
- 1.6. The Director of Finance shall normally assume the role of project owner for the capital discretionary programme, unless an alternative Executive Director is approved via the Executive Capital Management Group (ECMG).
- 1.7. An appropriate Executive level project owner will be agreed at ECMG for major capital schemes, with the Assistant Director of Planning (Capital and Estates) taking the role of Programme/Project Director.
- 1.8. Progress against schemes shall be monitored by ECMG.
- 1.9. ECMG shall approve a planned discretionary capital programme on behalf of the University Health Board, and oversee progress in the delivery of the overall capital programme.
- 1.10. Capital expenditure is defined by IAS (International Accounting Standards) 16 Property, Plant and Equipment as expenditure on items that:
are held for use in the production or supply of goods or services...

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are expected to be used during more than one period.

A tangible productive resource must have an expected life in excess of one year.

1.11. The capitalisation threshold has been determined as expenditure of £5,000 (including VAT where this is not recoverable) or more on:

- A discrete asset
- A collection of assets which individually may be valued at less than £5,000 but which collectively form a single capital asset because the items fulfil all of the following criteria:
 - the items are functionally interdependent
 - the items are acquired at about the same date and are planned for disposal at about the same date
 - the items are under single managerial control
 - each individual asset thus grouped has a value of over £250
- a collection of assets which individually may be valued at less than £5,000 but which form part of the initial equipping and setting-up cost of a new building

1.12. Items charged against the Capital Programme shall be in accordance with the above definition. Compliance is also required with International Financial Reporting Standards (IFRS), the Government FReM and the Capital section of the Manual for Accounts, on the identification of and accounting for, capital expenditure.

1.13. It is important for costs associated with a capital build/purchase that do not fall under the above definition to be identified from the outset. This includes ongoing costs such as depreciation, additional staffing costs, maintenance costs and consumables. These costs will need to be covered from revenue budgets and how this is to be achieved shall be included as part of the Business Case or Statement of Need.

2. CAPITAL GROUPS

2.1. Executive capital Management Group (ECMG)

2.1.1 The Executive Capital Management Group will be an executive led group responsible for approving and monitoring the development and delivery of the UHB's capital programme and will meet on a monthly basis.

Progress on the major and discretionary schemes will be monitored through receiving reports by the Project Director (Head of Capital)

Progress against the Capital Resource Limit (CRL) will also be monitored via reports from the Capital Finance Manager Schemes at business case stage will be reported by the Director of Finance or other relevant lead executive. ECMG will report on an exception basis to the Finance, Performance and Workforce Committee and/or the full Board, as required.

2.1.2 The group membership will consist of:

- Director of Finance (Chair)
- Chief Operating Officer
- Executive Director of Strategy & Transformation
- Director of Primary, Community & Mental Health (Chair of OCG)
- Assistant Director of Planning (Capital & Estates)
- Head of Capital
- Capital Finance Manager
- Deputy Head of Procurement (NWSSP)
- Other officers as appropriate

2.1.3 Executive Directors will appoint a deputy, if unable to attend the meeting. The Deputy will have full delegated powers of authority, in place of the Executive.

2.1.4 The Executive Capital Management Group shall be responsible for:

- Approving a detailed discretionary capital programme plan, to meet corporate priorities, prior to the start of each financial year for adoption by the board.
- Approving a future year's discretionary replacement programme.
- Approving a contingency programme should additional funds become available in year.
- Agreeing submissions, as appropriate, to the Management Board, depending on value and significance of scheme.
- Receiving reports, and recommendations, from Gateway Reviews and External Auditors.
- Formal reporting to WG.
- Receiving and evaluating reports from the Capital Monitoring Group, on progress of spend against the overall planned programme for discretionary schemes, and approve any appropriate variations.
- Receiving and evaluating reports on progress of spend against the overall planned programme for Major schemes, and authorise any appropriate corrective action.
- Examining any in year business justification cases, receiving and evaluating recommendations from the UHB's accommodation

group, statements of need and other requests for discretionary capital support, and to prioritise and approve accordingly in line with the CRL available.

- Ensuring appropriate evaluation is undertaken on all schemes in line with the original benefits anticipated.
- Ensuring CRL compliance and receiving monthly updates on the ledger position.
- Ensuring all major capital investment projects are appropriately organised, resourced and managed in accordance with local and national mandatory capital planning procedures.
- Establishing longer term capital plans, ensuring sufficient flexibility within the programme to manage capital cash resources.
- Overseeing any property disposals or acquisitions.
- Develop processes for receiving all Business Cases and/or statements of need that comply with strategic and operational objectives in UHB
- Urgent applications for funds will require approval by the ECMG. However if due to time restrictions this is not practical then a decision can be made by the Director of Finance in accordance with the process for agreeing Statements of Need and will be noted at the next ECMG meeting.
- Any approvals will be processed subject to the Financial Limits set out in the Scheme of Delegation.
- A minimum of 3 Executive Directors will be required for a quorum.

2.2. **Operational Capital Group (ECMG)**

- The operational capital group will meet on a monthly basis to prioritise capital requests between the care group leads
- The group membership will consist of:
 - Director of Primary, Community & Mental Health (Chair)
 - Head of Capital (Vice Chair)
 - Care group directors
 - Assistant Director of Facilities
 - Assistant Director of ICT
 - Deputy Head of Procurement (NWSSP)
 - Capital Finance Manager
 - Head of Business Support COO's Office
 - The Chair or Vice Chair must be present, in addition to representatives from the Care Groups (four will be needed), in order for the meeting to go ahead and be quorate.

The Operational Capital Group shall meet monthly and is responsible for:

- Reviewing Integrated Medium Term Plans / Service Plans to assist the development of a detailed discretionary capital programme in the following areas:
 - Replacement equipment
 - Service redesign and transformation
 - Information Technology developments
- Developing processes for examining in year Statements of Need and Business Cases for discretionary capital support, and to prioritise and recommend approval to the Executive Capital Management Group (ECMG) in line with the funding available.
- Ensuring that all decisions in relation to the allocation of the discretionary funds for the above mentioned funding areas is prioritised and links formally and clearly to the safety of patients and staff and the maintenance of a quality focus.
- Prioritising and developing a programme for any potential additional in year discretionary allocations.
- Receiving reports from the ECMG, on the progress of spend and risks against the overall planned programme to inform decision making and review funding allocations.
- Scrutinising urgent applications for funds which will be circulated to members for endorsement before requesting ECMG approval.
- Reviewing and prioritising strategic schemes requiring All Wales Capital investment and recommending the approval of fees for business case development where appropriate.
- Ensuring that asset registers are maintained through Care Groups, providing a forum for their review as appropriate.

The Operational Capital group will report with recommendations to the Executive Capital Management Group.

2.3. The Capital Monitoring Group (CMG)

2.3.1 The Capital Monitoring Group will review, on a monthly basis, the approved discretionary capital programme and the relevant timing and level of planned expenditure to ensure capital cash resources are spent within the year allocated.

2.3.2 The Capital Monitoring Group members will consist of representatives from

- Head of Capital (chair)
- Finance (Capital)
- Procurement
- IM&T
- Clinical Engineering (EBME)

2.3.3 The chair of the Capital Monitoring Group will be a member of ECMG.

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2.3.4 The Capital Monitoring Group shall be responsible for:

- Reviewing differences between anticipated spend and approved allocation and the reason for the movement, including slippage.
- Make recommendations to the Assistant Director of Planning (Capital and Estates) who has delegated authority to agree variations of less than 10%. Any approvals will be processed subject to the Financial Limits set out in the Scheme of Delegation.
- Reporting performance of the capital programme to ECMG, recommending corrective action where appropriate and identifying any adjustments that will require approval.
- Scrutiny of new Statements of Need (SON) prior to submission to ECMG.

2.3.5 The group will report all amendments to approved allocations regardless of value to ECMG

2.3.6 The group will also have a role in monitoring compliance with procedures and report to ECMG any non-compliance.

3. CENTRALLY FUNDED CAPITAL PROGRAMME

3.1. General

3.1.1 Capital schemes may be funded directly from WG where:

- They are major capital schemes
- They are specifically earmarked and driven by WG (earmarked schemes)

3.1.2 A separate source of funding will exist for such schemes. They will therefore need to be shown as a separate category to the University Health Board's discretionary capital funds, but subject to the same monitoring and reporting processes.

3.1.3 The risk attached to these schemes will naturally be greater due to the size of the scheme (meaning any slippage or overspend will be more difficult to manage) or tight timescales and other constraints associated with earmarked funds. Monitoring and reporting processes will clearly need to reflect these additional risks.

3.1.4 It is the University Health Board's responsibility to ensure that a balanced audit provision of capital across discretionary programme, centrally funded projects, and major schemes is agreed on an annual basis to provide the required ongoing assurance to the Audit Committee and the Health Board.

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3.1.5 Although it is the responsibility of the University Health Board to determine the extent of internal control in the organisation's systems, internal audit may contribute to internal control by examining, evaluating and reporting to management on the adequacy and effectiveness of that control.

3.1.6 Capital funded projects are frequently important to the strategic direction and success of an organisation, and therefore internal audit should be actively involved in providing assurance and advice. This will include scheduling reviews to deliver timely assurance around major project milestones, both during and on completion of schemes.

3.2. **Major Capital Schemes**

3.2.1 For any major schemes a business case must be submitted to Welsh Government for approval.

3.2.2 A business case must demonstrate that the proposed investment has been properly scoped and planned; offers optimum value for money; is commercially viable; affordable and achievable. In addition a case for any investments should show that the proposal has clearly identified service delivery benefits

3.2.3 For major investment proposals the Better Business Case approach using the 5-case model should be followed. Programmes should be developed and cost justified using Strategic Outline Programme (SOP) business cases. Major, novel or contentious projects should be developed and cost justified through three key iterations of the Business Case where formal approval to proceed is required; Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC).

3.2.4 A Strategic Outline Business Case (SOC) must be formally adopted as the initial stage of the business case process. The procurement process must not commence without prior approval of the Welsh Government. The SOC shall include the elements required within the strategic context stage together with elements of the Outline Business Case (OBC) as detailed in the relevant Welsh Health Circular.

3.2.5 The business case process must follow the latest NHS Capital Programme guidance from agreement of the SOC to OBC and Full Business Case (FBC) stages. Project organisation and management, commissioning and evaluation will also be expected to follow guidance outlined within the NHS Wales Infrastructure Investment Guidance and any relevant Welsh Health Circulars.

- 3.2.6 The Director of Finance shall take the lead on business case processes. The lead can be delegated by the Director of Finance to another Executive Director in the preparation of individual business cases.
- 3.2.7 Any internal Health Board approvals will be processed subject to the Financial Limits set out in the 'Capital Schemes funded by Welsh Government' section of the Scheme of Delegation.
- 3.2.8 Detailed monitoring on progress and financial implications on major schemes, for the capital programme as a whole, will be carried out by ECMG.
- 3.2.9 The financial state of each major capital scheme must be reported to the Welsh Government on a monthly basis as part of the monitoring returns. This will also include a comment on any particular issues around major schemes. The Director of Finance shall be responsible for submitting the return.
- 3.2.10 The Business Justification Case (BJC) provides the University Health Board with a simpler, truncated approach for smaller and less complex investments. The shorter approach retains compliance with the major requirements of good corporate governance and details strategic context, case for change, option appraisal, procurement route, affordability and management. The BJC should be adopted as the standard approach for most schemes under £4million for which firm prices are available.
- 3.2.11 Before embarking on the preparation of the business case, NHS organisations are required to agree the nature, type and content of each business case with the WG via a scoping document.

3.3. **Other Earmarked Schemes**

- 3.3.1 These will be schemes driven centrally by the Welsh Government in response to particular initiatives.
- 3.3.2 The Welsh Government will determine the rules in respect of bidding or applying for funds and the processes to follow thereafter.
- 3.3.3 Any application for such funds must be approved by ECMG or, if time restrictions do not allow, by the Director of Finance in accordance with the process for agreeing Statements of Need.
- 3.3.4 Any additional monitoring processes determined by the Welsh Government must be complied with, as well as the normal monitoring processes in place for the Capital Programme. Progress will be reported to ECMG.

4. DISCRETIONARY CAPITAL PROGRAMME

4.1. Identification of Requirements

4.1.1 To comply with WG monitoring returns guidelines the discretionary capital programme shall be split into the following categories:

- Statutory Compliance (works schemes)
- Equipment Replacement
- Estates Requirements/Backlog Maintenance
- IM&T Equipment
- New Equipment/Service Redesign Schemes
- Other

4.1.2 Directorates will be requested to prioritise their requirements for new and replacement equipment as part of their Integrated Medium Term Plans (IMTP), having due regard to agreed service developments (linked to operational and strategic objectives) and asset register respectively. Bids will need to be risk assessed using the standard UHB template prior to submission. Directorate Managers will be required to submit a Statement of Need to support the bids which will also need comments from the Head of Clinical Engineering (EBME), Procurement, and if relevant IC&T, Estates and Radiology. Care group leads will then prioritise these bids in the OCG.

4.1.3 Proposals to replace existing equipment must identify the equipment being replaced by noting the Asset ID and the Net Book Value of the item as detailed in the asset register.

4.1.4 The Senior Finance Officer (Capital) will check the Net Book Value of assets identified by Directorates for replacement. Assets which are shown as not having reached the end of their designated life, and therefore having a positive Net Book Value, will not be replaced without an explanation as to the circumstances and an assessment that the need to replace is unavoidable.

4.1.5 Schemes shall not be aggregated and shall be specific to an area of work or contract to be let.

4.1.6 ECMG may require a Business Justification Case prior to approving any particular works scheme or equipment purchase in addition to a statement of need. Other work may also be requested to support any requirement (e.g. equipment replacement strategy). All equipment replacement schemes will need to have been reviewed and commented on by the Head of Clinical Engineering (EBME).

4.2. Statement of need

4.2.1 A Statement of Need (SON) must be completed prior to the approval of any works scheme or equipment purchase as part of the Capital Programme. This is submitted by the electronic SON App

[Home Page - Capital SON Application](#)

4.2.2 The SON shall outline the requirements and state the benefits and impact of the investment upon the University Health Board.

4.2.3 The statement will need to include the following:

- Brief description of the proposal
- Brief outline of the benefits/consequences/risks to patients, staff & the University Health Board, linking to strategic and operational plans including the Directorate IMTP where appropriate
- An estimate of capital costs (including VAT) over each financial year should be sufficiently accurate and appropriately supported
- Details of ongoing revenue costs, and how they are to be funded
- Details of the procurement process (tendering, lead times etc). There should be sufficient information for Procurement to complete tender specifications
- Appropriate advice will need to be sought from other Departments to ensure the SON is completed fully and accurately. These will include, but not be limited to, individuals from Finance, Procurement, Estates, EBME, IC&T and Radiology
- If there are significant levels of estates work required then the Capital Planning department will also need to be consulted
- If medical equipment is required then the Clinical Engineering Department must be contacted.
- Confirmation as to whether advice has been sought from the relevant individuals/departments must be stated on the SON
- In general any equipment that is being replaced must be fully depreciated and beyond economical repair
- Clear identification of the staff leading the bid/scheme is required with the submission
- Bids will need to be risk assessed using the standard UHB template prior to submission and risks logged on the departmental risk register.
- If the SON is not appropriately completed or does not have adequate supporting documentation It will not progress through the approval process.

4.2.4 The Directorate Manager shall be responsible for the completion of a SON for any capital equipment or capital works scheme requested by them.

4.2.5 The Capital Management Group may request an option appraisal for the leasing of equipment as an alternative to purchase, prior to approval of

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a scheme/proposal. The Procurement Services team will assist with this process.

4.3. Business Justification Cases (BJC)

4.3.1 The Executive Capital Management Group may request that a BJC, be submitted before approval is granted. A BJC should follow the prescribed WG format as shown in Appendix 1

4.3.2 In preparing the costs of the bid and any option appraisal, advice should be sought from the Finance Department. Similarly, there will need to be liaison with the Procurement Department on any purchasing issues, including leasing options, and the Estates Department on any building or engineering works that may be required.

4.3.3 BJCs will be submitted to the Assistant Director of Planning (Capital and Estates) to be scrutinised prior to being considered by ECMG.

4.4 Capital Programme Approval

4.4.1 Once a statement of need is completed on the app the Capital team will check it for completeness and raise any queries with the Directorate Manager prior to review by the Capital Monitoring Group. Subject to timing it may be necessary to carry out this process via email with the members of CMG.

4.4.2 OCG will review registers and Statements of Need to prioritise and recommend approval to ECMG in line with the funding available

4.4.3 Depending on timing, urgent statements of need or variations in planned spend can be submitted by the Head of Capital directly to the Director of Finance for review, and approval if appropriate, out of committee.

4.4.4 If the SON is for the future year's programme or for the contingency programme the review by OCG will need to take place at the time of submission. If there is a significant delay between submission and final approval then OCG member will need to re-visit the review for significant changes.

4.4.5 Any approvals will be processed subject to the Financial Limits set out in the 'Capital Schemes funded by Discretionary Allocation' section of the Scheme of Delegation.

4.4.6 If the scheme or equipment purchase is approved by ECMG, the minutes will record the authorisation to proceed.

ECMG may initially over-commit the programme against the sources of funds available in order to provide flexibility for proper cash

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management. The level of over-commitment will be based on advice given by the Director of Finance. However the Final Capital Resource Limit (CRL) for the year cannot be breached.

- 4.4.7 Each approved SON or BJC will form part of the initial planned discretionary capital programme for the year.
- 4.4.8 Once approved the Senior Finance Officer (Capital) shall contact the appropriate Directorate Manager, copied as appropriate to the Head of Capital and procurement, to confirm the job number(s) allocated for each of their schemes. The job number is also added to the SON App.
- 4.4.9 Equipment or Works Schemes identified during the year shall follow the same process as that for the original programme.

4.5 Procurement Process

- 4.5.1 Procurement of capital items must follow the competitive tendering processes within the University Health Board's Standing Financial Instructions and Financial Control Procedure on Requisitioning of Goods & Services. Advertisements must be placed in the Official Journal of the European Community (OJEC) for any proposed purchases or contracts exceeding the threshold in existence at that time. All capital tenders will be completed by electronic tendering.
- 4.5.2 Construction Projects over £7million in value will be procured via a NHS building for Wales 2 construction and consultant framework.
- 4.5.3 The Directorates shall be responsible for raising requisitions. Authorisation of all capital requisitions must be in accordance with the financial limits and ordering of goods and services policy.
- 4.5.4 The job number allocated to each scheme must be quoted on all requisitions.
- 4.5.5 The Head of Procurement shall only process capital requisitions that have been authorised by the Executive Capital Management Group. Any requisitions that have not been authorised will be rejected and returned to the originator.

4.6 Adjustments to the Capital Programme

- 4.5.6 It may be necessary during the financial year to adjust the approved allocation for capital schemes either as a result of savings or increased spends.
- 4.5.7 Adjustments to planned expenditure (both increases and decreases) must be reported to the Executive Capital Management Group for approval. If a group meeting is not imminent, the Director of Finance

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shall be informed in writing as soon as there is an indication that a scheme's outturn expenditure may require adjusting.

- 4.5.8 The 'netting off' of schemes within a category or Directorate/Division is not permitted. However, if there are other schemes that will be completed under the approved amount, these should also be highlighted to the Group when seeking the additional approval.

5. SCHEME OF DELEGATION

Approvals will be processed subject to the Financial Limits set out in the 'Capital Orders and Payment Authorisation' section of the Scheme of Delegation.

5.1 Discretionary Schemes

- 5.1.1 For discretionary schemes the following is considered as an appropriate level of delegation:

- Assistant Director of Planning (Planning and Estates)
 - Approval of single variations up to £5k
 - Approval to be reported to ECMG
- Director of Finance
 - Approval of single variations up to £20k
 - Approval to be reported to ECMG
- ECMG
 - Approval of single variations over £20k

5.2 Capital Schemes Funded by Welsh Government (within approved sum)

- 5.2.1 For capital schemes the following is considered as an appropriate level of delegation. Note this excludes major capital schemes procured through the National or Regional frameworks where a Project Board has been set up with executive level membership. These schemes follow specific delegations detailed in 5.2.2

- External Project Manager
 - Approval of single variations up to £5k with discussion and agreement with the Head of Capital.
 - Groups of variation should be managed within a monthly limit of delegate's authority, which shall be a maximum of £20k.
 - Monthly financial reports shall be provided to the Head of Capital identifying the Project Managers' Instructions (PMIs) and the change to the quantified Risk account.

- Head of Capital
 - Approval of single variations up to a maximum of £20k, following discussion with the Assistant Director of Planning (Capital and Estates).
- Assistant Director of Planning/Programme Director (Capital and Estates)
 - Approval of Single variation up to a maximum of £50k.
 - The Programme Director to have delegated authority to approve variations of an urgent nature and seek approval retrospectively from the appropriate hierarchy.
- Director of Finance
 - Approval of single variation up to a maximum of £100k.
 - Approval to be reported to ECMG.
- ECMG
 - Approval of single variations over £100k.
 - Director of Finance to be one of the approvers.

5.2.2 Note the above excludes major capital schemes procured through the National or Regional frameworks where a Project Board has been set up with executive level membership. These schemes follow specific delegations detailed below

- Internal Project Manager
 - Approval of single variations up to £5k
 - External Project Manager can proceed with variations up to 5k if decision is required urgently and is immediately reported to the internal project manager or above
 - Groups of variation should be managed within a monthly limit of delegate's authority, which shall be a maximum of £25k.
- Assistant Director of Planning/Programme Director or Deputy SRO if applicable to the scheme
 - Approval of Single variation up to a maximum of £100k.
 - Groups of variation should be managed within a monthly limit of delegate's authority, which shall be a maximum of £50k
- Director of Finance
 - Approval of single variation up to a maximum of £250k.
 - Groups of variation should be managed within a monthly limit of delegate's authority, which shall be a maximum of £500k
- Project Board
 - Approval of single variations over £250k.

- Out of committee approval can be sought where the timing of meetings does not allow in line with the terms of reference for the Project Board

Any variation which impacts on the agreed financial outturn or the cash flow in- year requires approval from ECMG

5.2.3 The FCP in relation to electronic authorisation of orders is not affected by the above.

5.2.4 In the course of many schemes, variations to the scheme will be requested by a variety of users (e.g. nursing staff, medical staff, and statutory compliance personnel). It is proposed that, where these variations can be funded by the contingency risk pot, then the person authorised to approve that level of expenditure should seek advice from an appropriate level of management, relevant to the specific variation being requested.

- Changes up to £5k Head of Department or equivalent
- Changes up to £25k Directorate Manager or equivalent
- Changes up to £100k Assistant/Deputy Director
- Changes up to £250k Executive Director
- Changes up to £500k Director of Finance
- Changes over £500k Chief Executive

Users will be required to complete a risk assessment form, outlining the consequences of not approving the proposed change / variation.

6. LEASES

An entity is required to determine whether an arrangement is, or contains, a lease. A lease is present when the fulfilment of the arrangement depends on a specific asset and it conveys the right to use the asset.

6.1 International Financial Reporting Standard

6.1.1 IFRS 16 Leases was issued in January 2016 and is effective for annual reporting periods starting on or after 1 January 2019. It replaces IAS 17 Leases and related Interpretations.

6.1.2 NHS bodies adopted IFRS 16 from April 2022.

6.1.3 IFRS 16 changes the accounting substantially for lessees. The new Standard eliminates a lessee's classification of leases as either operating leases or finance leases. Instead, almost all leases are 'capitalised' by recognising a lease liability and right-of-use asset on the balance sheet.

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6.1.4 There is little change for lessors.

6.1.5 IFRS 16 introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value (below £5k).

6.1.6 A lessee is required to recognise a right-of-use asset representing its right to use the underlying leased asset and a lease liability representing its obligation to make lease payments.

6.1.7 As a consequence, a lessee recognises depreciation of the right-of-use asset and interest on the lease liability.

6.1.8 Directorates are required to notify the Capital Finance Manager of any new leases being entered into to decide if they should be reported under IFRS16.

6.1.9 Directorates must ensure there is sufficient capital funding available for leases, this will be done through liaison with the capital finance manager and Welsh Government.

6.2 **Finance Leases**

6.2.1 Details of all leases capitalised under IFRS16 will be held on the Prolease Lease register system. Any low value or other out of scope leases will be reported in the accounts Note 8.

6.3 **Information Required by Finance**

6.3.1 The Directorate Manager shall be responsible for the collation of the following, with comments from the Head of Clinical Engineering (EBME) for medical equipment and advice where appropriate from the Head of Procurement:

- Fair Value of the Equipment
- Initial Deposit (if Applicable)
- Annual Lease Charges
- Primary Lease Term
- Secondary Lease Term
- Termination Payment (if applicable)
- Estimated Residual Value (if any)
- Maintenance Costs
- Other Revenue Costs (e.g. Consumables)

6.3.2 The Directorate Manager and Procurement shall forward the details listed above, together with the financial details required for the purchase of the equipment to the Capital Accountant.

7. PROJECT BANK ACCOUNTS (PBA)

Welsh Government have instructed that from April 2020 onwards, any WG funded scheme valued at £2 million or over (net of VAT, insurance and other costs/overheads, preliminary/design stage costs) and for a duration longer than six months, will be required to set up a Project Bank Account (PBA).

7.1 PBA Governance

- 7.1.1 PBAs are ring-fenced bank accounts from which payments are made directly and simultaneously by a client to members of its supply chain.
- 7.1.2 PBAs have trust status which secures the funds in it and can only be paid to the beneficiaries ie the supply chain members named in the account.
- 7.1.3 The account is held in the names of the trustees; likely to be the client and lead contractor (but could also be members of the supply chain).
- 7.1.4 The advantage of trust status is that in the case of insolvency monies in the account due for payment to the supply chain is secure and can only be paid to them.
- 7.1.5 Two methods for operating a project bank account have been developed. These are the Dual Authority and the Single Authority.
- 7.1.6 The Single Authority approach requires that only the contractor is named on the bank mandate while the Dual Authority requires both the Client and Lead Contractor to be joint signatories.
- 7.1.7 Where 'compelling reasons' are identified not to apply a PBA, a decision report detailing those reasons must be completed and filed to allow for audit.

8. MONITORING OF EXPENDITURE

The approved capital programme will form the basis of the capital monitoring process.

8.1 Allocation of job details

- 8.1.1 The Senior Finance Officer (Capital) shall allocate a job number to each scheme within the capital programme upon the written confirmation that a scheme has been given approval.
- 8.1.2 The following details will be input into the capital monitoring system for each job:

- Brief description of scheme
- Main category heading
- Site & Department
- Total expected expenditure
- Timing of expenditure

8.2 **Allocation of Expenditure to Job**

- 8.2.1 The Financial Code used for all capital requisitions must include the job number within the analysis section of the code. This shall be the primary source of capturing expenditure against individual capital jobs.
- 8.2.2 The Senior Finance Officer (Capital) shall analyse all capital expenditure processed through the general ledger, and ensure that all expenditure is allocated to the correct job number. Any expenditure not allocated to a job number will be investigated and corrected.
- 8.2.3 The Senior Finance Officer (Capital) shall categorise the expenditure into cash payments and accruals, and input the expenditure onto the capital monitoring system on at least a monthly basis. A monthly expenditure statement shall be produced for each job, and for the programme as a whole.
- 8.2.4 The Senior Finance Officer (Capital) shall maintain a record of all retentions due and account for them appropriately. The record shall include the date at which the retention is likely to be paid and the likelihood of payment.

8.3 **Reconciliations**

- 8.3.1 The Senior Finance Officer (Capital) shall reconcile the expenditure statement with the General Ledger.
- 8.3.2 The Senior Finance Officer (Capital) shall produce working papers and schedules to identify:
- Cash spend
 - Outstanding Creditors/Debtors
 - Additions to Fixed Assets
 - Disposal of Fixed Assets
- 8.3.3 The Capital Accountant shall review the reconciliations and sign and date them accordingly.
- 8.3.4 The Senior Finance Officer (Capital) shall reconcile the Capital Expenditure Report with the Asset Register on a periodic basis.

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8.4 **Reporting**

- 8.4.1 The Senior Finance Officer (Capital) shall produce a report that compares the current expenditure with the total planned expenditure for each job on a monthly basis.
- 8.4.2 This report will be presented to the monthly Capital Monitoring Group meeting. A summarised report will be produced for ECMG
- 8.4.3 The Director of Finance shall report progress and spend position on the capital programme to the Management Board and WG.

8.5 **Adjustments to Jobs**

- 8.5.1 The Senior Finance Officer (Capital) will only amend the planned spend for schemes upon receipt of approval from ECMG.
- 8.5.2 All adjustments will be reported to ECMG.

8.6 **Brokerage**

- 8.6.1 The Capital Programme as a whole must be managed in such a way that obviates the need to request capital monies to be brokered from one year to the next.
- 8.6.2 The Head of Capital shall identify any slippage in the planned expenditure for the current financial year, for both Discretionary and Major schemes, and advise the ECMG accordingly.
- 8.6.3 Every attempt shall be made to manage the slippage internally on Discretionary schemes, either through bringing forward schemes planned for the following year or introducing new schemes into the Programme.
- 8.6.4 Conversely, unexpected Discretionary capital spends may result in a request for additional funds in the current year, to be repaid the following year. Again, this shall only be considered where there is no other option available to the University Health Board (e.g. delaying other schemes etc)
- 8.6.5 Any overspends, under spends or virements between Major capital schemes must be reported to the WG at the earliest opportunity. The Head of Capital, Estates and Facilities in the WG must be informed and Ministerial approval may be required in line with latest WG Capital Guidance.

- 8.6.6 Approval of any brokerage request to the WG cannot be guaranteed, and could therefore result in the loss of capital funding. It is therefore vitally important that the Capital Programme is monitored and managed in such a way that mitigates such risk.

9. TRANSFERS AND ACCOUNTING ADJUSTMENTS

9.1 Capital to Revenue Expenditure Transfers

- 9.1.1 Only expenditure that meets the definition of Capital Expenditure shall be included within the Capital Programme.
- 9.1.2 There may be instances where anticipated capital expenditure turns out to be revenue in nature when invoiced (e.g. cost is below £5,000). Such expenditure should be transferred to the relevant revenue expense account, and not be recognised within the capital programme.
- 9.1.3 The Director of Finance shall advise of any element within the planned spend on schemes that should be classified as revenue as early as possible to allow financial plans to be updated accordingly. The implications of these changes shall be reported to WG through normal reporting mechanisms.

9.2 Assets Acquired via Private Finance Initiative (PFI)

- 9.2.1 Where a capital scheme has been completed with private finance and it is determined to be within the scope of IFRIC 12 it will need to be accounted for as 'on balance sheet'. The capital asset should be recognised when it is first made available for use and in accordance with IAS 16.
- 9.2.1 Where there is an annual unitary payment from the NHS body to the operator, a finance lease liability is recognised for the same amount as the fair value of the asset. It is subsequently accounted for as a Finance Lease in accordance with IFRS16.
- 9.2.3 The Capital Accountant shall liaise closely with the Financial Accountant in order to determine the appropriate accounting entries for any PFI or Finance Lease assets.

10. EQUALITY IMPACT ASSESSMENT

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

CONTENTS

Appendix 1

1. PURPOSE

State clearly what the Business Justification is in support of: typically - *"This is to seek approval of ... for £ on in support of"*

2. STRATEGIC CONTEXT

Please provide an overview of the context in which the investment will be made. In other words, the strategy, work programme, service, project or operation, which the investment supports.

3. CASE FOR CHANGE

i. Business Needs

Please provide the compelling reasons for investment in the required services or assets, with reference to:

- a. the investment objects for the procurement; and,
- b. the problems with the status quo

ii. Benefits

Please provide a summary of the MAIN benefits associated with the investment, distinguishing between qualitative and quantitative; cash releasing and non-cash releasing; direct and indirect to the NHS organization, as appropriate.

i. Risks

Please provide a summary of the MAIN risks associated with the investment, distinguishing between business and service risks during the design, build and operational phases of the project, as appropriate.

4. AVAILABLE OPTIONS

Please provide a description of main options (or choices) for investment, together with their relative advantages and disadvantages (SWOT analysis).

Please bear in mind:

- a. that a minimum of **FOUR OPTIONS** should be included, including the "do minimum" or "do nothing" (unless there are compelling reasons to the contrary);
- b. that these options may differ in potential business scope, service solution, service delivery, implementation and funding, depending on the nature of the investment; and,

- c. that the investment appraisal for each option should be contained at Annex 1 and prepared in accordance with the tools and techniques set out in the Capital Investment Manual and Treasury Green Book.

5. PREFERRED OPTION

On the basis of the above, please:

- i. state why the recommended option optimizes *Value for Money* (VFM); and,
- ii. Describe the services and/or assets required.

6. PROCUREMENT ROUTE

Please state how the asset or service will be procured in accordance with EC/GATT rules and regulations.

This may involve the use of an existing contract; a call-off contract or framework agreement; or the requirement for a new procurement under the EC Services or Supply Directives.

7. FUNDING AND AFFORDABILITY

Please indicate:

- i. the capital and revenue costs of the proposed investment;
- ii. how the investment will be funded; and
- iii. Indicate any affordability gap (as appropriate).

8. FUNDING AND AFFORDABILITY

Please indicate how the investment will be delivered successfully with particular reference to:

- i. project management arrangement
- ii. business assurance arrangements (if applicable);
- iii. benefits realization monitoring
- iv. risk management;
- v. post project evaluation (if applicable)
- vi. contingency plans (if applicable)

Financial Control Procedure: Creditor Payments (FP6)

Document Type:	Non Clinical Organisational Wide Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Head of Corporate Finance
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	Audit, Risk & Assurance Committee
Approval / Effective Date:	14/08/2025
Review Date:	14/08/2028
Version:	v.2

Target Audience:

People who need to know about this document in detail	Executive Directors Assistant Directors Care Group Managers
People who need to have a broad understanding of this document	Budget Holders
People who need to know that this document exists	

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: Outcome:
Welsh Language Standard	No
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Ensure sustainability in all that we do, economically, environmentally and socially



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

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Policy Title: Financial Control Procedure: Creditor Payments

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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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- 2.** Processing of Invoices
 - 2.1** General Processes
 - 2.2** Capital Invoices
 - 2.3** Pharmacy Invoices
 - 2.4** No PO, No Pay
 - 2.5** Payments to staff
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 - 3.1** BACS payments
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- 4.** Supplier Maintenance
- 5.** Credit Notes
- 6.** Monitoring Controls
- 7.** VAT
- 8.** Month End Procedures
- 9.** Year End Procedures
- 10.** Financial Control Weakness or Suspected Fraud
- 11.** Equality Impact Assessment
- 12.** Appendices

1. SCOPE AND PRINCIPLES

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- 1.1. This procedure details the principles underlying the University Health Board's (UHB) system for paying creditors and the regulations required to operate these principles.
- 1.2. The objective of this procedure is to set out a control framework to ensure that payments to suppliers are made correctly and on a timely basis. Payments are required to be made within 30 days of the later of:

- receiving a valid invoice; or
- receiving the goods/service

In order to comply with the Public Sector Payment Policy.

95% of invoices must be paid within 30 days to comply with the target set by Welsh Government.

- 1.3. This procedure should be read in conjunction with the University Health Board's Standing Orders, Standing Financial Instructions and other relevant financial procedures - in particular, the procedure on Requisitioning of Goods and Services and the Scheme of Delegation.
- 1.4. The Director of Finance and Procurement shall be responsible for ensuring proper financial controls and segregation of duties exists in the processing of creditor payments.
- 1.5. The Director of Finance and Procurement shall ensure that control mechanisms are in place to identify any breaches and to take appropriate action. This shall include the use of internal and external auditors.
- 1.6. The Accounts Payable (AP) module of the University Health Board's financial management system (Oracle) will record and process amounts payable by the University Health Board.
- 1.7. Payments to creditors are undertaken by the NHS Wales Shared Services Partnership (NWSSP) on behalf of the University Health Board. All payments made by NWSSP shall be supported by an invoice, which matches the order and the goods/services receipted in terms of both price and quantity.
- 1.8. Where the term University Health Board is used this applies equally, unless otherwise specified, to JCC and EASC.

- 1.9. The standard process for the payment of invoices is as follows (See also Appendix 1):

Steps	Individual Involved
1. Requisition Raised on Oracle system	Requisitioner (UHB)
2. Requisition Authorised on Oracle system	Budget Holder/Approver (UHB)
3. If catalogue items, order created automatically and issued to supplier	(Automatic via Oracle workflow)
4. For Non-Catalogue items prices and suppliers checked and Purchase Order (PO) created on Oracle system	Procurement Team (NWSSP)
5. PO sent to Supplier	Procurement Team (NWSSP)
6. Supplier delivers goods and/or services	Supplier
7. Goods and Services booked (receipted) into Oracle to confirm that goods/services have been received	Departmental staff or staff in Receipt and Distribution centres (R&D) (UHB/NWSSP)
8. Invoice Received	Accounts Payable (NWSSP)
9. Invoice matched to PO on system	Accounts Payable (NWSSP)
10. Invoice Paid	System/Accounts Payable (NWSSP)

2. PROCESSING OF INVOICES

2.1. General processes

- 2.1.1. Goods/services should be receipted onto the Oracle system within two working days upon satisfactory receipt of the goods or services. Responsibilities for receipting of goods and services normally rest with individual departments. Where goods are received at a central R&D (Receipt & Distribution) point, the receipting responsibilities lie with NWSSP staff working in those areas.

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- 2.1.2. All invoices received in NWSSP for the University Health Board shall be entered into the Oracle system by the fourth day after receipt of the invoice.
- 2.1.3. All invoices must be matched appropriately to the purchase order quoted on the invoice. Once the matching exercise is complete the invoice can be approved for payment, or placed on hold where appropriate.
- 2.1.4. Any invoices received without a PO that are not on a pre-defined exception list must be referred to the budget holder, requesting that an order is raised in order to enable payment of the invoice.
- 2.1.5. Invoices received shall be batched and archived by scanning or other appropriate means, on a regular basis. Invoices "on hold" and being queried shall be detailed on an electronic report and reviewed by NWSSP Accounts Payable and Procurement staff.
- 2.1.6. Invoices where the goods are not yet receipted in Oracle shall be recorded automatically on the "on hold" report.
- 2.1.7. The "on hold" report will record all invoices which could not be passed for payment for reasons such as price, distribution or other variances beyond the agreed tolerance levels.
- 2.1.8. Invoices on the "on hold" report will be reviewed at regular intervals by NWSSP who are responsible for resolving queries and clear invoices for payment. The Accounts Payable Officer will enter notes explaining the action taken in the invoice history field on Oracle. Directorate based "on hold" reports shall be sent to Clinical Service Group Managers (or equivalent) each month for review and action.
- 2.1.9. Any disputes lodged with the Supplier that results in an invoice not being able to be paid must be reported to the Accounts Payable team immediately to ensure that the invoice is marked as "Disputed", therefore ensuring that the late or non payment of the invoice will not have an adverse affect on the Public Sector Payment Policy (PSPP) target.
- 2.1.10. The majority of invoices are received electronically by NWSSP. When manual invoices are processed a Batch Header is added which includes the batch number and total value of the invoices in the batch.
- 2.1.11. Invoices shall not be part-paid in respect of part delivery. Payment shall be made only when all items have been received.
- 2.1.12. The standard settlement term will be 30 days. The Head of Procurement (HOP) may agree reduced terms where appropriate.
- 2.1.13. Price tolerances shall be set in Oracle at 10% of the price with an upper limit of £5. Prices charged in excess of this level shall be entered onto

and the 'on hold' report and referred to the Procurement department. Changes to tolerance levels can only be authorised by the Director of Finance and Procurement.

2.2. **Capital Invoices**

2.2.1. Capital invoices shall be processed through the system in the same way as all other invoices and will be subject to the same checking and control procedures.

2.2.2. However, capital invoices subject to interim and final certificates shall be checked by the Capital Services Administrator and entered onto contractors' records. Checks shall be made to ensure that details on the current certificate agree with previous records. The Capital Services Administrator will notify the Senior Finance Officer (Capital) where retentions are withheld as indicated on the certificate and they will ensure they are appropriately accrued within the ledger. VAT shall not be paid unless an authenticated receipt or a VAT invoice is present.

2.3. **Pharmacy Invoices**

2.3.1. Weekly information on goods and services received in the Pharmacy department will be sent to the Accounts Payable department together with the supporting invoices and authority to pay form. The file information will be uploaded, via the FTP server, to Oracle by the Accounts Payable Officer.

2.3.2. Once uploaded the Accounts Payable Officer shall select the file and process the invoices ensuring agreement with the payments list and invoices/goods received notes.

2.4. **No PO, No Pay**

2.4.1. The UHB adopts the principle of a 'No PO, no Pay' approach, i.e. if no Purchase Order (PO) has been raised, a dispute will be raised with the supplier and no payment will be made for goods and services received until such time the PO is raised.

2.4.2. The Head of Procurement will be responsible for monitoring any non-compliance through retrospective raising of orders. Any department/s and or directorate/s who continually breach the process will be reported to the Director of Finance and Procurement and, where appropriate, to the Audit and Risk Committee.

2.5. **Payments to staff**

2.5.1. Payments directly to employed staff are specifically prohibited from the creditors system. All such payments must be paid and recorded via the UHB's payroll system.

3. PAYMENTS OF INVOICES

3.1. BACS Payments

- 3.1.1. All suppliers will be encouraged to accept the BACS method of payment. Accounts Payable Officers will request bank details and other necessary details from all new suppliers.
- 3.1.2. The payment of invoices by BACS shall be made in line with the agreed timetable unless otherwise directed by the Treasury Accountant. A minimum of two payment runs per week shall normally be processed, with additional payment runs if required.
- 3.1.3. A payment run report shall be generated two days prior to the payment date within NWSSP. The report will include all invoices passed and due for payment up until the cut off date. The pay through date will be the date of the next payment run
- 3.1.4. The Accounts Payable Team Leader shall liaise with the Treasury Accountant to ensure that sufficient cash will be available to make payment on the due date.
- 3.1.5. Any amendments requested shall be undertaken prior to payment run committal.
- 3.1.6. Remittance advice notes will be issued through email where possible and if not, by post.

3.2. Cheque Payments

- 3.2.1. A run of payable order payments will be produced in NWSSP weekly. These are payments made via the Government Banking Service using the Royal Bank of Scotland. This method is used only when the supplier is unable to accept payments via BACS, for urgent payments and losses and compensation payments.
- 3.2.2. Review and checking procedures will be the same as for the BACS payments procedure (3.1 – 3.5 above).
- 3.2.3. All payable order payments will be made in accordance with the cash and banking procedure.

4. SUPPLIER MAINTENANCE

- 4.1. All Supplier creation and amendment, including changes to supplier bank account details in Oracle is managed by the Supplier Maintenance Team at NWSSP. Oracle access to supplier maintenance functions of the system is therefore restricted to this group of staff.

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- 4.2. All requests for changes must be supported by official documentation from the supplier. Any bank account changes must include the original details as well as the new details

5. CREDIT NOTES

- 5.1. Credit notes will be matched appropriately against the order / invoice according to the nature of the credit.
- 5.2. The Accounts Payable Officers shall request a refund from suppliers in respect of outstanding negative balances. The Accounts Payable Officers will monitor the status of credit notes regularly and ensure payment is requested from suppliers who have credit notes outstanding for significant periods (at least six months old).

6. MONITORING CONTROLS

- 6.1. The Accounts Payable Officers shall ensure that creditors' correspondence and queries are responded to in an accurate and timely manner.
- 6.2. The Accounts Payable Officers shall check all supplier statements for dated and erroneous entries and take appropriate action.

7. VALUE ADDED TAX

- 7.1. Due to the volume of electronic invoices it is expected that the correct VAT code is applied when raising the PO wherever possible.
- 7.2. VAT shall be reclaimed on contracted out services in accordance with the relevant Treasury Direction.
- 7.3. VAT costs in respect of wholly trading services shall be posted to an input tax account.
- 7.4. Invoices shall be checked to ensure that VAT is only charged where a taxable supply has occurred.
- 7.5. VAT shall only be paid on receipt of a VAT invoice.

8. MONTH END PROCEDURES

- 8.1. The Accounts Payable Team Leader shall be responsible for the Payables Accounting Process and closure of the AP module of Oracle at the end of each period.
- 8.2. The Accounts Payable Team Leader will close the Inventory module of Oracle. Once closed, the Accounts Payable Team Leader will run the "Unaccounted Transactions Report" for the last and current period.
- 8.3. This report will be checked to ensure only those invoices with distribution variances are included. Any other entries shall be corrected and the report will be re-run.
- 8.4. The Accounts Payable Team Leader will then open the next period within the AP module and close the current period in the AP module. All unaccounted transactions will be transferred across to the new period.
- 8.5. The Accounts Payable Team Leader shall confirm the month-end closures with the Oracle Systems Team, which will enable them to generate the Procurement accrual report. The Accounts Payable Team Leader can then open the next Inventory module of Oracle.
- 8.6. The Accounts Payable Team shall reconcile payables by comparing the balances on the following reports:
 - Posted Invoices
 - Posted Payments
 - Trial Balance for the previous period.

All balances will be agreed to the appropriate Balance Sheet codes.

- 8.7. The Systems Administration team will subsequently upload the accrual file into the General Ledger.

9. YEAR END PROCEDURES

- 9.1. Finance staff are responsible for the compilation of year-end manual creditors and accruals.
- 9.2. Following the final creditors input, all goods received before the year-end not invoiced shall be reserved, together with invoices held in respect of old year deliveries.
- 9.3. Any remaining invoices or credit notes held on the AP system should also be reserved.

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- 9.4. Following the year-end the reserved creditors balance shall be monitored as part of the month end procedures.

10. FINANCIAL CONTROL WEAKNESSES OR SUSPECTED FRAUD

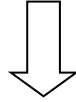
- 10.1. The Accounts Payable Manager will notify the Head of Finance and Procurement immediately of any concerns arising in relation to any breaches of, or apparent weaknesses in financial controls or governance. The Local Counter Fraud Specialist must be notified immediately of any concerns about fraud or suspected fraud.

11. EQUALITY IMPACT ASSESSMENT

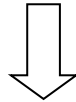
- 11.1. Following assessment, this policy is not felt to be discriminatory or detrimental in any way with regard to the following equality strands: Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights.

ACCOUNTS PAYABLE PROCESS

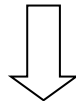
REQUISITION IS RAISED IN ORACLE BY
HEALTH BOARD



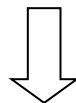
PURCHASE ORDER IS RAISED IN ORACLE
AND SENT TO SUPPLIER



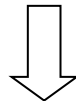
GOODS ARE SENT / SERVICES PROVIDED TO
HEALTH BOARD



PURCHASE ORDER IS RECEIPTED IN
ORACLE BY HEALTH BOARD



INVOICE IS RECEIVED IN ACCOUNTS
PAYABLE THEN INPUT AND MATCHED TO
PURCHASE ORDER



PAYMENT IS MADE TO SUPPLIER BY
ACCOUNTS PAYABLE

Financial Control Procedure: Manual Payments (FP8)

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Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	Audit, Risk & Assurance Committee
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People who need to know that this document exists	

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: Outcome:
Welsh Language Standard	No
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Ensure sustainability in all that we do, economically, environmentally and socially



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Ref: FP8

Policy Title: Financial Control Procedure: Manual payments

Page Number: 1

CONTENTS PAGE

- 1.** Introduction
- 2.** Manual Payment Vouchers
- 3.** Cancelled Cheques
- 4.** Out-of-date Cheques
- 5.** Equality Impact Assessment
- 6.** Appendices

1. INTRODUCTION

- 1.1. This procedure details the principles underlying the Cwm Taf Morgannwg University Health Board's manual payments process. The purpose of this procedure is to ensure:
- 1.2. The capitalisation threshold has been determined as expenditure of £5,000 (including VAT where this is not recoverable) or more on:
 - All manual payments are processed in a controlled environment and with appropriate authorisation.
 - Cancelled cheques and cheques over one financial year old are dealt with on a timely basis and as a result of appropriate authorisation.
 - All manual payments are recorded and accounted for accurately.
- 1.3. Where the term University Health Board (UHB) is used this applies equally, unless otherwise specified, to the NHS Wales Joint Commissioning Committee (JCC).

2. MANUAL PAYMENT VOUCHERS

- 2.1. Request vouchers for Manual payments may be received into the Cashier's Department from, but not limited to, the following sources:
 - Corporate Finance for Charitable Fund payments.
 - Shared Services Payroll Department for payments relating to staff and non-staff for lecture fees or travelling expenses.
 - Corporate Finance for refunds of duplicate payments, Category II fees, refunds of accommodation charges and reimbursement of patient's monies.
 - JCC for travelling expenses and Foreign Payments.
 - P2P for Foreign Payments and urgent payments.

The Committee will ensure that evidence based and timely interventions are implemented to drive forward improved performance thereby allowing the Health Board to achieve the requirements and standards determined for the NHS in Wales and as outlined within the Board's 3 Year Integrated Medium Term Plan.

- 2.2. Requests for manual payments from the Shared Services Payroll Department shall be actioned on emailed instructions, for travelling/interview expenses, and EARL download (Password protected excel file), for advances/refunds, due to the urgency of payments. Travelling/interview expenses vouchers should be accompanied by proof

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of bank details signed by the payee. Advances/refunds are downloaded directly from the EARL system so do not need additional documentation for bank details.

2.3. Before a payment can be raised the payment voucher/spreadsheet is checked by staff in the Cashiers Office to ensure:

- Details of the payee are clearly stated on the request. In some instances this may be different to the person receiving the payment.
- The invoice details or other supporting documentation agrees to the request and the total payable is correct.
- The request has been appropriately authorised.
- The financial code has been entered.
- The bank details are on a form signed by the Payee or from the beneficiary's personal e-mail address.

2.4. When these checks have been performed the Finance Officer - Cash shall raise a cheque or Faster Payment.

Cheque process

- Cashiers input details of the payment and print the cheques and cheque listing.
- Documents are checked to ensure cheque numbers run sequentially, payment details are correct and the appropriate revenue/charitable fund cheques are used.
- The documents are then passed to an authorised cheque signatory for signing.

Faster payment process

- Faster payments are processed using the UHB's bank website.
- Access to the UHB's bank account on the website is restricted to cashier staff and authorised signatories. Privileges ensure no single person can set up and approve a payment.
- Cashiers will access the website and enter payment details, and the payment request will be passed to the authorised signatory who will access the website to approve payment.

2.5. Before the cheque is signed/Faster Payment processed the authorised signatory should review any supporting documentation for the payment and agree the details to those on the cheque/Faster payment.

2.6. If collection of a cheque is requested evidence must be provided of the collector's identity and a signature obtained.

2.7. Accounting for manual payments issued:

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- Details of cheques/Faster Payment issued including the financial code, payee's name, cheque number and the reason for the cheque is entered from the payment vouchers into a manual record and this information will be input into the General Ledger monthly.
- Cheques raised on behalf of JCC will be accounted for as an intra-company transfer.

2.8. Charitable fund vouchers are entered onto the Charitable Fund System.

2.9. The Treasury Accountant will enter the total of manual payments each day in the appropriate cashbook. The cheque listing will be used to input cheques on the cheque reconciliation system

3. CANCELLED CHEQUES

3.1. Staff must immediately notify the Treasury Accountant if a cheque is lost or mislaid and complete a Cancelled Cheque Form (Appendix 1).

3.2. The Treasury Accountant (or their representative) will check with the UHB's banking system to ensure that the cheque has not been presented.

3.3. It is essential that as soon as information is received that a cheque is lost, the Treasury Accountant will enter the details on the bank software to request a stop to be placed on the cheque.

3.4. The Treasury Accountant must enter any cancelled cheques in the appropriate cashbook and prepare a manual journal for posting to the General Ledger to re-credit the expense code originally charged.

4. CHEQUES OVER ONE FINANCIAL YEAR OLD

4.1. Cheques are legal documents and do not go 'Out of Date' after 6 months, it is the discretion of the bank whether to honour the check after 6 Months.

4.2. The Treasury Accountant is responsible for identifying cheques that are over one Financial Year old and notifying the relevant Department.

4.3. Where appropriate the Treasury Accountant will contact the Bank and place a Stop on a cheque.

4.4. Cheques over one Financial Year old will not be replaced until a stop has been placed on the cheque and a written request is received from the original payee and appropriate authorisation is obtained.

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- 4.5. The Treasury Accountant is responsible for ensuring that the appropriate accounting entries are made in the ledger in respect of the cheques.

5. EQUALITY IMPACT ASSESSMENT

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



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Cwm Taf Morgannwg
University Health Board

CONTENTS

Appendix 1

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

STOP & CANCELLED CHEQUE FORM

To: Cashier's Department

Would you please cancel/place a stop on the following cheque:

Account (Please tick as appropriate)

UHB A/C	10008020
Main A/C	53803775
Charitable Fund A/C	13154475

Payee (Full Name on Cheque) _____

Amount £ _____

Cheque Number _____

Date Cheque Produced _____

Brief Reason _____

Expenditure Code _____

This cheque is to be WRITTEN BACK/REPLACED – (delete as required)

Completed by _____

Authorised by _____

Designation _____

Date _____

Ref: FP8

Policy Title: Financial Control Procedure: Manual payments

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Financial Control Procedure: Inventory of Non Capital Assets (FP11)

Document Type:	Non Clinical Organisational Wide Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk)
Author:	Head of Corporate Finance
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	Audit, Risk & Assurance Committee
Approval / Effective Date:	14/08/2025
Review Date:	14/08/2028
Version:	v.2

Target Audience:

People who need to know about this document in detail	Executive Directors Assistant Directors Care Group Managers
People who need to have a broad understanding of this document	Budget Holders
People who need to know that this document exists	

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date:
Welsh Language Standard	Outcome:
Date of approval by Equality Team:	No
Aligns to the following Wellbeing of Future Generation Act Objective	(00/00/0000)
	Ensure sustainability in all that we do, economically, environmentally and socially



Disclaimer:

Ref: FP11

Policy Title: Financial Control Procedure: Inventory of Non Capital Assets

Page Number: 1



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University Health Board

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Ref: FP11

Policy Title: Financial Control Procedure: Inventory of Non Capital Assets

Page Number: 2

CONTENTS PAGE

- 1.** Scope and Principles
- 2.** Thresholds
- 3.** Inventory Procedure
- 4.** Equality Impact Assessment

1. INTRODUCTION

- 1.1. This procedure details the principles underlying the University Health Board's system for maintaining an inventory of non-capital assets.
- 1.2. This procedure should be read in conjunction with the University Health Board's Standing Financial Instructions and other Financial Control Procedures.
- 1.3. The University Health Board (UHB) requires that all of its assets are secure and are being properly maintained and utilised.
- 1.4. This procedure aims to ensure that the UHB has robust controls to ensure that, as far as possible, all of its non-capitalised assets are secure from loss or theft.
- 1.5. Non-capitalised assets (excluding working stock & consumables) are items that do not meet the criteria to be capital assets and have an expected useful life in excess of 12 months. The definition of a capital asset is described in section 1 of FP1 Capital Monitoring.

2. THRESHOLDS

- 2.1. All non-capital assets valued over £1,000 (including VAT), will be required to be entered onto an inventory. This threshold may be reduced at the discretion of the Clinical Service Group Manager.
- 2.2. If the cost of an item is unknown, then a fair estimate of the cost of a replacement should be used.
- 2.3. All non-capitalised assets that cost greater than the threshold shall be known as 'Inventory Assets'.

3. INVENTORY PROCEDURE

- 3.1. A list of all inventory assets shall be created by each Directorate.
- 3.2. The Clinical Service Group Manager will be responsible for the control of an inventory within their directorate.
- 3.3. The Clinical Service Group Manager should delegate the responsibility within their directorate to officers with more manageable areas (e.g. Wards, Departments, and Rooms etc.).

- 3.4. The contents and format of the inventory will be at the discretion of the Clinical Service Group Manager, but should include as a minimum the following details:
- Brief Description
 - Make
 - Model
 - Serial number (if any)
 - Location / Room number
 - Estimated cost
 - Estimated Purchase Date
 - Estimated Life
- 3.5. If possible the inventory should be maintained in an electronic form (Database, Spreadsheet, Word Processor etc.) for ease of updates, maintenance and for security.
- 3.6. Capital assets should be excluded from the inventory, if any questions exist as to whether a particular item is a capital asset or not, they should be referred to the Senior Finance Officer (Capital), who will confirm those capital assets included on the UHB's Asset Register.
- 3.7. Any purchases or disposals should be noted on the inventory as soon as the change has occurred.
- 3.8. The inventory shall be updated and checked against actual items held, on at least a quarterly basis. A copy of the inventory should be signed and dated, then kept by the officer responsible. Internal Audit will undertake periodic checks to ensure compliance.
- 3.9. Any discrepancies between the inventory and the actual equipment held should immediately be reported to the Clinical Service Group Manager, who will investigate the reasons.
- 3.10. Losses, theft and condemnation must be reported in line with Financial Control Procedure FP15.

4. EQUALITY IMPACT ASSESSMENT

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



Agenda Item

5.3

Audit, Risk & Assurance Committee

Penalties for Late Submitted Evidence Update

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Concerns & Business Intelligence Richard Hughes, Deputy Executive Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Richard Hughes, Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Review

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	
CTMUHB	Cwm Taf Morgannwg University Health Board
WRP	Welsh Risk Pool
LFER	Learning from Events Report
LAP	Learning Advisory Panel

1. Situation /Background

The Health Board is required to submit a Learning from Events Report (LFER) to the Welsh Risk Pool (WRP) to provide evidence of the implementation of learning and improvement actions following claims and redress cases. The LFER is triggered on any of the following actions:

- Admission of qualifying liability
- Offer to settle made by CTMUHB
- Offer to settle accepted by CTMUHB
- Judgement awarded at trial

The Health Board has 4 months from the trigger date to submit a completed LFER to the WRP. Following submission, the LFER will be reviewed by the Learning Advisory Panel with the one of the following outcomes:

- **Approve:**
The Panel accept that the learning information submitted addresses all of the issues identified in the case. The Learning will be noted as approved and will be presented to the WRP Committee when reimbursement in the matter is requested, this will be approved.
- **Amber defer:**
The Panel determines that additional information is required to provide assurance about the learning. The approval of learning is deferred, subject to the requested information being received. Rather than take time at future panel meetings, the WRP Committee delegates approval to the Head of Safety & Learning following submission of the information identified.
- **Red defer:**
The Panel have identified that additional actions or information is required and that it should be re-presented back to a future panel once the additional information is provided. Approval of learning is deferred, requests for reimbursement are also deferred. Health Bodies are required to resubmit information within defined timescales after which reimbursement will not be accepted.
- **For discussion:**
The Panel identified issues which need to be considered by the WRP Committee. The case will be passed to the Committee with an outline of the considerations by the Panel.

Where a case is deferred, the Health Board has 12 months from the trigger date to submit further information and obtain final approval of an LFER.

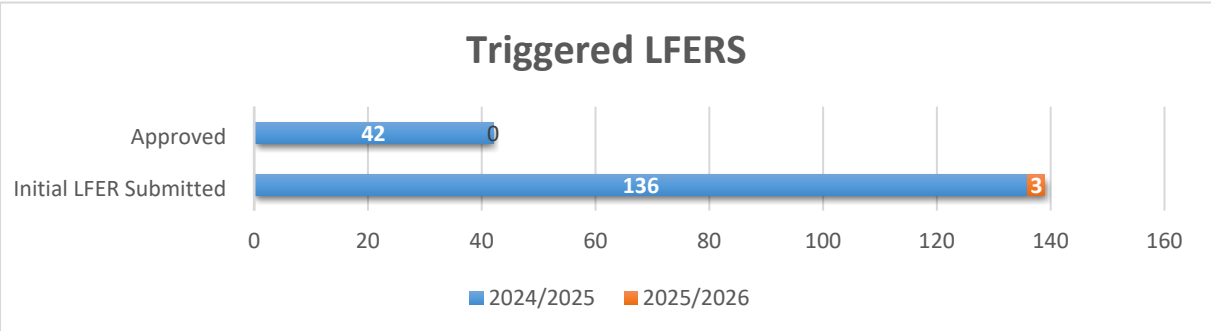
The Health Board will only be reimbursed by the WRP for monies paid in relation to a claim (damages/costs etc) once an LFER has been approved.

Data contained within the report for 2025/2026 relates to the time period of 01.04.25 to 31.07.25.

2. Specific Matters for Consideration

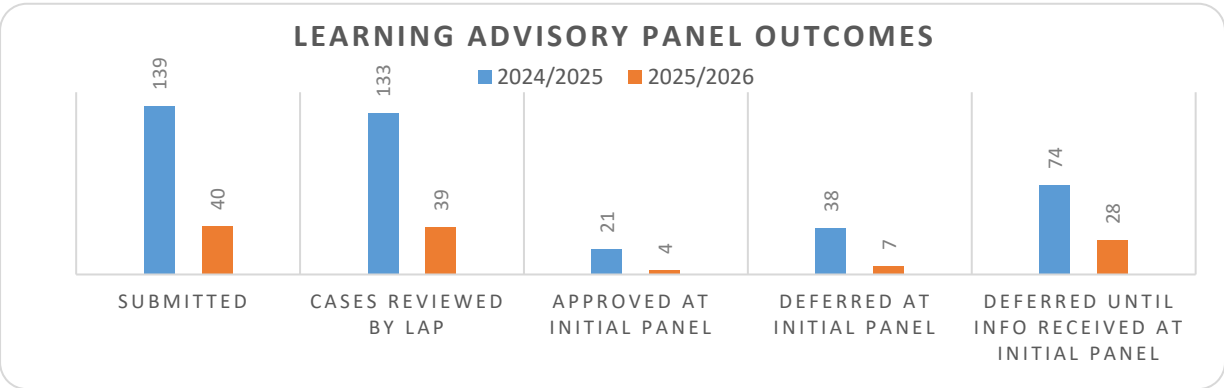
Triggered LFERs

From 01.04.24 to 31.07.25 the Health Board has triggered the completion of a 183 LFERs. Out of the 183 triggered, an initial LFER has been submitted for 139 with 42 receiving final approval.



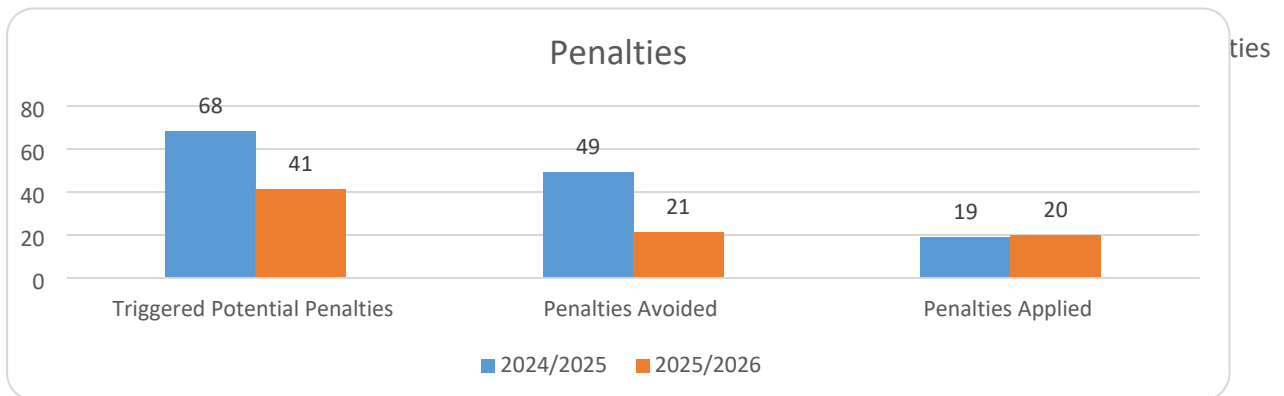
Submitted LFERs

Between the 01.04.25 and 31.07.25, the Health Board submitted a total of 179 LFERs. It should be noted that these would not necessarily have triggered in the same time period. During this time 172 cases were reviewed by the WRP Learning Advisory Panel (LAP). Of the cases reviewed by the Panel, 15% were approved at the initial LAP (2024/2025 – 16%, 2025/2026 – 10%).



Penalties

Where an LFER is not submitted and approved within the required timescales there is a risk of a financial penalty of £2,500 being imposed on the Health Board. Between the 01.04.24 and 31.07.25 the WRP identified a potential 109 penalties to be applied. As a result of focused work, 70 of the 109 were avoided. Of the remaining 39, a total of value of £69,500 financial penalties were applied. A breakdown is provided below with financial information for the previous three months.



Overall total value for WRP penalties for the months of July, June and May 2025 is £69,500 (broken down below).

July: total of 15

- 15 x £2,500 = £37,000

June: total of 8

- 3 x £2,500 = £7,500
- 5 x £2,500 **Credits = £12,500**

May: total of 10

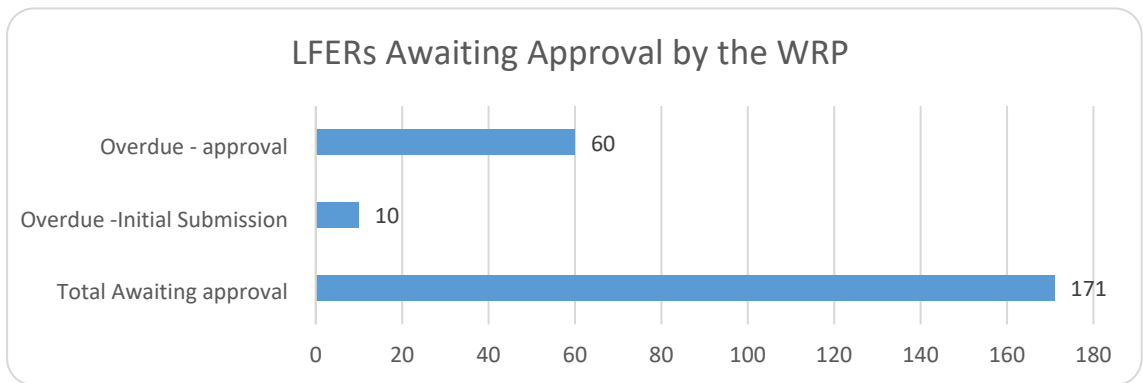
- 10 x £2,500 = £25,000

LFERs awaiting approval

As at the 31.07.25, the Health Board has a total of 171 LFERs awaiting approval by the WRP with the following status of learning:

- Submitted awaiting outcome – 30
- Awaiting initial submission – 52
- Deferred / further information requested – 89

Out of the 171, 70 are currently overdue and at risk of financial penalty from the WRP if the not submitted once the stay in proceedings on late submission penalties concludes.



3. Key Risks / Matters for Escalation

- 3.1

A Legal Services Recovery Programme, led by the Deputy Executive Director of Nursing, was implemented in April 2025 as a strategic initiative aimed at improving compliance, reducing risk exposure, and enhancing operational efficiency across CTMUHB’s legal services. The programme initially as a 12-week recovery plan with targeted actions such as backlog reduction, policy updates, and stakeholder engagement has since been extended now involving key stakeholder such as WRP and L&R services.
- 3.2

In response to potential penalties, the Head of Safety and Learning in WRP has applied one-time extensions for CTMUHB cases and a stay in proceedings on penalty action for 4 months from August, pushing the deadline to 22 October 2025. These extensions are intended to allow time for learning to be approved by the National Learning Advisory Panel. Furthermore, WRP advisors will be working within CTMUHB to advise and support the design of the CTMUHB LFER panel which will oversee performance as well as make assessments on cases ahead of formal submission. This move reflects a collaborative effort to avoid penalties while maintaining accountability.

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 (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 Timely Effective Person Centred
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: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	



	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below) Failure to comply with the WRP Learning from Events Report process will result in financial penalties being issued to the Health Board.

5. Recommendation

Members of the Audit, Risk and Assurance Committee are asked to:

- **NOTE** the content of the report
- **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
- **NOTE** the risks identified

6. Next Steps

6.1 Improvement actions identified within the report to continue to be monitored via the clinical executive team via the weekly Quality & Safety Executive Meeting.

6.2 The Organisational Change Process (OCP) for Legal Services, now concluded, sets the foundation for a more robust and streamlined operational model that will be implemented in due course. The revised structure introduces dedicated leadership roles such as Legal Services Managers for both Claims & Redress and Inquests reporting directly to the Head of Legal Services, thereby enhancing accountability and operational clarity. This restructuring aligns with broader Quality Governance reforms and reflects lessons learned from other Health Boards. Benchmarking insights from other Health Boards have revealed that many are contending with similar pressures around inquests and LFER processes. These comparative findings have informed CTMUHB's approach, reinforcing the value of a singular leadership focus within Legal Services to improve responsiveness, reduce risk exposure, and support sustainable performance.

6.3 The next phase of the Legal Services Recovery Programme will focus on consolidating the structural and procedural improvements initiated during the initial recovery cycle. With the Organisational Change Process (OCP) now concluded, implementation will begin across the service, embedding revised leadership roles and streamlined workflows. This includes finalising the appointment of Legal Services Managers and ensuring that the Head of Legal Services role is fully operationalised to provide oversight and strategic direction. Continued engagement with Care Groups will be essential to ensure that learning from events is embedded into practice, and that the revised

processes for LFER submissions are consistently applied to avoid future penalties.

6.4 In parallel, close collaboration with finance colleagues will support the development of financial statements for each Care Group, detailing claim values, associated penalties, and cost implications where appropriate. These statements will provide transparency and enable Care Groups to better understand the financial impact of legal claims and redress activity. This financial insight will be used to inform future planning and risk mitigation strategies, ensuring that operational decisions are aligned with both clinical governance and financial sustainability. The programme will also maintain regular reporting to the Welsh Risk Pool and internal governance bodies to monitor progress and ensure accountability



Agenda Item

6.1

Audit, Risk & Assurance Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting & Discussion

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



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

5. Recommendation

5.1 The Committee is requested **NOTE** and **DISCUSS** the report.

6. Next Steps

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



Cwm Taf Morgannwg University Health Board

Audit, Risk & Assurance Committee – 14th August 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	11
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	22
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	143	35
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	290	56
TOTAL	581	124

4. STRATEGIC GOVERNANCE

The NHS Counter Fraud Authority have now issued guidance in relation to the Economic Crime and Corporate Transparency Act 2023. The new legislation introduces a new offence of failure to prevent fraud and the Health Board will be required to comply. A review has been undertaken and findings presented in Appendix 1 to this report. The new legislation comes into effect on the 01 September 2025.

5. INFORM AND INVOLVE

The Counter Fraud Team are exploring the use of Viva Engage, an internal social media platform part of the Microsoft 365 package suite, as part of multi-modal means

of raising awareness amongst a dispersed workforce. The use of this app has been trailed with good early indications. Meetings have been established with partners with more mature use of the system to gain any available knowledge to enable effective delivery.

6. PREVENT AND DETER

There has been a recent encouragement arising from NHS Counter Fraud Authority to utilise the Fraud Prevention Figure formula established by that Organisation. There is some inertia to use this due to some outcomes being inflated or actually under reported when formula is applied. The formula and accompanying example is set out below.

If fraud has been detected, the following calculation can be used to determine the fraud prevention figure:

- (Total value of detected fraud) **divided by** (Duration of the offending in months) **equals** (Monthly value of fraud)
- (Monthly value of fraud) **multiplied by** (12 months) **equals** (preventative figure)

Example of Fraud prevented calculation:

A nurse has submitted false claims for expenses over a **14 month** period. The total value of the false expenses was **£30,000**.

- **£30,000** divided by **14 months** = **£2142** is the monthly value of the fraud.
- **£2142** multiplied by **12 months** = **£25,714** is the preventive figure that can be recorded

Applying the same formula to a false invoice payment of £1500 identified at point of second payment $1500/2 = 750$ monthly value of fraud $750 \times 12 = £9,000$ fraud prevention figure.

The divergence in extrapolation of outcomes is a concern when utilised for measure of performance. The local preference would be to utilise Fraud Risk Assessment work to demonstrate a maintenance or lowering individual risks to feed into an overall Fraud Risk Profile. This aligns directly with risk based approach of counter fraud activity and to the Health Board's overall approach to governance measurement.

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.

A Report on the Offence of Failure to Prevent Fraud under the Economic Crime and Corporate Transparency Act 2023

Author: Michelle Newport-Edwards
Local Counter Fraud Specialist

Date: July 2025

1. SITUATION

- 1.1. The Economic Crime and Corporate Transparency Act 2022 (ECCTA 2023) was created to strengthen the UK's ability to tackle fraud, money laundering and other forms of economic crime. ECCTA 2023 represents a major overhaul of the UK Government's framework for tackling financial crime and has brought into force several significant changes and bolstered existing legislation by introducing stricter regulation and increased transparency around corporate activities.
- 1.2. One of the most significant changes introduced by ECCTA 2023 is the new corporate offence of the failure to prevent fraud which comes into force on 1st September 2025.
- 1.3. Under the offence *an organisation may be criminally liable where an employee, agent, subsidiary, or other 'associated person', commits a fraud intending to benefit the organisation and the organisation did not have reasonable fraud prevention procedures in place.*
- 1.4. The offence will also apply where *the fraud offence is committed with the intention of benefitting a client of the organisation. It also does not need to be demonstrated that directors or senior managers ordered or knew about the fraud.*
- 1.5. As the offence sits alongside existing legislation tackling fraud and economic crime it means that an individual can be prosecuted for fraud while the organisation may also be prosecuted for failing to prevent it.
- 1.6. Prior to the offence coming into force the Government has issued guidance for organisations which defines the offence, the types of fraud covered by the offence, who can commit it and importantly the procedures organisations can put in place to prevent persons associated with them from committing fraud offences. NHS Counter Fraud Authority have since issued NHS specific guidance.
- 1.7. This report considers all available guidance and the Health Board's current policies and procedures that are in place to counter fraud and economic crime to seek to provide assurance that we have reasonable measures in place and any recommendations for additional controls to prevent the Health Board potentially being prosecuted for the Offence of Failure to Prevent Fraud.

2. BACKGROUND

- 2.1. In June 2022 the Law Commission published a paper entitled “Corporate Criminal Liability: an options paper” which examined options for improvement to the law with the aim of ensuring corporations are effectively held to account for committing serious crimes.
- 2.2. This led to the creation of ECCTA 2023 and the corporate offence of failure to prevent fraud. The aim of the offence is to drive a change in corporate culture by encouraging more companies to implement or improve fraud prevention procedures.

The Offence

- 2.3. Section 199 (1) and (2) of ECCTA 2023 defines the 2 ways in which the failure to prevent fraud offence can be committed:-
 - 2.3.1. Section 199(1) is aimed at large organisations and states that an offence is committed where:-
 - 2.3.1.1. the relevant body is a large organisation
 - 2.3.1.2. an associate of that relevant body commits a fraud offence
 - 2.3.1.3. the fraud offence takes place during a financial year of the relevant body
 - 2.3.1.4. the fraud offence is committed with the intention to benefit, either directly or indirectly the relevant body or any person to whom, or to whose subsidiary undertaking, the associate provides services on behalf of the relevant body.
 - 2.3.2. Section 199(2) is aimed at capturing parent companies when employees of their subsidiaries commit fraud. It provides that a relevant body will be guilty of failure to prevent fraud where:-
 - 2.3.2.1. an employee of the relevant body commits a fraud offence intending to benefit, either directly or indirectly, the relevant body
 - 2.3.2.2. the fraud offence takes place during a financial year of a parent undertaking of which the relevant body is a subsidiary undertaking, and

- 2.3.2.3. the parent undertaking is a relevant body which is a large organisation

Large Organisations

- 2.4. The offence is applicable to all sectors but specifically 'large organisations.' Section 201 of ECCTA 2023 defines a large organisation as an organisation that meets two or three of the following criteria
- 2.4.1. More than 250 employees
 - 2.4.2. More than £36 million in turnover
 - 2.4.3. More than £18 million in total assets
- 2.5. The above criteria apply to the whole organisation, including subsidiaries, regardless of where the organisation is headquartered or subsidiaries are located.

Fraud Offences

- 2.6. ECCTA 2023 refers to 'fraud offences' and these are defined at Section 199(6) as any of the fraud and false accounting offences outlined in Schedule 13 of ECCTA 2023 including the aiding, abetting, counselling, or procuring the commission of any of those offences. The guidance issued by the government confirms that these are known as 'base fraud' offences and include the following:-
- 2.6.1. Fraud by false representation – Section 2 Fraud Act 2006
 - 2.6.2. Fraud by failure to disclose – Section 3 Fraud Act 2006
 - 2.6.3. Fraud by abuse of position – Section 4 Fraud Act 2006
 - 2.6.4. Participation in a fraudulent business – Section 9 Fraud Act 2006
 - 2.6.5. Obtaining Services dishonestly – Section 11 Fraud Act 2006
 - 2.6.6. Cheating the Public Revenue – Common Law
 - 2.6.7. False Accounting – Section 17 Theft Act 1968
 - 2.6.8. False Statements by Company Directors – Section 19 Theft Act 1968
 - 2.6.9. Fraudulent Trading – Section 993 Companies Act 2006

When can corporate liability arise?

- 2.7. The failure to prevent fraud is a strict liability offence which can only be committed by corporations. The key factor in determining whether an organisation should be

prosecuted for a failure to prevent fraud is the issue of 'who was intended to benefit from the fraud'. As a fraud offence can be considered complete before any gain is received ECCTA 2023 also applies the same rationale and does not require any evidence that the organisation benefitted from the fraud. This means that corporate liability can arise simply by demonstrating that the organisation was intended to be the beneficiary of the fraud whether directly or indirectly.

- 2.8. An organisation could also be prosecuted for failing to prevent fraud even in circumstances where the fraud is committed by subsidiary's employee, for the benefit of the parent organisation and the parent organisation did not take reasonable steps to prevent it.
- 2.9. There is no requirement for an organisation to be aware of the fraud to be held criminally responsible.
- 2.10. It is also important to note that an organisation will not be prosecuted for a failure to prevent fraud where the organisation is the victim or the intended victim of a fraud that was supposed to benefit the organisations clients.

Who commits the offence leading to a potential prosecution?

- 2.11. ECCTA 2023 confirms that a base fraud offence must be committed by an 'associate of that relevant body'. The Government guidance confirms that "an employee, an agent or a subsidiary of the relevant body is automatically considered an 'associated person' for the purposes of the offence. It should also be noted that a person who provides services for or on behalf of the relevant body is also an associated person during the period that they are providing those services.
- 2.12. Corporate liability will only arise if an individual commits a base fraud offence whilst providing services and acting in the capacity of a person associated with the relevant

body. A base fraud offence that takes place outside this capacity, such as in the person's private life will not give rise to corporate liability.

- 2.13. It should also be noted that in establishing if a particular individual is an associated person there is a requirement to consider all relevant circumstances and not simply just the nature of the relationship between that individual and the organisation. This means that an individual can be considered an associated person under ECCTA 2023 even in circumstances where there is no contractual relationship.

Defence

- 2.14. To avoid prosecution for a failure to prevent fraud ECCTA 2023 at Sections 199 (4) and 199 (5) stipulates that an organisation will have a defence if they are able to demonstrate:

That they have reasonable procedures in place to prevent fraud, or

That it was not reasonable in all the circumstances to expect the organisation to have any fraud prevention procedures in place.

- 2.15. The question of whether an organisation has reasonable procedures in place to prevent fraud in the context of a prosecution is something that can only be resolved by a court. If an organisation is prosecuted for a failure to prevent fraud, then the onus will be on the organisation to prove 'on a balance of probabilities' that it had reasonable procedures in place to prevent fraud.

What are reasonable fraud prevention procedures?

- 2.16. The Government guidance suggests that for an organisation to demonstrate that they have reasonable procedures in place they need to implement a fraud prevention framework which should be informed by six principles:-

Top Level Commitment

Risk Assessment

Proportionate risk-based prevention procedures

Due Diligence

Communication (Including Training)

Monitoring and Review

- 2.17. The guidance is clear that the principles outlined above are intended to be flexible, outcome focussed and proportionate to the risk of fraud faced by the organisation.
- 2.18. It is important to note that if an organisation chooses to depart from some of the suggested procedures outlined within the government guidance does not automatically mean that, that organisation did not have reasonable fraud prevention procedures in place. Equally even strict compliance with the guidance will not necessarily amount to having reasonable procedures where the relevant body faces particular risks arising from the unique facts of its own business that have not been addressed

3. ANALYSIS

- 3.1. The LCFS has considered the guidance issued by the UK Government and that of NHS Counter Fraud Authority and we are of the view that the Health Board would meet the definition of a large organisation for the purposes of ECCTA 2023, therefore we need to consider the question of whether we have reasonable procedures in place to prevent fraud.
- 3.2. Cwm Taf Morgannwg University Health Board is required to comply with the Counter Fraud Government Functional Standards - NHS Requirements. The guidance issued by the UK Government acknowledges that public sector organisations are likely to have many of the elements of the fraud prevention framework already in place but there may be a need to adapt these procedures to ensure they consider the failure to prevent fraud offence.

- 3.3. The Health Board currently has measures in place via compliance with the Counter Fraud Standards which map directly to the six principles set out for defence against the new corporate offence:-

Top Level Commitment

Links with Standard component 1; to have an accountable individual at board level who is responsible for fraud, bribery and corruption. The Health Board is currently Green rated for this standard with Director of Finance holding responsibility for counter fraud matters and a nominated Fraud Champion.

Risk Assessment

Links with Counter Fraud Standard component 3; to have a fraud, bribery and corruption risk assessment that feeds into the organisational workplan and is managed in line with the organisation's local risk management policies. The Health Board is currently Green rated for this standard with a maturing integration with established risk management processes.

Proportionate Risk-Based Prevention Procedures

Links with Counter Fraud Standard component 5; to have an annual action plan that is informed by fraud risk, identifying activities to improve capability and resilience. The Health Board is currently Green rated for this standard with an annual Counter Fraud Work Plan agreed with the Director of Finance and approved by the Audit Committee.

Due Diligence

Links to a number of components including Counter Fraud Standard component 2; the organisation should align their counter fraud, bribery and corruption work to the NHSCFA's central strategy. The Health Board is currently Green rated for this standard with strategy set out in the Counter Fraud Work Plan and within Health Board policies such as the Counter Fraud Policy and Response Plan.

Communication (Including Training)

Links with Counter Fraud Standard component 7; to have well established and documented reporting routes for staff, contractors and members of the public where necessary to report fraud suspicions. The Health Board is currently rated Green for this standard with availability of multi-modal reporting routes for staff which are well established and documented.

This also links with Counter Fraud Standard component 11; ensuring that all staff have access to and undertake fraud awareness, bribery and corruption training as appropriate to their role. The Health Board is currently Green rated for this standard but continued compliance is always looking to improve this area.

Monitoring and Review

Links with Counter Fraud Standard component 6; to identify and report upon annual outcome-based metrics to support improvement in performance. The Health Board is currently rated Green in this area with KPIs set and measured on a quarterly basis which are submitted to Welsh Government and presented to the Health Board's Audit Committee for review.

4. RECOMMENDATIONS

- 4.1. ECCTA 2023 can only strengthen our collective fraud prevention efforts by enabling us to create an environment with an increased anti-fraud culture. This will continue to evolve once the offence comes into force and organisations are prosecuted for a failure to prevent fraud.
- 4.2. Currently the LCFS would make the following suggestions to help strengthen our position in demonstrating that we have reasonable procedures in place
 - 4.2.1. Conduct a formal Risk Assessment, to incorporate the NHS Counter Fraud Authority Advisory Checklist, on the potential risk to the Health Board of them being prosecuted for a failure to prevent fraud. This will enable us to formalise where we currently are, identify any weaknesses and log the risk for future review.
 - 4.2.2. Engage with Procurement and Finance to ensure that all policies, procedures and contracts are in compliance with ECCTA 2023 and that documentation is updated to include reference to the new offence.
 - 4.2.3. Counter Fraud should be included as a Risk Domain and as a Specialist Advisor in the Health Boards overarching Risk Management Policy.
 - 4.2.4. Consider making Counter Fraud Awareness training a mandatory requirement for all staff. This will be a key element to any defence the Health Board is required to raise should an employee go rogue which results in the Health Board benefitting.

Appendix 1 – Useful Links for Further Reading

[Failure to prevent fraud offence | NHS Counter Fraud Authority](#)

[Offence of 'failure to prevent fraud' introduced by ECCTA - GOV.UK](#)

Appendix 2 – NHS Counter Fraud Authority Advisory Checklist

Principle	Compliance
Top Level Commitment	
Having an accountable individual at board level who is responsible for fraud, bribery and corruption.	
The board of directors, partners and or relevant senior management of a relevant organisation committing to preventing fraud and fostering a culture in which fraud is never acceptable.	
The chief executive officer (or equivalent) making a statement about the organisation's fraud prevention approach and measures.	
Ensuring that an effective whistleblowing facility is in place to facilitate the reporting of allegations or suspicions of fraud and other criminal conduct, and ensuring that there is board-level oversight of whistleblowing.	
Discussion of key issues amongst senior management, thinking about key milestones between now and implementation date and if appropriate and necessary, taking professional legal advice on how the offence applies to the organisation.	
Senior management should be aware of and accept the initiatives and ensure that they are embedded in corporate culture.	
Monitoring the progress of measures to mitigate identified risks at a senior level.	
Fraud Risk Assessment	
Having a fraud, bribery and corruption risk assessment that feeds into the organisational work plan and is managed in line with the organisations local risk management policies (GovS 013 Component 3: Fraud, bribery and corruption risk assessment).	
Undertaking risk analysis in line with Government Counter Fraud Profession fraud risk assessment methodology and recording this on the appropriate risk registers.	
Consideration of fraud risks within any associated subsidiary of the NHS organisation.	
Taking legal advice where appropriate and necessary on the identification of associated persons (employees, agents, subsidiaries or other person who provides services for or on behalf of the organisation). For example, contractors may be associated persons when they are providing services for or on behalf of the organisation.	
Undertaking effective fraud risk assessments which will inform proportionate fraud prevention controls	
Consideration of whether current risk assessments cover the risk of fraud that is in scope of this offence (fraud that is intended to benefit the organisation, or in some circumstances, it's clients and fraud committed by 'associated' persons).	
Adaptation of current risk assessments to include fraud risks in scope of this offence.	

COUNTER FRAUD

Principle	Compliance
If appropriate, responsibility for conducting a documented risk assessment which is kept under regular review, assessing the nature and extent of the organisations exposure to the risks of associated persons committing fraud in scope of this offence.	
Consideration of the changes made to the 'identification doctrine' under ECCTA and whether current risk assessments cover 'senior manager' risk (see section on The ECCTA for guidance on the identification doctrine and the definition of 'senior manager').	
Proportionate Risk Based Prevention Procedures	
Having an annual action plan that is informed by fraud risk, identifying activities to improve capability and resilience (GovS 013 Component 5: Annual action plan).	
Using the fraud prevention information, guidance and resources provided by NHSCFA, ensuring that clear, practical and enforced procedures are in place to prevent fraud by associated persons.	
Ensuring that these procedures are proportionate to the fraud risks it faces and to the nature, scale and complexity of the organisation's advice.	
Thinking about what a fraud prevention plan/framework will look like (i.e. what the proportionate, risk-based, fraud prevention procedures will be).	
Checking what anti-fraud procedures are currently in place and assessing whether they are sufficient to counter the risks identified in the risk assessment.	
Using NHSCFA's fraud prevention guidance documents to develop or adapt local fraud prevention policies, procedures and systems (see guidance on procurement fraud, payroll fraud, invoice and mandate fraud, pre-contract procurement fraud, management and control of prescription forms, employment agency fraud).	
Having a proportionate fraud prevention policy which may form part of a general code of conduct or which may be a stand-alone policy.	
Deciding what resources and governance structures are needed to adapt to this change in the law.	
Being able to demonstrate a strong anti-fraud culture within the organisation.	
Ensuring that an effective whistleblowing facility is in place to facilitate the reporting of allegations or suspicions of fraud and other criminal conduct and ensuring that there is board-level oversight of whistleblowing.	
Having disciplinary procedures in place, which enable the organisation to take appropriate disciplinary action against an employee who commits a fraudulent act.	
Establishing clear reporting pathways in place for reporting suspected fraud.	
Adaptation of existing policies to include the failure to prevent offence (for example, whistleblowing, HR, fraud, external communications, media etc).	

COUNTER FRAUD

Principle	Compliance
Ensuring that sub-contractors are within the scope of fraud prevention procedures.	
Ensuring that fraud prevention procedures address how the relevant measures will prevent fraud by service provision.	
For contracting relationships, updating standard wording to require compliance with fraud prevention policies.	
Due Diligence	
Ensuring alignment of the organisation's counter fraud, bribery and corruption work to the NHSCFA's central strategy (GovS 013 Component 2: Counter fraud, bribery and corruption strategy).	
Application of proportionate and risk based due diligence procedures in respect of persons who perform or will perform services for or on its behalf to mitigate identified fraud risks.	
Ensuring due diligence procedures are in place and considering the organisation's existing due diligence checks in relation to such parties and whether they are sufficiently robust to identify previous allegations or suspicions of fraud against a third party.	
Reviewing agreements with any agents, distributors, representatives, and other third-party intermediaries to ensure they contain appropriate contract terms in relation to fraud.	
Ensuring pre-employment checks and procedures are in place.	
Implementing the actions within the Due Diligence Quick Guide to assist NHS procurement teams in making informed risk management decisions on whether to engage with suppliers.	
Communication (including training)	
Having well established and documented reporting routes for staff, contractors and members of the public where necessary to report fraud suspicions (GovS 013 Component 7: Reporting routes for staff, contractors and members of the public).	
Ensuring all staff have access to and undertake fraud awareness, bribery and corruption training as appropriate to their role (GovS 013 Component 11: Access to and completion of training).	
Regular measurement of staff awareness levels.	
Reviewing and delivering appropriate training to ensure awareness of coming changes.	
Ensuring that the fraud prevention policy or code of conduct is proactively communicated to all staff, fully implemented, and demonstrably effective.	
Measuring levels of awareness of the code of conduct among staff.	
Being able to demonstrate a strong anti-fraud culture within the organisation.	
Ensuring that an effective whistleblowing facility is in place to facilitate the reporting of allegations or suspicions of fraud and other criminal conduct.	
Ensuring that the NHS Fraud and Corruption Reporting Line (telephone hotline and online reporting tool) is publicised.	

COUNTER FRAUD

Principle	Compliance
Having a mechanism for recording referrals and allegations of suspected fraud, bribery and corruption.	
Using NHSCFA's fraud awareness toolkit to raise awareness of NHS fraud.	
Using communication as a fraud fighting tool.	
Using the NHS Fraud Reference Guide to raise awareness of types of NHS fraud.	
Seeking to ensure that it's prevention policies and procedures are communicated, embedded and understood throughout the organisation, through internal and external communication.	
Monitoring and Review	
Identifying and reporting upon annual outcome-based metrics to support improvement in performance (GovS 013: Component 6: Outcome based metrics).	
Monitoring and reviewing its fraud prevention procedures and making improvements where necessary.	
Learning from investigations and whistleblowing incidents and reviewing information from its own sector.	
Reviewing and updating policies and procedures.	
Ascertaining what anti-fraud procedures are currently in place.	
'Testing' procedures.	
Reviewing internal systems and controls.	
Thinking about whether internal investigation mechanisms need to be updated.	



Item 6.1 – Appendix

Counter Fraud Investigations Update Report

Summary

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

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

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

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

Case Status		
Cases Under Investigation	Cases Pending 3rd Party Outcome	Cases Closed 2025/26
10	1	5
Case Rates		
Referrals Received 2025/26	Cases Under Investigation for Over 12 Months	
2	4	
Sanctions/Outcomes		
Criminal Sanctions	Civil Sanctions (Inc. Financial Recovery)	Disciplinary Sanctions
0	0	0

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. Proceeds of Crime hearing was listed for 01.05.2025 for mention to proceed with the Confiscation Order a further mention hearing was undertaken on 18.07.2025. The final POCA hearing has been set for 14.08.2025.

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. A linked case has resulted in authorisation of charges. Full assessment between investigator and CPS reviewing lawyer to be undertaken once this trial has taken place in September.

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. Enquiries ongoing, data requested from Prescribing Services and Suppliers before considering further reasonable lines of enquiry. Case Transferred into CFS Wales for investigation on 09 May 2025.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/25/00458	17/02/2025	Overseas Patient receiving treatment on the NHS	Referral received via the fraud and corruption reporting line that an individual is residing in the Philippines and returning to the area for treatment on the NHS.	Subject is using a family address for registration with a GP in the CTM UHB area. Enquiries carried out with Border Force for dates subject had returned back to the UK to establish whether any treatment has been provided by the NHS during these periods. An interview under caution has been undertaken and the subject has provided an account. Further supporting documentation has been forwarded and is being assessed.
INV/25/00632	04/03/2025	Allegation of theft of Health Board property by staff working in the Estates Department.	Allegation that the staff working out of PCH estates department have removed pipes and cables from a decommissioned area of the site and sold them for scrap.	Meetings held with Senior Management around Health Board processes. Enquiries have not established evidence to support ongoing investigation. A wider review in this area is be undertaken to strengthen counter fraud controls.

Open Cases				
Reference Number	Date Opened	Allegation	Case Information	Update
INV/25/01378	15/05/2025	Concerns around qualification and experience of a senior nurse	Concerns raised due to performance falling below expectations of a nurse of this experience and backing qualifications.	Enquiries have corroborated the training and previous employment via requests to learning institutions and previous employers. Further concerns around the whereabouts of this subject whilst on shift have led to further enquiries around potential secondary employment.
INV/25/01536	03/06/2025	Staff member requesting further wage payments	Member of staff has repeatedly stated wages have been not been received and is seeking further payments to be made. Initial enquiries have established that all wage payments had in fact been made.	Support gained from Financial Investigators at CFS Wales to corroborate payments into subject's bank account. Further account established and checks being undertaken with that bank.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
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.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
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.

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
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. Subject attended a voluntary interview under caution and provided mitigating information around variability in pay and receipt of large sums of money linked to family gifts at the time of overpayment. Subject agreed to repay the overpayment in full and a repayment plan is in place.
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

Closed Cases			
Reference Number	Date Opened	Allegation	Outcome
			investigation which covers a similar allegation to this fraud matter as well as other concerns. Measures put in place locally to prevent excessive overtime hours being allocated/claimed. NMC investigation ongoing and will be supported separately to this investigation.
INV/25/01503	30/05/2025	Patient is alleged to be selling their prescribed controlled drugs illicitly	Information shared with South Wales Police Drugs Liaison Officer for intelligence purposes. Liaison with subject's GP Practice to highlight concerns for management and safeguarding.
INV/25/01800	26/06/2025	Patient is alleged to be selling their prescribed controlled drugs illicitly as well as Class B and Class A drugs	Information shared with South Wales Police Drugs Liaison Officer for intelligence purposes. Liaison with subject's GP Practice to highlight concerns for management and safeguarding.



Agenda Item

7.1

Audit, Risk & Assurance Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	14 August 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	Cally Hamblyn, Assistant 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 Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	4 August 2025	Management sign off received - <i>Pending</i>

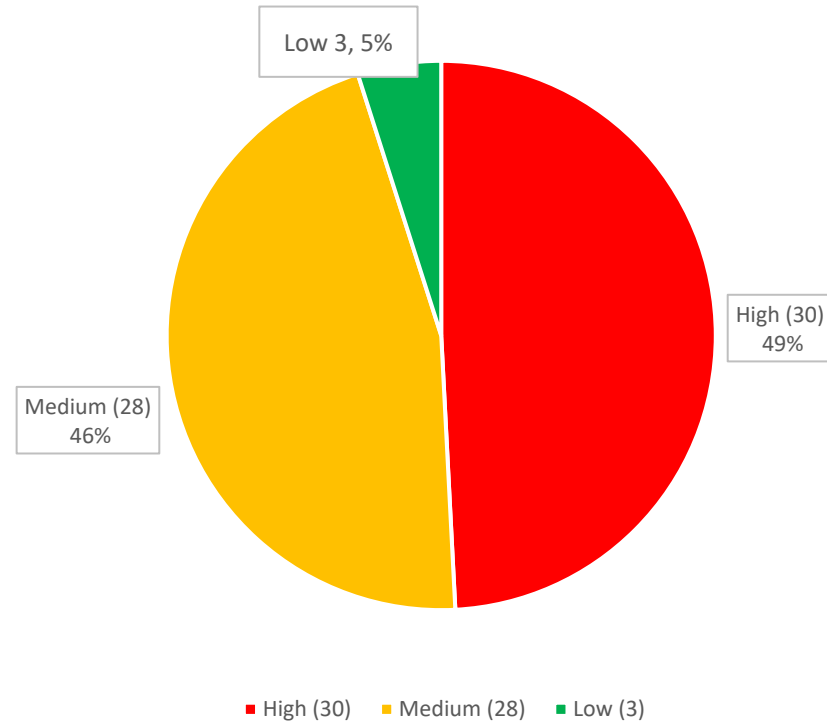
Acronyms / Glossary of Terms	
AMaT	Audit Management and Tracking
HIW	Healthcare Inspectorate Wales

Internal Audit Activity Limited Assurance Overdue Activity Comparison

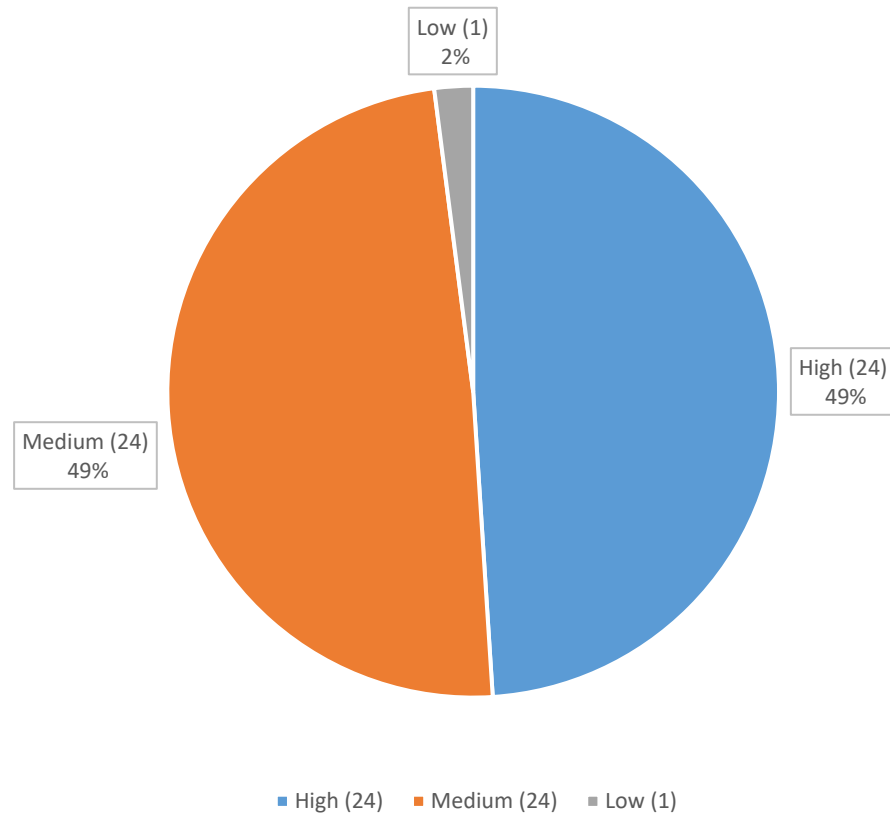
The following pie charts relate to **Limited Assurance** reports only and highlights the total 'overdue' actions based on the originally assigned due date. The position as at the last ARAC in May is included as a comparator for the July ARAC position. The actions are also split by the priority of High, Medium and Low as assigned at the finalisation of the Audit Review.

May 2025

Limited Assurance reports only - Overall overdue Internal Audit open Inspection Recommendation Actions (total days overdue from Original Due Date) by Action Priority as at 24/04/2025



July 2025



Narrative Commentary - The number of overdue actions exceeding their original due date has reduced by 12 from the report presented to the May 2025 Committee meeting. Reduction of 6 high priority, 4 medium and 2 low priority.

Internal Audit Areas of suggested focus

The following Internal Audit Reviews have the longest overdue audit actions against the original due date for Limited Assurance rated reports:

Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024

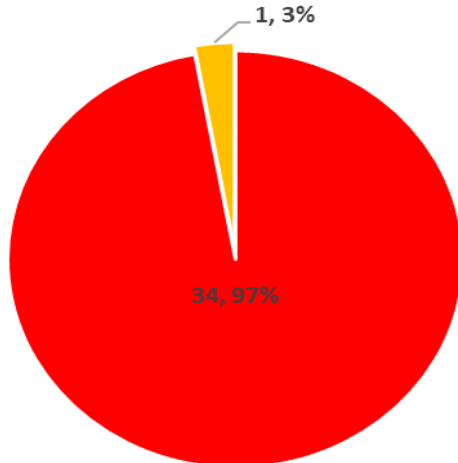
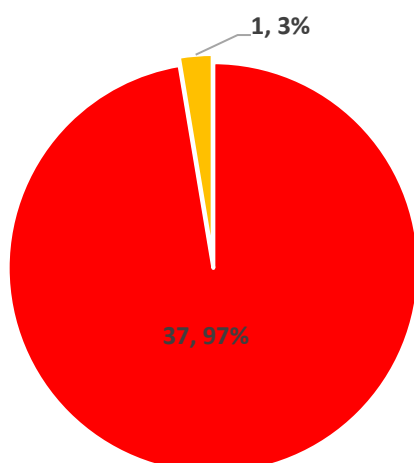
Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023

4-hour Emergency Department Performance Reporting Final Internal Audit Report February 2024

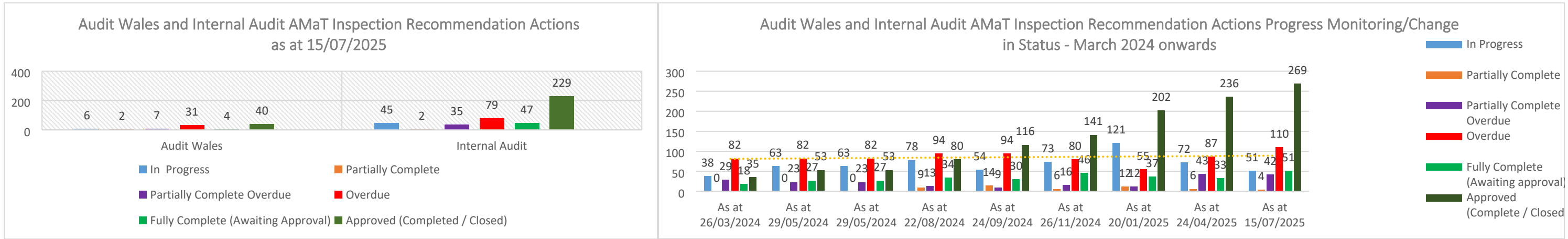
These areas will be escalated to the Executive Lead to ensure targeted focus on completing action activity.

Overdue Limited Assurance Actions – Breakdown by Executive Portfolio

Overdue actions that fall within the portfolio of the Chief Operating Officer	23
Overdue actions that fall portfolio of the Executive Director of Strategy	2
Overdue actions that that are split between the functions under the portfolios of the Medical Director and Executive Director for People	17

Audit Wales Activity Limited Assurance Overdue Activity Comparison		Audit Wales Areas of suggested focus
The following pie charts relate to 'overdue' actions from Audit Wales reviews. The position as at the last ARAC in May is included as a comparator for the July ARAC position. The actions are also split by the priority of High, Medium and Low as assigned at the finalisation of the Audit Review.		The following Audit Reviews have the longest overdue audit actions against the original due date for Audit Wales Reports: Audit Wales/2021/144 - Audit Wales Quality Governance Follow Up Review Audit Wales/2022/12 - Transformational Leadership Programme Board – Baseline Governance Review Audit Wales/2024/196 - Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit These areas will be escalated to the Executive Lead to ensure targeted focus on completing action activity.
May 2025	July 2025	
Overall overdue Audit Wales open Inspection Recommendation Actions (total days overdue from Original Due Date) by Action priority as at 24/04/2025  ■ High (34) ■ Medium (0) ■ Low (0)	Overall overdue Audit Wales open Inspection Recommendation Actions (total days overdue from Original Due Date) by Action priority as at 15/07/2025  ■ High (37) ■ Medium (1) ■ Low (0)	
Narrative Commentary - The number of overdue actions exceeding their original due date increased by 5 from the report presented to the May 2025 Committee meeting. High priority actions increased by 3 and medium priority by 1 this period.		

Overall position summary of all outstanding actions for Internal Audit and Audit Wales



1. Background

- 1.1 The main purpose of this report is to present an update to the Audit, Risk & Assurance Committee on reported progress of audit report recommendations with an increased focus on overdue actions with a Limited Assurance rating.
- 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 **22nd July 2025**.

2. Specific Matters for Consideration

- 2.1 This report has been prepared using an updated format in order to highlight the areas of focus within the 'Overdue Actions Tracker' with increased focus on those actions with a Limited Assurance rating. The 'Overdue Actions Tracker' is included as *Appendix 1*, however please note if members would like to view the full tracker this will be made available to all members for scrutiny in the supplementary folder available on Admincontrol.
- 2.2 The performance dashboard on page 3 of this report focusses on Limited and Overdue actions in response to the recent discussions with Members of the Committee in April 2025. Following further engagement with committee members this report has been further adapted to provide more clarity and assurance. Further engagement on the report format is welcomed as the team will endeavour to provide accurate assurance reporting.
- 2.3 Please note that AMaT is a live system and therefore the data is true at the time of reporting which for 14th August 2025 Committee was the 15th July 2025.
- 2.4 The Dashboard found at the front of this report has been designed to evidence any progress and highlight areas that need an increased focus. This written report will add some narrative to the graph data to add context to the data.
- 2.5 The first graph is a direct comparison looking at Overdue Limited Assurance by action priority. Following on from a positive recent Internal Audit Report, the team have been looking at ways to improve upon the assurance provided and have made the move to return all data reports back to their overdue status based on **original due date**. This will provide members and teams with a truer picture in terms of overdue status. Teams will still be able to provide a revised implementation date for completion which again will allow members the ability to accurately scrutinise ongoing work.



- 2.6 The data for overdue Limited Assurance reports highlights an overall reduction of 12 which include 6 high priority, 4 medium and 2 low priority actions.
- 2.7 Graph four is a new initiative allowing a highlighted focus to audits and actions that either need further attention or present a higher risk to the organisation. This is the first step towards triangulating the data we collect making scrutiny for Committee Members more meaningful and focus driven on areas that may need improvement. The areas of focus highlighted in the performance dashboards indicate those audits of which actions have the longest number of overdue days based on their original implementation date.
- 2.8 Cleansing of the Tracker continues in order to identify any recommendations that are easily achievable or may have been superseded in an attempt to make the Tracker a more manageable governance tool ensuring the focus is on current, existing and ongoing governance and assurance priorities of CTM. The team continue to engage Executive colleagues and Internal Audit as well as regular and increased meetings with the Business Managers for each Care Group in order to track the progress of ongoing Audit Recommendations.
- 2.9 Progress on this work continues to be reported to this Committee following appropriate Executive approval at Executive Leadership Group before closure on the system. There have been **51 total completed actions** proposed for **closure** this period with a further **50** new actions added.
- 2.10 The current position on the status of recommendation actions which are overdue can be viewed in *Appendix 1*, with the most recent updates provided in red.
- 2.11 The Quality Assurance and Compliance team continue to offer support to Care Groups and leaders to independently update actions onto AMaT and is a step-by-step guide has been sent out to all involved to encourage prompt, succinct and quality updates. 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.
- 2.12 As mentioned previously in this report, the Tracker was subject to review by Internal Audit recently. Overall, the report was very positive with small, achievable recommendations. As a result of this and to improve the reporting process, the User Guide for the use of AMaT in audit tracking has now been updated. From July 1st all Audit Actions will be measured from the **original due date**. Whilst it is recognised that there may be shifting priorities within Care Groups and the Health Board as a whole, it is felt that measuring from the original due date offers the most transparent assurance and also allows the team to use the AMaT system to produce system reports

as originally intended. This is also in line with other Health Boards in Wales who were consulted as part of a scoping exercise.

2.13 Tracker Updates

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

- **11 New** Internal Audit Review has been added to the Audit Recommendations Tracker including **50** new actions.
- **6** Internal Audit Reviews have been completed and **47** audit recommendation actions are proposed for **CLOSURE**.

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

- **0 New** External Audit Reviews have been added to the Audit Recommendations Tracker.
- **0** Audit Wales Reviews have been completed, however there are **4** audit recommendations actions are proposed for **CLOSURE**.

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 and Experience Committee at its meeting on the 22nd July 2025:

- **2 New** agreed Improvement Plans added resulting in **22 New** actions.
- **513** Inspection actions **Fully Complete-Closed** and a further **21** 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.
- Please note that HIW figures no longer include Death in Custody figures.

3. Key Risks / Matters for Escalation

- 3.1 The audit tracker will continue to be updated with a targeted focus on actions with Limited Assurance and are overdue from original due date. As previously mentioned, this report and tracker are continuously evolving with the aim of providing a transparent and assurance focus account of the Health Board's position.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies, please list below:



Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	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))	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 (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 (<i>Pobl /Ariannol</i>) / Resource Impact (<i>People / Financial</i>)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATION

- 5.1 The Audit, Risk & Assurance Committee are being asked to **NOTE** the report and **AGREE** that where applicable the progress updates provide Members with sufficient assurance, particularly in relation to closed recommendations.

AMaT Inspection Code	Title	Type	Date of Inspection	Executive Lead	Overall Assurance Rating	Recommendations	Actions	Parent Inspection
Audit Wales/2021/144	Audit Wales Quality Governance Follow Up Review_Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 1234567)	New	01/08/2021	Greg Dix, Executive Director of Nursing & Deputy CEO	N/A	7	7	
Audit Wales/2021/12	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 293442022)	New	01/08/2022	Claire Thompson, Executive Director of Strategy & Transformation	N/A	5	5	
Audit Wales/2021/149	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3030A2023)	New	01/10/2023	Gareth Watts, Director of Corporate Governance & Board Secretary / Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	N/A	6	6	
Audit Wales/2023/118	Structured Assessment 2022 – CTMUHB 2022_Febuary 2023 (Document reference: 3131A2023)	New	01/02/2023	Gareth Watts, Director of Corporate Governance & Board Secretary / Sally May, Executive Director of Finance / Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	N/A	8	8	
Audit Wales/2023/23	Orthopaedic Services in Wales – Tackling the Waiting List Backlog_Report of the Auditor General for Wales_March 2023	New	01/03/2023	N/A	N/A	3	3	
Audit Wales/2024/168	Review of Resilience Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	New	01/02/2024	Hywel Daniel, Executive Director for People	N/A	6	6	
Audit Wales/2024/136	Follow up review: Temporary Closure of the Yborf Cem Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 4361A2024)	New	01/07/2024	Greg Dix, Executive Director of Nursing & Deputy CEO	N/A	1	2	
Audit Wales/2024/205	CDO/CH/NTM: Audit of Accounts Report Addendum – CTMUHB 2023-24_October 2024 (Document reference: 4365A2024)	New	01/08/2024	Sally May, Executive Director of Finance	N/A	7	7	
Audit Wales/2024/212	Primary Care Follow-Up Review – CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	New	30/11/2024	Gethin Hughes, Chief Operating Officer	N/A	6	11	
Audit Wales/2024/213	Review of Cost Savings Arrangements – CTMUHB 2023-24_October 2024 (Document reference: 4643A2024)	New	31/10/2024	Sally May, Executive Director of Finance	N/A	8	8	
Audit Wales/2025/234	Structured Assessment 2024, CTMUHB 2024, November 2024 (Document reference: 4578A2024)	New	23/01/2025	Gareth Watts, Director of Corporate Governance & Board Secretary / Sally May, Executive Director of Finance / Claire Thompson, Executive Director of Strategy & Transformation / Greg Dix, Executive Director of Nursing & Deputy CEO / Gethin Hughes, Chief Operating Officer / Philip Daniels, Executive Director for Public Health	N/A	13	14	
Internal Audit/2020/65	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMUHB-2223-03)	New	26/07/2020	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	2	2	
Internal Audit/2020/74	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMU-1620-458)	New	24/01/2020	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	
Internal Audit/2021/76	Swansea Health & Wellbeing Centres_Final Internal Audit Report August 2021 (Review reference: CTMUHB-2020-69)	New	06/08/2021	Sally May, Executive Director of Finance	Reasonable Assurance	15	15	
Internal Audit/2022/161	Continuing Health Care and Funded Nursing Care_Final Internal Audit Report February 2022 (Review reference: CTMUHB-21-23-36)	New	14/02/2022	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	1	1	
Internal Audit/2022/67	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUHB-2223-03)	New	24/10/2022	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	5	5	
Internal Audit/2024/295	Follow up Medical & Dental Rostering_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-21)	New	15/06/2022	Don Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People	Reasonable Assurance	1	1	
Internal Audit/2023/97	Medical Records Management_Final Internal Audit Report October 2023 (Review reference: CTMU-2223-06)	New	10/10/2022	Stuart Morris, Director of Digital	Reasonable Assurance	1	1	
Internal Audit/2023/100	Welsh Risk Pool Claims_Final Internal Audit Report May 2023 (Review reference: CTMUHB-2223-24)	New	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	3	3	
Internal Audit/2023/107	Reconfiguration_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-25)	New	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	5	5	
Internal Audit/2023/113	National Incident Framework_Final Internal Audit Report August 2023 (Review reference: CTMUHB-2223-05)	New	08/08/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	8	8	
Internal Audit/2023/117	Performance Reporting – Integrated Performance Report_Internal Audit Report July 2023 (Review reference: CTMUHB-2223-35)	New	28/07/2023	Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	Reasonable Assurance	2	2	
Internal Audit/2023/134	Follow up Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-28)	New	31/05/2023	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	4	4	
Internal Audit/2023/146	Interventions Not Normally Undertaken (NNU)_Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	New	11/10/2023	Gethin Hughes, Chief Operating Officer	Limited Assurance	8	8	
Internal Audit/2023/148	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	New	09/10/2023	Stuart Morris, Director of Digital	Reasonable Assurance	5	5	
Internal Audit/2023/154	Medical Variable Pay – Agency Costs_Final Internal Audit Report February 2023 (Review reference: CTMUHB-2223-17)	New	06/02/2023	Don Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People	Limited Assurance	7	7	
Internal Audit/2024/162	4 hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	New	06/02/2024	Gethin Hughes, Chief Operating Officer	Limited Assurance	15	15	
Internal Audit/2024/163	IT Service Management_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-18)	New	08/02/2024	Stuart Morris, Director of Digital	Reasonable Assurance	11	12	
Internal Audit/2024/169	Management of Controlled Drugs_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-06)	New	11/04/2024	Don Hurford, Executive Medical Director	Reasonable Assurance	17	18	
Internal Audit/2024/170	Swish Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-01)	New	12/04/2024	Gethin Hughes, Chief Operating Officer	Limited Assurance	7	7	
Internal Audit/2024/171	Decarbonisation Internal Audit Report_April 2024 (Review reference: CTMUHB-2324-13)	New	09/04/2024	Claire Thompson, Executive Director of Strategy & Transformation	Limited Assurance	9	9	
Internal Audit/2024/187	Leadership and Management Development Programme Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-08)	New	06/06/2024	Hywel Daniel, Executive Director for People	Reasonable Assurance	4	7	
Internal Audit/2024/188	Welsh Risk Pool Claims_Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	New	11/06/2024	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	5	9	
Internal Audit/2024/189	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	New	07/06/2024	Stuart Morris, Director of Digital	Reasonable Assurance	6	6	
Internal Audit/2024/190	Risk Management Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-17)	New	02/06/2024	Gareth Watts, Director of Corporate Governance & Board Secretary / Greg Dix, Executive Director of Nursing/Deputy Chief Executive / Gethin Hughes, Chief Operating Officer	Reasonable Assurance	9	9	
Internal Audit/2024/192	Adult Mental Health CSG review Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-09)	New	04/06/2024	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	15	27	
Internal Audit/2024/199	Intelligence Led Organisation Final Internal Audit Report_October 2024 (Review reference: CTM-2425-07)	New	04/10/2024	Stuart Morris, Director of Digital	Reasonable Assurance	7	8	
Internal Audit/2024/200	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	New	16/09/2024	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	7	8	
Internal Audit/2024/202	Follow up: Reasonable Offer Final Internal Audit Report - October 2024 (Review reference: CTM-2324-25)	Re-inspection	02/10/2024	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	4	4	Reasonable Offer Process_Internal Audit Report April 2023 (Review reference: CTMUHB-2223-04)
Internal Audit/2024/203	Follow up: Patient Pathways Final Internal Audit Report - September 2024 (Review reference: CTM 23/24-31)	Re-inspection	27/09/2024	Gethin Hughes, Chief Operating Officer	Limited Assurance	9	9	Follow-up: Patient Pathway Appointment Management Process_Final Internal Audit Report June 2022 (Review reference: CTM 21/22-15)
Internal Audit/2024/211	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24-25-09)	New	10/12/2024	Don Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People	Limited Assurance	21	36	
Internal Audit/2024/214	Group Management 2024/25 (Review Reference CTMUHB-SBU-2425-16)	New	12/12/2024	Sally May, Executive Director of Finance	Reasonable Assurance	4	4	
Internal Audit/2024/215	Charitable Funds 2024/25 (Review Reference CTM-2425-20)	New	09/12/2024	Sally May, Executive Director of Finance	Reasonable Assurance	4	4	
Internal Audit/2024/216	PCR Supply Chain Management_2024/25 (Review Reference CTM-SBU-2425-40)	New	13/02/2025	Sally May, Executive Director of Finance	Reasonable Assurance	6	6	
Internal Audit/2025/126	Vaccination Policy Implementation_2024/25 (Review Reference CTM-2425-17)	New	13/01/2025	Philip Daniels, Executive Director of Public Health	Limited Assurance	3	3	
Internal Audit/2025/211	Regional Collaboration Fund_2024/25 (Review Reference CTM-2425-23)	New	15/01/2025	Claire Thompson, Executive Director of Strategy & Transformation	Reasonable Assurance	3	3	
Internal Audit/2025/212	Medical Job Planning_2024/25 (Review Reference CTM-2425-17)	New	13/01/2025	Don Hurford, Executive Medical Director	Limited Assurance	5	6	
Internal Audit/2025/233	Follow up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33)	Re-inspection	29/01/2025	Claire Thompson, Executive Director of Strategy & Transformation	Reasonable Assurance	6	6	Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2323-17)
Internal Audit/2025/230	City of Cardiff_March 2025 (Review reference: CTMUHB-2324-10)	New	31/03/2025	Greg Dix, Executive Director of Nursing & Deputy CEO	Reasonable Assurance	10	11	
Internal Audit/2025/231	Cancer Tracking Process_2024/25 (Review reference: CTM-2425-02)	New	22/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	7	7	
Internal Audit/2025/232	Service User Experience_2024/25 (Review reference: CTM-2425-13)	New	09/05/2025	Greg Dix, Executive Director of Nursing & Deputy CEO	Limited Assurance	1	1	
Internal Audit/2025/233	New Care Group Model_2024/25 (Review reference: CTM-2425-01)	New	12/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	
Internal Audit/2025/234	PCR Key Project Objectives_2024/25 (Review reference: CTM-SBU-2425-18)	New	13/05/2025	Sally May, Executive Director of Finance	Reasonable Assurance	2	2	
Internal Audit/2025/235	New Personnel Development Review (PDR) process_2024/25 (Review reference: CTM-2425-15)	New	14/05/2025	Hywel Daniel, Executive Director for People	Reasonable Assurance	3	4	
Internal Audit/2025/236	Estate Condition_2023/24 (Review reference: CTM-SBU-2324-03)	New	17/04/2025	Sally May, Executive Director of Finance	Limited Assurance	6	6	
Internal Audit/2025/237	Capital Systems_2024/25 (Review reference: CTM-SBU-2425-18)	New	12/04/2025	Sally May, Executive Director of Finance	Limited Assurance	7	7	
Internal Audit/2025/238	Digital Benefits Realisation_2024/25 (Review reference: CTM-2425-08)	New	15/05/2025	Stuart Morris, Director of Digital	Limited Assurance	4	4	
Internal Audit/2025/239	Follow up: 4 hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28)	Re-inspection	27/03/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	6	6	4 hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)
Internal Audit/2025/240	Follow up: Arrangements for Financial Savings_May 2025 (Review reference: CTM-2425-31)	Re-inspection	22/05/2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUHB-2223-07)

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.

AMaT Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive Lead	Original Due Date	Days Overdue from the ORIGINAL due date	Current / Revised Due Date	Action Rating	AMaT Progress Status	Comments/Updates
Audit Wales/2021/144	01/08/2021	Audit Wales Quality Governance Follow Up Review, Audit and Risk Committee Update – CTMUH8_August 2021 (Document reference: 123A2017)	Audit Wales/HNW 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 IIC 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.	Executive Director of Nursing, Midwifery & Patient Care	01.10.2021	1383	31.10.2024	High	Partially complete (Overdue)	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - 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.
Audit Wales/2022/12	01/08/2022	Transformational Leadership Programme Board – Baseline Governance Review R4 Baseline Governance Review – CTM Regional Partnership Board 2021-22, August 2022 (Document reference: 293A2022)	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 TUPB 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.	Executive Director of Strategy & Transformation	31.03.2023	837	31.03.2025	High	Overdue	June 2025 Update - a Section 33 agreement has been drafted and is going through appropriate governance arrangements in each of the four statutory organisations. This will establish an integrated approach to resource implementation (in specific areas) and support the integrated services agenda. Regional funding allocations via the Regional Partnership have risk registers in place.
Audit Wales/2023/149	01/10/2023	Structured Assessment 2023 – CTMUH8 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.	Director of Corporate Governance & Board Secretary Executive Director of Strategy & Transformation Director of Digital	01.02.2024	530	01.02.2024	High	Overdue	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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/2023/18	01/02/2023	Structured Assessment 2022 – CTMUH8 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R7 Whilst the Health Board's financial control procedures are generally effective, we identified opportunities to strengthen some controls and update the information available on the Health Board's website. The Health Board should: a) review the delegated upper financial limit for the Chief Executive; b) ensure there is a clear process in place for the Board to review and approve capital programmes and projects; and c) ensure out-of-date financial control procedures are removed from its website and replaced with the current versions - NOT COMPLETED	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 £5M 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.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Director of Digital	31.12.2023	562	31.12.2024	High	Partially complete (Overdue)	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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/2023/18	01/02/2023	Structured Assessment 2022 – CTMUH8 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	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Director of Digital	30.09.2023	654	31.12.2023	High	Overdue	June 2025 Update - update as per April 2025. 9/7/25 Executive Lead has reviewed the update to this action and is happy to sign off this update April 2025 Update - a board development session is scheduled for 2025 with a focus on the integrated performance report
Audit Wales/2023/18	01/02/2023	Structured Assessment 2022 – CTMUH8 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R5 We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring: a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	Audit Wales/2023/18/MD6/1	a) All plans and strategies will contain an executive summary setting out this information. As set out above, work is ongoing around outcome measures. b) Executive Directors are clear on their responsibilities for delivery so we will ensure this is more visible. c) Reports will be reviewed to ensure they provide the Board with sufficient information to assess the impact of implementation of key actions and deliverables on the Health Board's Performance.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Director of Digital	30.06.2023	746	30.06.2023	High	Partially complete (Overdue)	June 2025 Update - Update as below in April 2025. 9/7/25 Executive Lead has reviewed the update to this action and is happy to sign off the update. April 2025 Update - a future board development session focused on the integrated performance dashboard is planned for 2025 and will support delivery of these actions
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 CTMUH8.	Chief Operating Officer	01.04.2024	470	01.04.2024	High	Overdue	July 2025 Update - PROMS implementation is ongoing, with the discussion around utilising 'MyMobility' regionally. These conversations are ongoing with potentially review of the specific system/app. Weekly RTT reviews have been implemented by planned care directors to monitor and have oversight of waiting lists and address any underlying issues, directly focusing on bringing the waiting list down to <104 weeks. Deputy COO signed off 14.07.25. April 2025 Update - progress against this action is being made within the care group
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 specialities, Nurse led, Consultant led and AHPs. • A full workforce and demand and capacity analysis is being undertaken through the regional and local reconfiguration work • The UHB now has FCP clinicians across all GP clusters except Merthyr 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.	Chief Operating Officer	01.01.2024	561	01.01.2024	High	Overdue	July 2025 Update - Service Manager confirms there is no further update on this at the moment. Deputy COO signed off 14.07.25. April 2025 Update - progress against this action is being made within the care group
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 GIRT implementation will be included in the reconfiguration programme and updated through the improving Care Board • Increase the capture of PREMs and PROMs data, digitally captured via MyMobility and through the HB website wherever possible. RGH does not have a system for PROMs or PREMs. Old CTM PCH only had funding and support from Clinical Audit and no funding or support was agreed by the HB. Would need a commitment to roll out MyMobility HB wide • Improve rehabilitation pathways with increased Therapies support. The HB is looking at centralising Trauma and Elective surgery and ensuring the appropriate services are available on these sites. • Implement an Orthogeriatric Service on both trauma sites to ensure management of patient pathways and rehabilitation needs. There will be a focus on early discharges from acute sites. This timing of this will depend upon funding availability. • Introduce a FLS service to prevent repeat fractures—timing will depend upon funding. • Actively consider the provision of a seven day service including Therapies service to ensure earlier discharges and increased throughput. • Consider seven day Theatre working when possible (longer term aim). • Increase clinician engagement • Updated GIRT action plan to be created with new CD and monitored through the reconfiguration programme. • Weekly Orthopaedic Reconfiguration Group ongoing. All key stakeholders are fully involved.	Chief Operating Officer	01.05.2023	806	01.05.2023	High	Overdue	July 2025 Update - Progress has been made in implementing the GIRT recommendations and improving orthopaedic services across CTM. A new Band 6a Pre Assessment Senior Nurse has been appointed to lead the standardisation of pre assessment pathways and enhance the management of patients across all sites. The GIRT program report of being achieved implemented waiting plans for the return to POWH as a dedicated elective site from September 2025, supporting more efficient service delivery. Seven day elective orthopaedic services have been trialled through PCH insourcing, alongside weekend elective work at RGH, to increase throughput and reduce waiting times. Wider communication efforts are ongoing to improve clinician engagement, ensuring that staff are informed and involved in shaping service developments. Additionally, a weekly Service Improvement Group has been established, with plans to expand membership to include pathway leads, fostering greater collaboration and momentum. It is recognised that progress on some of the other recommendations remains dependent on the availability of funding and time, which continues to be monitored and addressed as part of the broader strategic planning. Deputy COO signed off 14.07.25 April 2025 Update - Progress against this action is being made within the care group January 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2024/168	01/02/2024	Review of Workforce Planning Arrangements – Cwm Taf Morgannwg University Health Board (Document reference: 4157A2024)	To 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/MD4/1	• 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 – Evidence based practice – Use the benchmarking data and information e.g. HEW 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	Executive Director for People	01.10.2024	287	31.03.2025	Medium	Partially complete (Overdue)	July 2025 Update - Due to a transition of M&D bank and agency (JHP and HSS) contract to a new provider (Locum's best) and a focus on internal system improvements, this has been further delayed while we embed and operationalise the system and the workforce system management updates to support operational delivery. The horizon scan is key to anticipate further considerations for organisational preparedness and readiness, so this still remains a key priority. It is expected that this action will be updated by end of Q3. April 2025 Update - due to gaps in the team this work has not progressed to completion by end of March as intended. Look to extend to June 2025 when new resources in place.
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, HEW workforce Plans	Executive Director for People	01.03.2025	136	01.03.2025	High	Overdue	July 2025 Update - Work is underway to improve the interoperability and controls within our workforce systems which underpins the accuracy and integrity of the workforce data to support workforce plans, and to align to the SDP. The LHP workforce requirements are being developed alongside clinical pathways, demands and transformation opportunities. April 2025 Update - Awaiting priorities for ASCP to start to map the workforce demands/supply. LHP workforce requirements will be submitted for the Outline Business Case this month. Regional working plans are currently in their infancy. Work around establishment reporting and risks will inform this work. Expected to have progressed further by next meeting with LHP plans to be developed by September 2025.

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.	Executive Director for People	01.10.2024	287	30.04.2025	High	Partially complete (Overdue)	July 2025 Update - focused work underway to support the transition of the CTM M&D bank and agency (AHP and HSS agency) contract to Locum's Nest to support the Savings Delivery Programme. This will provide opportunities to improve data, reporting and controls and a reduction in high cost temporary spend, alongside an improvement plan for a number of workforce systems to support actions, targets and trajectories to minimise risks, across ESR, Health Roster and Staff Bank. Actions, targets and trajectories for improvement with outcome measures will be aligned to the four quadrants of the People Plan priorities, enabling actions to support progress under the IMTP to reduce agency spend/usage with more appropriate workforce solutions (use of automation and changes to process/practices) and to support the Ministerial Advisory Group (MAG) workforce recommendations around headcount and productivity (linked to the Savings Delivery Programme targets reported to Medical Workforce Productivity and Nurse Productivity Programmes). April 2025 Update - Baseline data via establishment control/reporting is underway to identify vacancies which should be completed for M&D staff group in May 2025. The IMTP CG returns, identified fragile services which will be aligned to the workforce risks on the risk register to inform key priority areas. Anticipated priority areas will align to the workforce efficiency programme which is underway, to establish workforce solutions. Further update on actions will be informed by this work in readiness for the next meeting.
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.	Executive Director for People	01.09.2024	317	31.03.2025	High	Overdue	July 2025 Update - Health Education Improvement Wales website with tools and supporting materials have been shared while we develop internal materials and toolkits that align to the People Plan priorities. Work continues to build skills, assess requirements to improve capabilities and to consider wider opportunities to embed strategic workforce planning into practice. These include forthcoming changes to embed SWP principles (return to PCW) etc. These considerations will be reviewed and updated by end of Q2. April 2025 Update - Due to IMTP priorities this action is still in progress and will be reviewed alongside HEIW's, training videos, materials and toolkits to adapt for CTM. This action is also being reviewed alongside the ACPSP, Regional Working priorities and the current workforce efficiencies programme. It is reliant on the establishment control work with M&D data being the initial focus by end of May 2025. This action can progress in July 2025 but will need to factor in other work that contributes to this action being completed, so this is likely to extend this further to October 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.	Executive Director for People	01.06.2024	409	01.06.2024	High	Partially complete (Overdue)	July 2025 Update - Reporting will align to the People Plan priorities, IMTP, Ministerial Advisory Group and enabling actions from the IMTP to reduce agency spend/usage. Also to align to any horizon scan, Committee and Local Partnership Forum as well as longer term plans to Strategic Delivery Committee. 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.
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/MD3/1	• 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.	Executive Director for People	01.05.2024	440	31.03.2025	High	Partially complete (Overdue)	July 2025 Update - Establishment reporting has been developed across SIP and the financial ledger for Medical and Dental in collaboration with Finance and Care Groups. Work is underway to plan, agree timescales and actions required to roll out to nursing and midwifery/HCSNs, as the biggest staff groups to support service and workforce plans. Alongside this, work will commence to support a change and controls process to maintain the establishment data across all systems for improved data accuracy and reporting. This will align to the enabling actions to understand our agency usage/spend aligned to appropriate controls for Health Roster and alignment to ESR/ledger. This will also support IMTP education commissioning and student streamlining numbers going forwards. April 2025 Update - SIP has been automated against Ledger for Medical and Dental staff group with plans in place to finalise for approval and implementation end of May 2025. A timeline for extending to other staff groups to be agreed before the next update.
Audit Wales/2024/196	01/07/2024	Follow up review: Temporary Closure of the Yblyth 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.	Executive Director of Nursing, Midwifery & Patient Care	31.05.2023	776	31.01.2025	High	Overdue	January 2025, April, June Update - An update against this recommendation has not been provided on these occasions. 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 Yblyth 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.	Executive Director of Nursing, Midwifery & Patient Care	31.03.2023	837	31.01.2025	High	Overdue	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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 - CTMUHJB 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.	Executive Director of Finance	30.04.2025	76	30.04.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April, which are currently being prepared.
Audit Wales/2024/205	01/08/2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHJB 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.	Executive Director of Finance	30.04.2025	76	30.04.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April, which are currently being prepared.
Audit Wales/2024/205	01/08/2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHJB 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.	Executive Director of Finance	30.04.2025	76	30.04.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update - No update as this will be implemented on completion of 2024/25 accounts in April, which are currently being prepared.
Audit Wales/2024/205	01/08/2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHJB 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/NIS/Cyber 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.	Executive Director of Finance	29.11.2024	228	29.11.2024	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. January 2025 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 - CTMUHJB 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.	Executive Director of Finance	29.11.2024	228	29.11.2024	High	Overdue	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions. November 2024 Update - No update yet, implementation end of this month.
Audit Wales/2024/212	30/11/2024	Primary Care Follow-Up Review - CTMUHJB 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/MD2/2	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.	Chief Operating Officer	31.03.2025	106	31.03.2025	High	Overdue	July 2025 Update - IMTP (including cluster plans) has been developed and shared at Board. Priorities that have been identified are aligned to ACPSP, the 2030 strategy and ministerial prioritise. Deputy COO sign off 10.07.25. April 2025 Update - IMTP (including cluster plans) has been developed and shared at Board. Priorities that have been identified are aligned to ACPSP, the 2030 strategy and ministerial prioritise.
Audit Wales/2024/212	30/11/2024	Primary Care Follow-Up Review - CTMUHJB 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.	Chief Operating Officer	31.03.2025	106	31.03.2025	High	Overdue	July 2025 Update - A summary of all the cluster initiatives have been compiled for the new financial year 2025/26. Now this has been done an evaluation of the schemes can be taken forward and standardised evaluations put in place to inform the commissioning of services going forward. Deputy COO sign off 10.07.25. April 2025 Update - January 2025 update is ongoing.
Audit Wales/2024/212	30/11/2024	Primary Care Follow-Up Review - CTMUHJB 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/MD6/4	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.	Chief Operating Officer	31.03.2025	106	31.03.2025	High	Overdue	July 2025 Update - A new Communications Post is being reintroduced into the corporate team as part of the Primary Care Transformation Programme. The recruitment process has commenced. Deputy COO sign off 10.07.25 April 2025 Update - Strengthening the cluster leadership has been undertaken through the primary care transformation programme. This is an active programme with support of National Association of Primary Care.
Audit Wales/2024/212	30/11/2024	Primary Care Follow-Up Review - CTMUHJB 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/MD1/1	R5a - Each IPB will have a role to review and develop the clusters maturity and to report into Primary Care and Community Transformation Board.	Chief Operating Officer	31.03.2025	106	31.03.2025	High	Overdue	July 2025 Update - The review of the IPB has not yet taken place but is an action under the Primary Care Transformation Programme but is scheduled. The oversight of clusters will be considered through this. Additional support is being provided with 3 additional Locality GP transformation leads who's responsibility it is to work with clusters around Health Board Priorities. Additional resource has been sourced through Communications post, Performance and Informatics post and corporate posts aligned to the transformation programme. Deputy COO sign off 10.07. April 2025 Update - This remains in progress and has now been incorporated into the primary care transformation programme.
Audit Wales/2024/212	30/11/2024	Primary Care Follow-Up Review - CTMUHJB 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.	Chief Operating Officer	31.01.2025	165	31.01.2025	High	Overdue	July 2025 Update - 1. The dashboard continues to be developed. Approval has been given to appoint a dedicated Band Ba Performance and Information post for the Care Group which will progress this dashboard. Deputy COO sign off 10.07.25. April 2025 Update - progress is being made in building dashboard, bringing directorate reports into the dashboard. Delivery delayed due to vacancy with care group medical director. Post has been advertised, but unsuccessful on this occasion and is not in the process of being advertised. 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)	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.	Chief Operating Officer	31.01.2025	165	31.01.2025	High	Overdue	July 2025 Update - IMTP submission has been complete and will has been shared at Board. This has set out the primary care position and the service plans, including resource allocation. Deputy CDO sign of 10.07.25. April 2025 Update - IMTP submission has been complete and will has been shared at Board. This has set out the primary care position and the service plans, including resource allocation.
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 ACPSP 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 charges 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.	Executive Director of Finance	31.03.2025	106	31.03.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update - The IMTP has been approved by the board and submitted to Welsh Government. The next phase of the ACPSP is in development.
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	Executive Director of Finance	31.03.2025	106	31.03.2025	High	Overdue	July 2025 Update - The UHB utilised a wide range of modelling and analytical work to map out bed requirements under a range of service models and our elective recovery plans. This included factoring in efficiencies on length of stay, management of delays, theatres, avoidance of admissions by shifting closer to home, theatre and clinic utilisation and productivity rates to inform the IMTP, most of which were premised on the attainment of GIBFT benchmarks. Monitoring of delivery of these have been via the development of a number of additional reports used by the to inform the PT and SGs. In addition, following the move across to Power BI from Qlik, the UHB has sought to increase the use of data and intelligence by increasing the training, offering in the use of BI tools by service managers and clinicians. To improve the use of benchmarking, and mitigate for the capacity constraints within the information team, the UHB has procured Archus as an external partner, with an initial focus on mortuary, to provide greater insight into quality enhancement and saving opportunities. A report is expected imminently.
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	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	Executive Director of Finance	31.03.2025	106	31.03.2025	High	Overdue	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions.
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	Executive Director of Finance	31.03.2025	106	31.03.2025	High	Overdue	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2025/234	23/01/2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	R10.1 - The Health Board Should: 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;	Audit Wales/2025/234/MD12/1	R10.1 - 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.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy &	30.06.2025	15	30.06.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2025/234	23/01/2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	R5.1 - 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;	Audit Wales/2025/234/MD3/1	R5.1 - 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.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Executive Director of Nursing & Deputy CEO Chief Operating Officer Executive Director for Public Health	31.05.2025	45	31.05.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2025/234	23/01/2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	R5.2 including appropriate milestones and targets to help the reader understand when it is aiming to achieve priorities.	Audit Wales/2025/234/MD6/1	R5.2 - Appropriate milestones will be included following the clarification of the required targets to help the reader understand the aim of the priorities.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Executive Director of Nursing & Deputy CEO Chief Operating Officer Executive Director for Public Health	31.05.2025	45	31.05.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2025/234	23/01/2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	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.	Audit Wales/2025/234/MD11/1	R9.1 - 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.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy &	30.04.2025	76	30.04.2025	High	Overdue	June 2025 Update - Building Healthier Communities reporting underway via Strategic Development Committee. 9/7/25 Executive Lead has reviewed the update to this action and is happy to sign off the update. April 2025 Update - SDC has been established and Building Healthier Communities has started to report via the Committee.
Audit Wales/2025/234	23/01/2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	R2 - The Health Board should introduce arrangements for identifying and monitoring actions arising from its listening and learning stories.	Audit Wales/2025/234/MD2/1	R2 - 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 stories at Board & Committee will be presented through the Care Groups OSRE 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.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Executive Director of Nursing & Deputy CEO Chief Operating Officer Executive Director for Public Health	31.03.2025	106	31.03.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion.
Audit Wales/2025/234	23/01/2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	R4 -The Health Board should strengthen its Integrated Performance Dashboard by clearly articulating whether actions to improve underperformance are achieving their intended impact.	Audit Wales/2025/234/MD4/1	R4 - The performance report narrative will be stripped back to focus on remedial action and their impact, then updates on impact.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Executive Director of Nursing & Deputy CEO Chief Operating Officer Executive Director for Public Health	31.03.2025	106	31.03.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 update - a Board development session is planned for 2025 which will focus on the Integrated Performance Dashboard

AMaT Inspection Code	Date of Inspection	Overall Assurance Rating	Inspection Title	Recommendation	AMaT Reference Number	Action	Executive Lead	Original Due Date	Days overdue from the ORIGINAL due date	Current / Revised Due Date	Action Rating	AMaT Progress Status	Comments/Updates
Internal Audit/2020/65	26/07/2020	Reasonable Assurance	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMUJ-1930-23)	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.	Chief Operating Officer	01.04.2021	1566	31.07.2024	High	Overdue	July 2025 Update - a desk top exercise will be carried out by the UEC business support over the next 6 months. Signed off by Deputy COO 11.07.25. April 2025 Update - a new structure as been established and continue to work through actions to align to existing model. It is queried if the action would be best considered for review to align to the new model and structure, to better ensure that appropriate oversight of the recommendation.
Internal Audit/2020/66	26/07/2020	Reasonable Assurance	Directorate review: Acute Medicine and A&E Directorate_Final Internal Audit Report July 2020 (Review reference: CTMUJ-1930-23)	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.	Chief Operating Officer	01.12.2020	1687	30.04.2024	Medium	Overdue	July 2025 Update - UEC business support will carry out a desktop review of the policies and procedures that are attached to unscheduled care, with a view then to bring that back to SMAT for colleagues to assign the reviews or ownership of the policies where appropriate. COO business manager will support this process as part of a wider review and standard approach for all care groups, now with there being a care group structure. Deputy Coo sign off 11.07.25. April 2025 Update - a new structure as been established and continue to work through actions to align to existing model. It is queried if the action would be best considered for review to align to the new model and structure, to better ensure that appropriate oversight of the recommendation.
Internal Audit/2020/74	24/01/2020	Reasonable Assurance	Medical Equipment and Devices - Follow up Internal Audit Report 2019/20 January 2020 (Review reference: CTMUJ-1930-45b)	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 updated 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 (E244.8k), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Chief Operating Officer	01.04.2020	1931	31.01.2024	Medium	Partially complete (Overdue)	July 2025 Update (01/07/2025) - Linux Kitrack up and running. Power BI issue partially resolved, however licensing model of UHB limits the dashboard to specific users of system. Handheld scanner devices working but Wi-Fi connectivity variable. Initial API work started - but a compromise workaround may be required if RAM5000 supplier unable to provide some elements of this. Internal official process/SOP required for adding/removal of equipment. Plan to roll out/re-launch to be done. Otherwise system is functional. Any further project to extend to PCH and or use of active tags will require further planning and capital bid. (Will have to await completion of refurb due to ward/dept changes on-going) Deputy COO signed off 14.07.25 April 2025 Update (08/04/2025) - New linux Server and apps installed on hand held scanner in March 2025 following various ICT access issues resolved. Data migrated and undergoing tests by Clin Eng prior to confirming switch off of k2 windows and full go live and re-launch of platform to staff. Asset Power BI team to respond regarding dashboard template provided as part of web application. Further background API work can proceed following data/app checks are completed and confirmed all working correctly).
Internal Audit/2022/161	14/02/2022	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	01.05.2022	1171	30.04.2024	Medium	Overdue	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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/2022/67	24/10/2022	Reasonable Assurance	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.	Chief Operating Officer	30.11.2022	958	31.12.2023	High	Partially complete (Overdue)	July 2025 Update - No change - Business Case for radiography staffing that would utilise fellow sessions and mitigate the lack of 24/7 MRI for cauda equina is awaiting a decision at exec level. Without this we cannot match the increased demand for CT and have been using short term funding from planned care recovery for schemes in Quarter 1. These have not continued into Quarter 2 and the waiting times are increasing again. The Demand and capacity work shows this modality as well as Non obstetric ultrasound is not in balance. Deputy COO sign off 14.07.25 April 2025 Update - No change. Business Case still not approved at exec level. Insourcing EO not signed off at exec level.
Internal Audit/2022/95	15/06/2022	Reasonable Assurance	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.	Executive Medical Director Executive Director for People	01.11.2022	987	30.04.2024	Medium	Partially complete (Overdue)	July 2025 Update - The contract for M&D rostering (Allocate) has been extended in June 2025 with a view to improved practice and optimisation of the system, and aligning to the Savings Delivery Programme to incorporate improved productivity and increased job planning compliance. With this in mind the M&D Rostering policy will need to incorporate any revised updates and is being reviewed. Any changes will be updated prior to the next Audit Committee Meeting. April 2025 Update - Policy drafted and comments from LNC have been sought to incorporate into the document. Expected to complete May 2025.
Internal Audit/2022/97	10/10/2022	Reasonable Assurance	Medical Records Management_Final Internal Audit Report October 2022 (Review reference: CTMUH-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 Princes 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.	Director of Digital	01.07.2024	379	01.09.2025	Medium	In progress	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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 CTO 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 SOPs have been implemented and workflow 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	Reasonable Assurance	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 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.	Executive Director of Nursing, Midwifery & Patient Care	01.06.2023	775	31.12.2024	Medium	Partially complete (Overdue)	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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.
Internal Audit/2023/100	31/05/2023	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	01.06.2023	775	31.03.2025	Medium	Partially complete (Overdue)	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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.
Internal Audit/2023/107	08/08/2023	Reasonable Assurance	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/MD1/1	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 IP&C Committee meeting.	Executive Director of Nursing, Midwifery & Patient Care	01.10.2023	653	01.10.2023	Medium	Overdue	January, April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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/2023/113	06/08/2023	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	01.11.2023	622	28.02.2025	Medium	Partially complete (Overdue)	March 2025 Update - As part of the revision of the Putting Things Right regulations, a Stakeholder reference Group was established. Once the revised documentation has been agreed, an All Wales Implementation Group is to be established which will develop a training and education package for roll out across all organisations. The package will outline the varying levels of training and those staff that require training. Whilst no firm date for launch has been identified, it is anticipated that this training package will be available at the latter part 2025.
Internal Audit/2023/117	26/07/2023	Reasonable Assurance	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.	Executive Director of Strategy & Transformation Director of Digital	01.01.2024	561	30.06.2024	High	Overdue	July 2025 Update - The new Director of Strategy is now in post, engagement between the new Director and colleagues in Digital & Data has started with a view to sharing information on the performance report framework. Recommend a new target date of January 2026. 10/7/25 confirmation received that Executive Lead, Claire Thompson has reviewed the update to this action and is happy to sign off the update. April 2025 Update - A draft performance report framework has been created which has been considered by the current Executive Director of Strategy. This will be taken forward by the new Director once they are in post, with progress expect by the end of Q1. Once the performance report framework has been confirmed the SOP for creating the report can be progressed.
Internal Audit/2023/117	26/07/2023	Reasonable Assurance	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.	Executive Director of Strategy & Transformation Director of Digital	01.01.2023	926	31.12.2024	Medium	Overdue	July 2025 Update - The new Director of Strategy is now in post, engagement between the new Director and colleagues in Digital & Data has started with a view to sharing information on the performance report framework. Recommend a new target date of January 2026. April 2025 Update - A draft performance report framework has been created which has been considered by the current Executive Director of Strategy. This will be taken forward by the new Director once they are in post, with progress expect by the end of Q1.
Internal Audit/2023/124	31/05/2023	Reasonable Assurance	Follow-up: Concerns_Final Internal Audit Report May 2023 (Review reference: CTM 22/23-20)	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.	Executive Director of Nursing, Midwifery & Patient Care	01.10.2023	653	31.10.2024	Medium	Partially complete (Overdue)	June 2025 Update - An update against this recommendation has not been provided on this occasion. March 2025 - As part of the revision of the Putting Things Right regulations, a Stakeholder reference Group was established. Once the revised documentation has been agreed, an All Wales Implementation Group is to be established which will develop a training and education package for roll out across all organisations. The package will outline the varying levels of training and those staff that require training. Whilst no firm date for launch has been identified, it is anticipated that this training package will be available at the latter part 2025.
Internal Audit/2023/146	11/10/2023	Limited Assurance	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.	Chief Operating Officer	01.03.2024	501	01.03.2024	High	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update - progress against this action is being made within the care group 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.
Internal Audit/2023/146	11/10/2023	Limited Assurance	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.	Chief Operating Officer	01.03.2024	501	01.03.2024	Medium	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update - progress against this action is being made within the care group 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.

Internal Audit/2023/146	11/10/2023	Limited Assurance	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.	Chief Operating Officer	01.03.2024	501	01.03.2024	Medium	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update - progress against this action is being made within the care group
Internal Audit/2023/146	11/10/2023	Limited Assurance	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	Chief Operating Officer	01.03.2024	501	01.03.2024	Low	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update - progress against this action is being made within the care group
Internal Audit/2023/146	11/10/2023	Limited Assurance	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.	Chief Operating Officer	01.01.2024	561	01.01.2024	High	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update -progress against this action is being made within the Care Group
Internal Audit/2023/146	11/10/2023	Limited Assurance	Interventions Not Normally Undertaken (INNU)_ Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Interventions not Normally Undertaken 2.0 For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy or within WHSSC guidance has been met. Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	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.	Chief Operating Officer	01.01.2024	561	01.01.2024	High	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update - progress against this action is being made within the care group
Internal Audit/2023/146	11/10/2023	Limited Assurance	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	Chief Operating Officer	01.01.2024	561	01.01.2024	Medium	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update - Progress is being made against this action within the care group
Internal Audit/2023/146	11/10/2023	Limited Assurance	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.	Chief Operating Officer	01.09.2023	683	01.09.2023	High	Overdue	July 2025 Update - This is being delivered via the PIT programme, awaiting further national guidance. Deputy COO signed off 14.07.25 April 2025 Update - Progress against this action is being made within the care group
Internal Audit/2023/148	09/10/2023	Reasonable Assurance	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."	Director of Digital	30.06.2024	380	30.03.2025	Medium	Overdue	July 2025 Update - A new Head of Datacentres and Cloud has been appointed and have been in post for 4 months. He has reviewed Solarwinds and is now starting an activity to re-implement Solarwinds identifying clear technical owner ship leading to the development of appropriate alertings and processes. It is recommended that a <u>new target date of January 2026</u> be set. April 2025 Update - The process of recruiting additional staff is continuing. A review of our tooling is also going to commence in April, this review all of the differing management software we have and assigned technical owners.
Internal Audit/2023/148	09/10/2023	Reasonable Assurance	IT Infrastructure_Final Internal Audit Report October 2023 (Review reference: CTM-2324-19)	IT Infrastructure 1.1a Work to complete the register / CMD8 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 CMD8 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.	Director of Digital	31.03.2024	471	31.07.2025	Low	In progress	July 2025 Update - The Armis passive network monitoring tool is now providing visibility and insight into what is connected to the network. Other inventory tools are configured to feed ARMIS. A replacement to our current IT Service Management tooling (ServicePoint) noted in Internal Audit - CTMUHB-2324-18 - is needed to fully manage this in the most effective way. This activity will enable us to get a greater sense of our digital assets enabling us to assess and manage the flexibility and adequacy of the digital physical asset base. April 2025 Update - Armis software has now been purchased and is in the process of being implemented.
Internal Audit/2024/162	06/02/2024	Limited Assurance	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.	Chief Operating Officer	01.06.2024	409	01.06.2024	High	Partially complete (Overdue)	July 2025 Update - the merger of POW WPAS over to CTM has been complete now enabling comparable data to be presented. signed off by Deputy COO 14.07.25. The existing training SOPs have been complete and training programme was rolled out in May 2025. Standardisation of data capture across the 3 ED's has been completed. Next step - embedding a culture where clinicians update the system live to accurately report on ED activity. Development of Rapid Improvement Plan (30/60/90) - including sign-off of internal professional standards. Care group continue to work towards their action plan and regularly update WG on their progress and performance. April 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 to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed. The existing training SOPs are in the process of being updated – Date for completion 30th April 2025 Roll out training programme 1st May 2025 to align with the WPAS POW merger.
Internal Audit/2024/162	06/02/2024	Limited Assurance	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.	Chief Operating Officer	01.06.2024	409	01.06.2024	Medium	Partially complete (Overdue)	July 2025 Update - POW WPAS merger has now been complete enabling the 3 sites to standardise their codes across all sites. signed off by Deputy COO 14.07.25. April 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 to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed. The existing training SOPs are in the process of being updated – Date for completion 30th April 2025 Roll out training programme 1st May 2025 to align with the WPAS POW merger on 4th May 2025.
Internal Audit/2024/162	06/02/2024	Limited Assurance	4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	2.3Staff 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.	Chief Operating Officer	01.06.2024	409	01.06.2024	High	Overdue	July 2025 Update - Pan CTM ED weekly meetings where performance and issues impacting on ambulance handover are discussed. Clinical pathway changes are also discussed. System escalation process - development of Emergency Department 45 minutes ambulance handover and 12 hour ED performance Action Cards in draft. Shared with SMT for comment. Anticipated 'go live' 21st August. Signed off by Deputy COO 14.07.25 April 2025 - progress is monitored through the care groups action plan.
Internal Audit/2024/162	06/02/2024	Limited Assurance	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.	Chief Operating Officer	01.06.2024	409	01.06.2024	Medium	Overdue	July 2025 Update - Development of Rapid Improvement Plan (30/60/90) - including closer to sign off of internal professional standards. Signed off by Deputy COO 14.07.25 April 2025 update - A new casualty 'CAS' card has been developed and is to be implemented across all sites by May 2025. Key date and time information will be recorded on the cards. However, the updated tracker process means this information, as well as the breach reason codes, will also be directly recorded in the WPAS. As such, the CAS cards are no longer the primary source for capturing time and reason codes.
Internal Audit/2024/162	06/02/2024	Limited Assurance	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.	Chief Operating Officer	01.06.2024	409	01.06.2024	High	Partially complete (Overdue)	July 2025 Update - The existing training SOPs have been updated. Roll out of training programme was 1st May 2025 to align with the WPAS POW merger. Pan CTM ED weekly meetings where performance and issues impacting on ambulance handover are discussed. Signed off by Deputy COO 14.07.25 April 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 to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed. The existing training SOPs are in the process of being updated – Date for completion 30th April 2025. Roll out training programme 1st May 2025 to align with the WPAS POW merger
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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.	Director of Digital	01.04.2025	105	30.04.2026	Low	In progress	July 2025 Update - We are still actively looking for funding opportunities for a new ITSM tool. April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will stated that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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	Director of Digital	01.04.2025	105	30.04.2026	Low	In progress	July 2025 Update - We are still actively looking for funding opportunities for a new ITSM tool. April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will stated that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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	Director of Digital	01.04.2025	105	30.04.2026	Low	In progress	July 2025 Update - We are still actively looking for funding opportunities for a new ITSM tool. April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will stated that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation. 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.

Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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	Director of Digital	01.04.2025	105	30.04.2026	Low	In progress	July 2025 Update - We are still actively looking for funding opportunities for a new ITSM tool. April 2025 Update - We have added the need for a replacement to ServicePoint at CTM in the IMTP for 25/26. We are also undertaking a review of the tooling we use to manage IT services. We are also actively looking for opportunities to identify funding. DHCW are in the process of developing requirements to purchase a replacement to ServicePoint, but will state that they will keep ServicePoint available for the FY 25-26. Recommend new completion date of April 26 to work through options and implementation.. January 2025 Update - Conversations have started with DHKW about their approach to replacing ServicePoint, they are developing an approach and we are waiting for them to progress.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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.	Director of Digital	01.01.2025	195	31.07.2025	Medium	In progress	July 2025 Update - The New Head of Digital Service Management is now in post. He has started looking for an appropriate maturity assessment and has had conversations at the National Service Management Board, and with peers in other Health Boards. April 2025 Update - We are looking to undertake an ITIL maturity assessment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process. 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, that activity alongside the improvements to the Service Catalogue will enable us to progress this activity. Request to revise due date to July 2025.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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.	Director of Digital	01.01.2025	195	31.07.2025	Medium	In progress	July 2025 Update - The New Head of Digital Service Management is now in post. He has started looking for an appropriate maturity assessment and has had conversations at the National Service Management Board, and with peers in other Health Boards. April 2025 Update - We are looking to undertake an ITIL maturity assessment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process. This is also linked to the need for ITSM tooling. 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.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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/MD3/2	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.	Director of Digital	01.10.2024	287	31.07.2025	Medium	In progress	July 2025 Update - The New Head of Digital Service Management is now in post. He has started looking for an appropriate maturity assessment and has had conversations at the National Service Management Board, and with peers in other Health Boards. April 2025 Update - We are looking to undertake an ITIL maturity assessment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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.	Director of Digital	01.10.2024	287	31.07.2025	Medium	In progress	July 2025 Update - There are a number of silos of information that need to be drawn into a single view of contract management. When scoping the ITIL maturity assessment, we will ensure that supplier and contract management is focused on to support our thinking in this space. April 2025 Update - Meetings are already in place between the Digital Business Admin team and with Procurement and Finance, thinking and conversations are taking place to improve the way we identify unknown contracts.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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	Creationof a tiered frameworkcategorising high, medium andlow value/importancesuppliers and contracts, and the appropriate level of governance and level of management given to each category.	Director of Digital	01.10.2024	287	31.07.2025	High	In progress	July 2025 Update - There are a number of silos of information that need to be drawn into a single view of contract management, which will underpin a tiered framework. When scoping the ITIL maturity assessment, we will ensure that supplier and contract management is focused on to support our thinking in this space. April 2025 Update - We are looking to undertake an ITIL maturity assessment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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.	Director of Digital	01.10.2024	287	31.07.2025	High	In progress	July 2025 Update - There are a number of silos of information that need to be drawn into a single view of contract management. When scoping the ITIL maturity assessment, we will ensure that supplier and contract management is focused on to support our thinking in this space. April 2025 Update - We are looking to undertake an ITIL maturity assessment in Q2 FY 25-26, and will work with Procurement to find a third party consultancy to assist us in the process.
Internal Audit/2024/163	08/02/2024	Reasonable Assurance	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.	Director of Digital	01.07.2024	379	30.09.2025	Medium	In progress	July 2025 Update - work is in progress to build out infrastructure dependencies for Services in the Service Catalogue.. April 2025 Update - A supplier management workstream has been started with the new Head of Digital Service Management, resource and support is being identified, expected completion now September 2025.
Internal Audit/2024/169	11/04/2024	Reasonable Assurance	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.	Executive Medical Director	01.09.2024	317	01.09.2025	Medium	In progress	June 2025 progress - no update from ESR but this is being chased for an update shortly April 2025 Update - No progress made. ESR team still state that it may take some time for this action to be completed. Medicines Management Nurse chasing for an update of progress
Internal Audit/2024/169	11/04/2024	Reasonable Assurance	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.	Executive Medical Director	01.05.2024	440	30.09.2025	Low	Partially complete	June 2025 Update - as per previous update, Digital Pharmacy team working on this at the moment with an expected deadline of September 2025 April 2025 Update- still being reviewed by digital pharmacy team. suggest update of deadline to September 2025
Internal Audit/2024/170	12/04/2024	Limited Assurance	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 unsettled referrals. Regular reporting at a Care Group level should take place to enable management to effectively review and understand the efficiency of referral throughput and assist with the planning of services. Consideration should be given to other ways in which the data currently collected can be used to identify potential issues in processes and inform decision making to improve service delivery.	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.	Chief Operating Officer	31.12.2024	196	31.05.2025	Medium	Overdue	July 2025 Update - Following recent discussions between the Directorate Manager and Internal Audit it has been agreed that this action is currently paused with a Follow Up on the implemented agreed actions expected in 2025/26 at which time all actions will be reviewed. The Care Group have been in contact with NWVSP Internal Audit who are aware of the extent of our plans for the LGI Cancer Pathway and they are supportive of the realistic timeframe in place. There is a departmental meeting on Monday and we will be able to provide further updates at this time. Deputy COO signed off 14.07.25 April 2025 Update - a new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPO.
Internal Audit/2024/170	12/04/2024	Limited Assurance	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.	Chief Operating Officer	30.09.2024	288	31.05.2025	Medium	Overdue	July 2025 Update - Following recent discussions between the Directorate Manager and Internal Audit it has been agreed that this action is currently paused with a Follow Up on the implemented agreed actions expected in 2025/26 at which time all actions will be reviewed. The Care Group have been in contact with NWVSP Internal Audit who are aware of the extent of our plans for the LGI Cancer Pathway and they are supportive of the realistic timeframe in place. There is a departmental meeting on Monday and we will be able to provide further updates at this time. Deputy COO signed off 14.07.25 April 2025 Update - a new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPO.
Internal Audit/2024/170	12/04/2024	Limited Assurance	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.	Chief Operating Officer	30.09.2024	288	31.05.2025	Medium	Overdue	July 2025 Update - Following recent discussions between the Directorate Manager and Internal Audit it has been agreed that this action is currently paused with a Follow Up on the implemented agreed actions expected in 2025/26 at which time all actions will be reviewed. The Care Group have been in contact with NWVSP Internal Audit who are aware of the extent of our plans for the LGI Cancer Pathway and they are supportive of the realistic timeframe in place. There is a departmental meeting on Monday and we will be able to provide further updates at this time. Deputy COO signed off 14.07.25 April 2025 Update - a new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPO. January 2025 Update - LGI/Surgery now have a full electronic pathway. Revised due date of May 2025 from September 2024.
Internal Audit/2024/170	12/04/2024	Limited Assurance	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 expected process to be followed for areas such as GP and internal referrals, the triage and triage process and timeframes for undertaking the various stages in the process. The draft SOP should be agreed at an appropriate level within the Health Board. Where there are variations in service delivery, such as the Nurse Led Rapid Access One Stop Colorectal Clinic based at PCN, then a separate SOP should be formalised for use.	Internal Audit/2024/170/MD1/1	A CTM Standardised LGI SOP to be developed, reviewed and agreed.	Chief Operating Officer	30.06.2024	380	31.05.2025	High	Overdue	July 2025 Update - Following recent discussions between the Directorate Manager and Internal Audit it has been agreed that this action is currently paused with a Follow Up on the implemented agreed actions expected in 2025/26 at which time all actions will be reviewed. The Care Group have been in contact with NWVSP Internal Audit who are aware of the extent of our plans for the LGI Cancer Pathway and they are supportive of the realistic timeframe in place. There is a departmental meeting on Monday and we will be able to provide further updates at this time. Deputy COO signed off 14.07.25 April 2025 Update - a new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPO. January 2025 Update - Draft SOP to be ratified in the March Surgical Business Meeting. Revised due date of May 2025 from June 2024.
Internal Audit/2024/170	12/04/2024	Limited Assurance	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.	Chief Operating Officer	30.06.2024	380	31.05.2025	Medium	Overdue	July 2025 Update - Work is still ongoing to develop a Pan CTM Lower GI Cancer Pathway. Clinical team are linking in with Primary Care colleagues to incorporate relevant Health Care Pathways. Deputy COO signed off 14.07.25 April 2025 Update - a new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPO.
Internal Audit/2024/170	12/04/2024	Limited Assurance	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 IAG guidelines.	Chief Operating Officer	30.06.2024	380	31.05.2025	High	Overdue	July 2025 Update - Following recent discussions between the Directorate Manager and Internal Audit it has been agreed that this action is currently paused with a Follow Up on the implemented agreed actions expected in 2025/26 at which time all actions will be reviewed. The Care Group have been in contact with NWVSP Internal Audit who are aware of the extent of our plans for the LGI Cancer Pathway and they are supportive of the realistic timeframe in place. There is a departmental meeting on Monday and we will be able to provide further updates at this time. Deputy COO signed off 14.07.25 April 2025 Update - a new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPO. 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.

Internal Audit/2024/170	12/04/2024	Limited Assurance	Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	2. Work should continue to explore the feasibility of integrating the WPRS and WCP/WPAS at PCH and RGH sites and negate the need for the current process of printing referrals from one system for scanning into another system. Management should remind staff that referral and triage documentation for cases should be complete, and records saved within WCP/WPAS.	Internal Audit/2024/170/M03/1	1. Need confirmation for go live date for LG/Surgery. 2. Set up meeting with Records and Digital Team	Chief Operating Officer	30.04.2024	441	31.05.2025	Medium	Overdue	July 2025 Update - Following recent discussions between the Directorate Manager and Internal Audit/ it has been agreed that this action is currently paused with a Follow Up on the implemented agreed actions expected in 2025/26 at which time all actions will be reviewed. The Care Group have been in contact with NWSVP Internal Audit who are aware of the extent of our plans for the LG Cancer Pathway and they are supportive of the realistic timeframe in place. There is a departmental meeting on Monday and we will be able to provide further updates at this time. Deputy COO signed off 14.07.25 April 2025 Update - a new lead has been in post and taken the lead on the actions and are working through the actions, in contact and discussed with auditor during the last quarter. An update was also shared at Welsh Governments IQPO.
Internal Audit/2024/171	09/04/2024	Limited Assurance	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/M05/1	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.	Executive Director of Strategy and Transformation	01.03.2025	136	31.03.2025	High	Partially complete (Overdue)	June 2025 - Work is still progressing to understand the required costs - This is likely to be impacted but the publication of a new Strategic Delivery Plan by Welsh Government in "Autumn". 8/7/25 Executive Lead has reviewed the update to this action and is happy to sign off the update April 2025 Update - A costed plan is under development with staff supporting its creation.
Internal Audit/2024/171	09/04/2024	Limited Assurance	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/M07/1	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.	Executive Director of Strategy and Transformation	01.03.2025	136	31.03.2025	Medium	Overdue	June 2025 - In progress - Assessments are already required in some of the decision making processes (Procurement/ Buildings upgrades). Board and committee also have an environmental impact section in all papers to showcase how decisions will have a positive impact on the environment. Further work is required to ensure transformational decisions are being taken with environmental impacts in mind. A paper will be produced for ESG in September outlining recommendations on how this could be implemented. 10/7/25 Executive Lead has reviewed the update to this action and is happy to sign off the update April 2025 Update - In progress - More work is required to ensure decarbonisation and climate adaptation forms part of decision making.
Internal Audit/2024/187	06/06/2024	Reasonable Assurance	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/M03/2	2.1b • In-line with the relaunch of Inspire, apply HEW'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.	Executive Director for People	30.09.2024	288	30.09.2024	High	Partially complete (Overdue)	July 2025 Update - Evaluation ongoing, with forms and discussions embedded into each module. Participant engagement is also continually monitored via the Participant Tracker. In terms of producing a summative report/ briefing to capture this evaluative data, this will be delivered upon completion of the programme in May/June 2026, to show overall impact and learning against the initial programme objectives over the course of the programme. An interim evaluation report/ briefing can be prepared if required, with the mid-point of the programme now being October 2025. April 2025 Update - Evaluation data for Inspire is being collected via MS Forms and participant tracker, and will be reported on once the dataset is big enough and represents coverage across a meaningful portion of the programme. An Interim Evaluation & Impact Report will be written and presented at the midway point of Inspire (currently scheduled for Sep / Oct. 2025).
Internal Audit/2024/188	11/06/2024	Reasonable Assurance	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/M01/1	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.	Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	288	31.03.2025	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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.
Internal Audit/2024/188	11/06/2024	Reasonable Assurance	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/M01/2	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.	Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	288	31.03.2025	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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.
Internal Audit/2024/188	11/06/2024	Reasonable Assurance	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/M03/1	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.	Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	288	30.09.2025	Medium	In progress	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - work is ongoing to complete this action on 30/09/2025
Internal Audit/2024/188	11/06/2024	Reasonable Assurance	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/M05/1	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.	Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	288	30.09.2024	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - Following being updated, the SOP to be finalised and approved. Training undertaken in September 2024 for Claims Investigations Officers.
Internal Audit/2024/188	11/06/2024	Reasonable Assurance	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/M05/3	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.	Executive Director of Nursing, Midwifery & Patient Care	30.09.2024	288	30.09.2024	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - Due to operational pressures and restructuring of staff - action continues on this recommendation.
Internal Audit/2024/188	11/06/2024	Reasonable Assurance	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/M05/2	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.	Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	318	31.08.2024	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - Action remains open. Team to contact WRP Task & Finish Group.
Internal Audit/2024/188	11/06/2024	Reasonable Assurance	Welsh Risk Pool Claims Final Internal Audit Report_June 2024 (Review reference: CTMUHB-2324-14)	5.1a The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed. 5.1b Management should liaise with the Once for Wales task and finish group to determine the outcome of their work on defining the key stages within Datix. The SOPs should be updated accordingly, including the 'closure' section with clear guidance on what the stages are for closed cases in Datix. 5.1c It should be ensured the authorisation details in the SOPs align to the information contained on the various forms. 5.1d All SOPs should be finalised and made available to staff.	Internal Audit/2024/188/M05/4	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 DCQ system.	Executive Director of Nursing, Midwifery & Patient Care	31.08.2024	318	31.08.2024	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - Action remains open. Team to contact WRP Task & Finish Group.
Internal Audit/2024/189	07/06/2024	Reasonable Assurance	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	3.1 Once the DR site has been provisioned the resilience position should be tested to ensure it operates as anticipated. Going forward resilience should be subject to regular testing, failing over between rooms and across sites to ensure it still operates.	Internal Audit/2024/189/M03/1	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.	Director of Digital	31.12.2024	196	31.05.2025	Medium	Overdue	July 2025 Update - Further progress towards this was discussed at meeting held on 8/7/2025. As part of the system and server categorisation restore capabilities are identified (i.e. if virtual server we have replication technology allowing seamless failover) where as if a server have a physical form a standard restore from backup would be required. - new target date 31st December 2025- need to carry out after planning has been completed in action Internal Audit/2024/189/M02/1. April 2025 Update - Awaiting finalisation of the cyber vault installed before testing. Operational pressures have affected the timescales - new target date of 31st May 2025.
Internal Audit/2024/189	07/06/2024	Reasonable Assurance	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/M05/1	The criticality of systems will be prioritised based on criticality. The exercise to document DR plans for all critical systems as defined by NHS 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.	Director of Digital	30.12.2024	197	31.05.2025	Medium	Overdue	July 2025 Update - An agenda item will be added to the Cyber Security Assurance Board to progress this action. New Expected / revised due date 31st October 2025. April 2025 Update - Plans have been updated and is under peer review, once peer review is complete action can be closed. Expected / revised due date 31st May 2025.
Internal Audit/2024/189	07/06/2024	Reasonable Assurance	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/M06/1	This links to the work being carried out for the NIS Regulations. This will be complete in line with MA6 2.5.	Director of Digital	30.12.2024	197	31.05.2025	High	Overdue	July 2025 Update - Further work is required that the plan covers all four areas with adequate amount of detail. New Expected / revised due date 31st October 2025. April 2025 Update - Plans have been updated and is under peer review, once peer review is complete action can be closed. Expected / revised due date 31st May 2025.

Internal Audit/2024/189	07/06/2024	Reasonable Assurance	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.	Director of Digital	30.09.2024	288	31.10.2025	Medium	In progress	July 2025 Update - Meeting held 8/7/2025 with Server Team in relation to continuing the categorisation and tiering of server resources, this is with a specific objective of prioritising restore order and times and assessing capacity requirements to support this. The Lead infrastructure and Security Architect / IT Clinical Systems Manager will also meet with the CCO to develop a clinical view of the structure and precedence for clinical systems to be brought back online. April 2025 Update - Using year end capital the recover capacity has been expanded. Further work to continue to complete the criticality mapping. Action due date be revised to October 2025 due to operational pressures. January 2025 Update - A workshop has been arranged for 28th January 2025 to develop plans and processes around recovery capacity and capabilities.
Internal Audit/2024/189	07/06/2024	Reasonable Assurance	Technical Resilience Final Internal Audit Report_June 2024 (Review reference: CTM-2324-20)	4.1 The DR plan should be updated to reflect the new environment. The plan should consider the main types of failure such as IT, power, communications and cover the network infrastructure. • The DR plan should include processes to follow in order to restore services in the event of varying degrees of failure such as: • Failure of site provision of failover instructions, restore priorities; • Failure of rack provision of failover and restore instructions; • Failure of VM restore and restore from backup; and • Failure of system – VM restore / backup restore.	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 DHCP services - Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCP, PSBA & Internet)	Director of Digital	30.09.2024	288	31.05.2025	Medium	Overdue	July 2025 Update - Further work is required that the plan covers all four areas with adequate amount of detail. New Expected / revised due date 31st October 2025. April 2025 Update - Plans have been updated and is under peer review, once peer review is complete action can be closed. Expected / revised due date 31st May 2025.
Internal Audit/2024/199	04/10/2024	Reasonable Assurance	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 necessary 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	30.04.2025	76	30.04.2025	Medium	Overdue	July 2025 Update - UHB's proposed AI policy has completed the consultation stage with no comment. Will now be considered by the Board. Can the target date be extended to October 2025 to allow Board time to consider the policy. April 2025 Update - The UHB has drafted a proposal for assuring AI initiatives which will be considered by the IG Group and subsequently by the Exec Leadership Group in May 2025, with a number of AI developments being supported in the interim
Internal Audit/2024/199	04/10/2024	Reasonable Assurance	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	30.04.2025	76	30.04.2025	Medium	Overdue	July 2025 Update -This has a target date of 'Continuous Improvement and Deployment'. We have sought guidance on how we would meet this target. Can the target date be extended to October 2025 to allow time for guidance to be returned. April 2025 Update - AI strategic environment continues to evolve with UK government publishing AI tactical plan implying (without granularity) how they envisage AI's application in health. WG have initiated procedures to develop a Welsh approach to which we are contributing. Can the target date be extended to October 2025 to allow WG time to develop approach.
Internal Audit/2024/199	04/10/2024	Reasonable Assurance	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	31.03.2025	106	31.03.2025	Medium	Overdue	June 2025 Update - Recruitment to additional roles is taking longer than expected. Can the target date be extended to January 2026 to allow time to recruit. April 2025 Update - In this year's IMP we are enhancing our data capabilities with additional roles to provide support and education on the use of data. It is hoped that these will be in place by the end of Q2.
Internal Audit/2024/199	04/10/2024	Reasonable Assurance	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 characteristic's 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 MOR programmes moving into rapid delivery phases.	Director of Digital	31.01.2025	165	31.01.2025	Medium	Overdue	June 2025 Update - UHB's proposed Data Quality policy has completed the consultation stage with no comment. Will now be considered by the Board. Can the target date be extended to October 2025 to allow Board time to consider the policy. April 2025 Update - The data quality policy has been re-drafted to incorporate not only 'data' in the conventional sense, but also to the algorithms, tools, and workflows that led to that data, noting this is a requirement when considering the quality of data in development and adoption of AI materials. It is due to be considered by the IG group in May.
Internal Audit/2024/199	04/10/2024	Reasonable Assurance	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	31.01.2025	165	31.01.2025	Medium	Overdue	June 2025 Update - The UHB has incorporated data governance within five new policies which have all just completed the consultation process and will now be considered by the board. These set out requirements for data governance in line with NHS England guidance. In addition the UHB has recently engaged in developing the data governance framework for NHS Wales. Can the target date be extended to October 2025 to allow Board time to consider the policy. April 2025 Update - A data governance framework complementary to the data quality policy, and incorporating the numerous mandated requirements placed on the UHB, which is applicable for the development and adoption of AI has been drafted and will be considered by members of the IG group in May 2025.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	196	31.12.2024	Low	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - Work has been undertaken within the Children & Families Care Group. These have now been standardised in the QPSE 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 QPSE, these are also provided from the maternity HoMs as well. The terms of reference were updated accordingly in August 2024, the quoracy 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.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	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 (LFEs), 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).	Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	196	28.02.2025	Low	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 update - Slide Decks have been reviewed and approval of final template will be agreed by 28 February 2025.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	196	31.12.2024	High	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - Discussions continue with Pathology Department. Action Quality Work Plans to be agreed for other QPSEs thereafter.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	31.12.2024	196	28.02.2025	Low	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - this action is ongoing and it is anticipated to be complete at 28 February 2025.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	Embedding the Quality Framework Final Internal Audit Report_September 2024 (Review reference: CTMUHB-2324-15)	1.2a- The quoracy arrangements for the QPSE meetings should be reviewed and made clearer. A review of attendees at the Children & Families QPSE meetings should take place to make efficient use of time, whilst also adhering to any quoracy requirements. 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 quoracy 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.	Executive Director of Nursing, Midwifery & Patient Care	30.11.2024	227	28.02.2025	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 update 1.2a- The quoracy 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.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	30.11.2024	227	28.02.2025	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	31.10.2024	257	31.10.2024	Medium	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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.
Internal Audit/2024/200	16/09/2024	Reasonable Assurance	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.	Executive Director of Nursing, Midwifery & Patient Care	15.10.2024	273	15.10.2024	High	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. January 2025 Update - Discussions continue with Pathology Department. Action Quality Work Plans to be agreed for other QPSEs thereafter.
Internal Audit/2024/202	02/10/2024	Reasonable Assurance	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	1.1 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.	Chief Operating Officer	31.01.2025	165	31.01.2025	Low	Partially complete (Overdue)	July 2025 Update - POWN now sat in centralised Medical Records function. Phase 2 will be bringing in POWN Orthopaedics this year. Deputy COO signed off 14.07.25 April 2025 Update - This action is in progress in the care group
Internal Audit/2024/202	02/10/2024	Reasonable Assurance	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 / specialities.	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.	Chief Operating Officer	31.01.2025	165	31.01.2025	Medium	Partially complete (Overdue)	July 2025 Update - Wpas team send out to teams and include Directorate Managers and Service Managers. Also reiterated in RTT meetings. - NHS EXEC review Validation process across Wales Deputy COO signed off 14.07.25 April 2025 Update - this action is in progress in the care group
Internal Audit/2024/203	27/09/2024	Limited Assurance	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.	Chief Operating Officer	31.01.2025	165	30.06.2025	High	Partially complete (Overdue)	July 2025 Update - New RTT guidance released by WGS in May 2025 - Training packages being developed and to be implemented 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.

Internal Audit/2024/203	27/09/2024	Limited Assurance	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.	Chief Operating Officer	30.11.2024	227	30.06.2025	High	Overdue	April, June 2025 Update - An update against this recommendation has not been provided on these occasions. 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.
Internal Audit/2024/203	27/09/2024	Limited Assurance	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.	Chief Operating Officer	30.11.2024	227	30.06.2025	Medium	Partially complete (Overdue)	July 2025 Update - ongoing and update needed with WG RTT guidance issued in May 2025 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.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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.	Executive Medical Director Executive Director for People	31.03.2025	106	31.03.2025	Medium	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. Through work that has commenced via the SOP, we have identified key actions that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. April 2025 Update - In accordance with the previous actions, the FCP and SOP are partially complete subject to including any changes as a result of the workforce efficiency programme work. Accessibility and training will be organised once both documents are approved for implementation.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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.	Executive Medical Director Executive Director for People	31.03.2025	106	31.03.2025	Medium	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include appropriate booking practices and any reports will be shared with MWPP (was PEG) now Delivery Group. It is anticipated that these will be addressed with the new system which has tighter controls to avoid deviations. April 2025 Update - Drafts of these reports are currently produced and shared in the weekly operational meeting. The Retinue team are working on automating these for all CG's. Bank/job planning close to completion but we are still working on the agency data with Retinue.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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/MD1/2	This is covered in 6.1. To be analysed and trends will be shared at MWPP: PEG	Executive Medical Director Executive Director for People	31.03.2025	106	31.03.2025	Medium	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include the appropriate use of retrospective shifts. The new Locum's Nest system has built in controls so higher rates will be more difficult to deviate. The OOHs cover/support is currently being worked through as we transition fully to Locum's Nest and the appropriate access is provided to on call leads. A Guide/ Standard Operating Procedure is being worked through and should be available in August 2025. January 2025 Update - This is on target. Data to support discussions is in development.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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.	Executive Medical Director Executive Director for People	31.03.2025	106	31.03.2025	Medium	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. There will be an initial lag in data with reporting from the Retinue, Patchwork, internal process for agency and Locum's Nest for the next month but once complete, the reporting will come direct from Locum's Nest and will report to MWPP - now Delivery Group (was PEG). The breaks option is available via Locum's Nest and the process to support is being clarified with training to follow. April 2025 Update - Working with Retinue to produce reports for MWPP:PEG. Completion date to be confirmed but an update will be shared for the next audit meeting. January 2025 Update - Work is underway with Retinue to develop reporting for monitoring at MWPP:PEG.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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 WU 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 WU / 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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	High	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. Through work that has commenced via the SOP, we have identified key actions that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. April 2025 Update - the SOP is drafted. Before submitting for approval it will need to be updated to reflect the changes to the FCP in light of the workforce efficiencies programme. This should be updated by end of May 2025. tice.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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 WU 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 WU / 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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	High	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. Through work that has commenced via the SOP, we have identified key actions that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. April 2025 Update - The SOP is updated and does include the points above. The SOP will need to reflect the workforce efficiency programme work so may need further amending before approvals. Expected completion end of May 2025.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	Medium	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3 which will include appropriate booking practices. April 2025 Update - The appropriate booking approaches and when to be used will be included in the FCP and SOP, which should be available end of May 2025 to align to the workforce efficiency programme.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	Medium	Partially complete (Overdue)	July 2025 update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include appropriate booking practices. April 2025 Update - This will be covered in the SOP once aligned to the workforce efficiency programme. It is expected to be ready for submission at the end of May 2025. 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	Limited Assurance	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	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	High	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the Medical and Dental Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3, which will include long shift controls and reason codes for improved reporting. Through work that has commenced via the Savings Delivery Plan, we have identified key actions that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. April 2025 Update - The SOP includes the approach to working long shifts and the appropriate reason codes. We are just waiting to align any changes due to the workforce efficiencies work.
Internal Audit/2024/211	10/12/2024	Limited Assurance	Additional Medical Pay - Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09)	5.3 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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	Medium	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include the updated reason codes and when they should be used. Through work that has commenced via the SOP, we have identified key actions and updates that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. April 2025 Update - The SOP has been drafted but will need to be aligned to the workforce efficiency programme before final sign off. The reason codes have been recently agreed and the SOP will be updated to reflect the new coding by end of May 2025. January 2025 Update - This is on target. The SOP will include the reason codes to be utilised.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	High	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include the appropriate controls and use of retrospective shifts. The new system will have tighter controls so we should see improved reporting and limited ability to deviate. Through work that has commenced via the SOP, we have identified key actions that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. April 2025 Update - the SOP will need to be aligned to the workforce efficiency programme. The approval control process and appropriate use of retrospective shifts within the Retinue and Patchwork is included in the SOP. It is anticipated this will be completed by end of May 2025.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	High	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include the appropriate controls and use of retrospective shifts and any follow up with Care Groups. The new system will have tighter controls so we should see improved reporting and limited ability to deviate. Through work that has commenced via the SOP, we have identified key actions that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. January 2025 Update - This is on target. Monitoring of retrospective shifts with CGs is underway.
Internal Audit/2024/211	10/12/2024	Limited Assurance	Additional Medical Pay - Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09)	9.3 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.	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	High	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HSS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The WU process is being managed manually and centrally by the COO's office before the process transfers over to Locum's Nest, timings for the transfer is currently being mapped over the next month. January 2025 Update - This is on target to confirm the approach for WLIs in the SOP.
Internal Audit/2024/211	10/12/2024	Limited Assurance	Additional Medical Pay - Additional Duty Hours & Waiting List Initiatives_December 2024 (Review reference: CTMUHB-24/25-09)	9.4 Management should remind staff that WU 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	Executive Medical Director Executive Director for People	28.02.2025	137	28.02.2025	Medium	Partially complete (Overdue)	July 2025 Update - Use of WLIs is managed centrally by the COO's office to ensure appropriate practices. The arrangements have been communicated to CGs with the plan to automate the process via Locum's Nest over the next few months. January 2025 Update - This is on target, in conjunction with the COO's office and SWP Team.

Internal Audit/2024/211	10/12/2024	Limited Assurance	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 / seasonal 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.	Executive Medical Director Executive Director for People	31.01.2025	165	28.02.2025	High	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the Medical and Dental Bank and Agency (including Allied Health Professionals (AHPs) and Health Care Sciences (HCS) agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The Financial Controls Procedure (FCP) and Standard Operating Procedure (SOP) will be revised to confirm the new arrangements by the end of Q3. Through work that has commenced via the Savings Delivery Plan I, we have identified key actions that need to be updated within our workforce systems to facilitate and maintain any introduction of financial controls. April 2025 Update - The FCP has been drafted for comment but will need to be aligned to the workforce efficiencies programme work which commenced 1 April 2025. This will be reviewed and updated by end of May 2025. approval. Request to extend the deadline to 28/2/25.
Internal Audit/2024/211	10/12/2024	Limited Assurance	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/MD1/1	This is covered in 6.1. Controls for retrospective approvals will be confirmed.	Executive Medical Director Executive Director for People	31.01.2025	165	31.01.2025	Medium	Overdue	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HCS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include the appropriate use of retrospective shifts. The new Locum's Nest system has built in controls so it be more difficult to deviate. 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	Limited Assurance	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.	Executive Medical Director Executive Director for People	31.01.2025	165	31.01.2025	Medium	Partially complete (Overdue)	July 2025 Update - From 26 June 2025, the M&D Bank and Agency (including AHP and HCS agency) provider (Retinue (sub contractor Patchwork) contract ended and a new provider (Locum's Nest) commenced with M&D Bank, with Agency to follow in a few weeks. The FCP and SOP will be revised to confirm the new arrangements by the end of Q3. This will include reference to timesheets for uploading and approving. April 2025 Update: The timesheet process is in place with Retinue and Patchwork. However, issues were identified with the two-step approval process which Retinue are addressing to ensure the correct authorisation process is followed. This is expected to be completed in May 2025 and is incorporated in the SOP.
Internal Audit/2024/214	12/12/2024	Reasonable Assurance	Energy Management_2024/25 (Review reference: CTMUHB-24/25-19)	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 HTM07-03 Encode after 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	CTM Estates will raise the proposal for twice-yearly site walkarounds at the next Environmental Steering Group meeting. Decision by the group to implement or derogate from the recommendation to be recorded in minutes and action plan.	Executive Director of Finance	31.03.2025	106	31.03.2025	Medium	Overdue	June 2025 Update - Discussed at the 10-Apr-2025 Energy Compliance Group and the 10-Apr-2025 Environment Sustainability Group. Uploaded minutes state the following "the HTM 07/02 recommendation for twice-yearly site walkarounds was reviewed. The group expressed reservations about this blanket approach, suggesting a more efficient, data-informed model. A counterproposal with timeline will be presented at the next meeting". April 2025 Update - proposal for twice-yearly site walkarounds is included in the 10-04-2025 Estates report to the Environmental Steering Group, requesting a decision from the group to implement or derogate from the recommendation to be recorded in minutes and action plan.
Internal Audit/2024/214	12/12/2024	Reasonable Assurance	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	Executive Director of Finance	31.03.2025	106	31.03.2025	Medium	Overdue	June 2025 Update - As mentioned in the April 2025 Update, a meeting has been scheduled with Pavithra Murgan (Senior Data Analyst) for 5th August 2025. An update, following this meeting, will be made available in readiness for November 2025 Audit, Risk & Assurance Committee. April 2025 Update - All Wales benchmarking dashboards have been received from NWSSP-Special Estates Services. CTMUHB have met with NWSSP-SES to agree a benchmarking exercise at site level to compare All-Wales data. NWSSP-SES have agreed to conduct the benchmarking exercise and are scheduling resources to complete the exercise on our behalf. A meeting has been scheduled with Pavithra Murgan (Senior Data Analyst) on 5th August 2025. Pavithra is unavailable until that date.
Internal Audit/2024/214	12/12/2024	Reasonable Assurance	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 IMP 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.	Executive Director of Finance	31.03.2025	106	31.03.2025	Medium	Overdue	June 2025 Update - Energy risk register to be commenced at the July 2025 Energy Compliance Group meeting with high risks being fed through to the Environmental Steering Group via the Capital and Estates highlight report to that group. April 2025 Update - Energy Support Officer Rhian Giddy has been appointed on 31st March-2025, part of her duties will be to compile the risk register from the submitted energy feedback forms. Any risks that require escalation will be reported to the relevant group. I.e. ISO 14001 Environmental Management System group. No risks to be reported at this stage.
Internal Audit/2024/215	09/12/2024	Reasonable Assurance	Charitable Funds_2024/25 (Review reference: CTM-2425-30)	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 ABC 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.	Executive Director of Finance	28.02.2025	137	28.02.2025	Medium	Partially complete (Overdue)	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update - The new hierarchy is now ready to be implemented and training is to take place with the fund holders. This will include the use of forms, procedures and guidance. This is due to be completed through the summer period.
Internal Audit/2025/230	31/01/2025	Limited Assurance	Vaccination Policy Implementation_2024/25 (Review reference: CTM-2425-22)	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.	Internal Audit/2025/230/MD1/1	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.	Executive Director of Public Health	30.06.2025	15	30.06.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update (24/04/25) - More detailed update to follow.
Internal Audit/2025/230	31/01/2025	Limited Assurance	Vaccination Policy Implementation_2024/25 (Review reference: CTM-2425-22)	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	Internal Audit/2025/230/MD1/1	Review existing vaccination resource and effectiveness against the implementation and equity plans.	Executive Director of Public Health	30.06.2025	15	30.06.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update (23/04/25) - More detailed information will follow and an update will be given by end of June/July 2025.
Internal Audit/2025/230	31/01/2025	Limited Assurance	Vaccination Policy Implementation_2024/25 (Review reference: CTM-2425-22)	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.	Internal Audit/2025/230/MD3/1	There is a planned intention to review the current reporting arrangements for Vaccination programmes with a view to streamlining the current governance structure.	Executive Director of Public Health	30.06.2025	15	30.06.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. April 2025 Update (23/04/25) - More detailed information will be provided at the next update June/July 2025.
Internal Audit/2025/232	31/01/2025	Limited Assurance	Medical Job Planning_2024/25 (Review reference: CTM-2425-17)	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 Alcorate, has shown that of the 588 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.	Internal Audit/2025/232/MD2/1	• To agree and update guidance with a timescale for completing job plans for new starters.	Executive Medical Director	30.06.2025	15	30.06.2025	High	Overdue	July 2025 Update - The job planning guidance is now updated and will be shared with all this month to enable this action to be closed by next meeting. Monitoring to ensure this is activated will also follow and a review of how we report this to the MWPP Delivery Group will also be considered. April 2025 Update: The job planning guidance will be updated to confirm a timescale for job plans for new starters within the first 6 months of joining CTM/new role.
Internal Audit/2025/232	31/01/2025	Limited Assurance	Medical Job Planning_2024/25 (Review reference: CTM-2425-17)	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 Alcorate, has shown that of the 588 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.	Internal Audit/2025/232/MD2/4	• Monitor at MWPP-PEG	Executive Medical Director	31.05.2025	45	31.05.2025	High	Partially complete (Overdue)	July 2025 Update - Job planning compliance across completed, those without a job plan and those out of date is reported to Medical Workforce Productivity Programme meetings. April 2025 Update: Job planning compliance is reviewed at MWPP-PEG and will be aligned to the workforce efficiency programme to improve the process for annual job plans and for new starters/those never had a job plan. This will be updated in terms of actions in May 2025.
Internal Audit/2025/233	29/01/2025	Reasonable Assurance	Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33)	2.2 Management should complete the ongoing work to ensure agreements not yet updated on the register are reviewed, and the register updated accordingly.	Internal Audit/2025/233/MD2/1	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.	Executive Director of Strategy and Transformation	30.04.2025	76	30.04.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Previous Matter Arising 2: A system to accurately capture SLA agreements (Operation) which formed part of Internal Audit/2023/37 Arrangements for Managing Service Level Agreements_Final Internal Audit Report June 2023 (Review reference: CTMUHB-2223-17), Internal Audit/2023/37/MD2 is considered to be partially implemented and has been superseded by this new Recommendation / Action as was presented to the Audit, Risk & Assurance Committee on Thursday 13th February 2025.
Internal Audit/2025/233	29/01/2025	Reasonable Assurance	Follow-up: Arrangements for Managing Service Level Agreements_January 2025 (Review reference: CTM-2425-33)	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.	Internal Audit/2025/233/MD3/1	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.	Executive Director of Strategy and Transformation	30.04.2025	76	30.04.2025	Medium	Overdue	June 2025 Update - This action remains ongoing. 9/7/25 Executive Lead has reviewed the update to this action and is happy to sign off the update June 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	2.1a Regular analysis of data on the variations in harm levels at the various stages in the incident process should be undertaken to look for any trends or patterns. For example, if the under or over stating of harm levels is predominantly linked to certain care groups or departments.	Internal Audit/2025/250/MD2/1	Monthly assessment of variations in harm levels to be undertaken and feedback provided monthly Care Group reports.	Executive Director of Nursing, Midwifery & Patient Care	30.06.2025	15	30.06.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	5.1 The Health Board should consult with the Candour network to ensure a consistent and unified approach to dealing with complex cases involving other health boards or trusts is set out and prevent possible delays.	Internal Audit/2025/250/MD3/1	Consult with Duty of Candour Network to identify best practice for management of complex cases and incorporate into Standard Operating Procedure.	Executive Director of Nursing, Midwifery & Patient Care	30.06.2025	15	30.06.2025	Low	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025

Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	2.2 To encourage a consistent and more accurate assessment of harm levels at the various incident stages, information and guidance should be incorporated into any operating procedures that are developed. (see Matter Arising 3)	Internal Audit/2025/250/MD4/1	The Incident Management Framework to be updated to include information and guidance in relation to harm assessment and its application to Duty of Candour.	Executive Director of Nursing, Midwifery & Patient Care	31.05.2025	45	31.05.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	3.1a Detailed operating procedures should be developed to aid staff in ensuring the correct application of the Duty of Candour and the capture of essential information within the Datix system.	Internal Audit/2025/250/MD5/1	3.1a The Incident Management Framework to be updated to include flow charts as appendices to support the implementation of Duty of Candour and accurate completion of Datix Cymru.	Executive Director of Nursing, Midwifery & Patient Care	31.05.2025	45	31.05.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	4.1 As part of the development of an SOP to provide clarity to staff on the capture of information, staff should be reminded of the importance of comprehensively and accurately completing the required fields in Data and saving copies of relevant documents to the Datix record.	Internal Audit/2025/250/MD6/1	The Incident Management Framework to be updated to include flow charts as appendices to support the implementation of Duty of Candour and accurate completion of Datix Cymru.	Executive Director of Nursing, Midwifery & Patient Care	31.05.2025	45	31.05.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	3.2 A review of the current forms used within Datix Cymru by the Health Board should take place with a view to reinstating the workstream approved form in the system that have mandatory elements in-built and prevent fields being left unpopulated.	Internal Audit/2025/250/MD6/1	Review of Datix Cymru forms allocated to be undertaken and updated as required.	Executive Director of Nursing, Midwifery & Patient Care	30.04.2025	76	30.04.2025	High	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	1. Information and a link to the ESR Duty of Candour training module should be included on the Duty of Candour intranet pages. Consideration should be given to identifying those staff that would most benefit from attending Duty of Candour training and direct communications to encourage participation.	Internal Audit/2025/250/MD1/1	1.a) Duty of Candour Intranet pages to be updated to include links to training programmes.	Executive Director of Nursing, Midwifery & Patient Care	31.03.2025	106	31.03.2025	Low	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	6.1 The Health Board should ensure the reports it utilises for monitoring of Duty of Candour are in line with the standard reports produced by the OIW Central Team.	Internal Audit/2025/250/MD9/1	Review all reports produced in relation to Duty of Candour are in line with Once for Wales templates and reports.	Executive Director of Nursing, Midwifery & Patient Care	31.03.2025	106	31.03.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/250	31/03/2025	Reasonable Assurance	Duty of Candour_March 2025 (Review reference: CTMUHB-2324-10)	6.2 The Health Board should undertake a review of 2023/2024 data to validate all matters which are closed with a harm grading of moderate or greater. Assistance for this task can be obtained from the OIW Central Team. A regular review/audit of closed records should be undertaken to identify which have a closed status, a harm grading of moderate or greater and insufficient clarification regarding Duty of Candour status.	Internal Audit/2025/250/MD10/1	Review of 2023 / 2024 data to be completed and learning identified to inform improvement action. Weekly review of closed records to be implemented and monitored via the weekly Quality & Safety data meeting.	Executive Director of Nursing, Midwifery & Patient Care	31.03.2025	106	31.03.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Added to tracker May 2025
Internal Audit/2025/251	22/05/2025	Reasonable Assurance	Cancer Tracking Process_2024/25 (Review reference: CTM-2425-02)	3. Training records Training and development arrangements Cancer services supervisors are responsible for planning, supervising and undertaking the necessary training for new and existing staff within the CSU. Training consists of new starters in the Cancer Service Information Assistant/MDT coordinator roles shadowing experienced colleagues in their roles until deemed competent by their cancer services supervisor. We note that supplementary training guidance is in place and training logs should be kept documenting the competency sign off process. However, our review of the training logs found that they had not been updated since 2021.	Internal Audit/2025/251/MD3/1	Training records for cancer trackers and MDT coordinators be kept up to date.	Chief Operating Officer	30.06.2025	15	30.06.2025	Medium	Overdue	July 2025 Update - An induction package has been developed and in place for new starters. A monitoring tool is in development. Once the SOP's have been reviewed and ratified, training will be provided to new starters with the new guidance. MDT training document not currently available across health boards, subsequently inhouse development to take place within the following month. Signed off by Deputy COO 14.07.25 Added to tracker May 2025
Internal Audit/2025/251	22/05/2025	Reasonable Assurance	Cancer Tracking Process_2024/25 (Review reference: CTM-2425-02)	4. Validation and breach reporting backlogs Month-end validation At the end of each month, Cancer Services Supervisors undertake a validation exercise of the cancer tracking database to ensure that the correct information has been captured such as the initial point of suspicion, the treatment date, and treatment type. Accuracy of data in these fields is important as they are used for calculating breaches to the SOP timescales. At the time of our fieldwork in February, the January data should have been validated. Whilst Prince Charles Hospital (PCH) and Princess of Wales (POW) data for the two departments that we sampled confirmed they were up to date, our testing found that the Royal Glamorgan Hospital (RGH) validation data for urology and gynaecology was last fully undertaken in November 2024. The validation work for December 2024 and January 2025 was only partially completed. Breach reports Cancer Services Supervisors create a monthly summary report of the validated records of confirmed and treated cancer pathways that have breached the SOP target. These reports are then issued to managers within departments for information so that lessons can be learnt. At the time of our review not all breach reports had been undertaken for the latest available and validated data (up to end of January 2025): • POW – the last breach reports urology and gynaecology were issued for data up to the end of October 2024. There is a backlog for all breaches that have occurred since November 2024. • PCH and RGH – up to date on gynaecology breach reports, but the last urology breach reports were issued for data up to the end of November 2024. There is a backlog of urology breaches that have occurred since December 2024. The findings were acknowledged by the cancer services supervisors, and we were informed that the backlogs to validation and breach reports have arisen as a result of capacity constraints within the teams. Each month Breach numbers are reported Welsh Government. The data reported to Welsh Government for January 2025 appears incorrect as the Health Board reported a 100% completion of breach reports, but the backlog identified above suggests that this would not be accurate.	Internal Audit/2025/251/MD4/1	Arrangements be put in place to ensure that validation and breach reports backlogs are addressed and in future, are undertaken in a timely manner.	Chief Operating Officer	31.05.2025	45	31.05.2025	High	Overdue	July 2025 Update (08.07.25) mandatory breach reports of >146 have now been completed and fed back to the services for learning. The over >62 are currently being worked through as part of good practice. The breach report SOP is currently being reviewed as part of the wider review which will support timely completion of breach reports going forward. Added to tracker May 2025.
Internal Audit/2025/256	17/04/2025	Limited Assurance	Estates Condition_2023/24 (Review reference: CTM-SSU-2324-02)	2. The NHS Estates Risk Based Methodology to Backlog guidance (2013) outlines a process for updating the findings of the detailed survey (condition and risk rankings and associated costings) on an annual basis. This guidance highlights that an annual update should take account of the following, for example: 1. inflation. 2. service schedules. 3. vacant assets awaiting disposal. 4. new sub-standard elements. 5. further deterioration of previously identified elements. 6. recent acquisition of property. 7. refurbishments/alterations since previous survey. 8. regulatory changes. 9. proposed strategic shift in service provision. Management had advised that an annual meeting takes place to update results for the EPPMS submission to Welsh Government. However, there were no local procedures surrounding how the UHB would undertake this review i.e.: 1. How and who would be involved in the process. 2. What methods would be used to calculate inflation. 3. How further or new deterioration of the estate would be validated. 4. Where the results of the review would be reported (internally within the UHB). The formulation and application of standard procedures would ensure consistency over financial years and help provide benchmarking criteria across the NHS Wales estate. Also, an annual review puts pressure on the availability and accuracy of information, it may be prudent for reviews to be undertaken more frequently if resources allow.	Internal Audit/2025/256/MD2/1	A standard operating procedure will be developed to ensure consistency of approach at the annual desk top updates.	Executive Director of Finance	30.06.2025	15	30.06.2025	Medium	Overdue	July 2025 Update - The operating procedure methodology has been implemented. This is to be followed up with a written procedure. Added to tracker May 2025
Internal Audit/2025/256	17/04/2025	Limited Assurance	Estates Condition_2023/24 (Review reference: CTM-SSU-2324-02)	3. WHBN 00-08 2018 Estate code outlines that the Estate Strategy should represent the vision for the future estate to deliver and satisfy the current/anticipated business plans and operational services. Management confirmed that a standalone Estate Strategy was not in place, as they view this as integral to their overall Acute Clinical Services Plan (ACSP). Whilst noting that the current IMTP does address aspects of the ongoing management of the estate it does not comprehensively cover the details that would be expected within a Specific Service Strategy (covering estate issues).	Internal Audit/2025/256/MD1/1	The UHB are currently developing their Acute Clinical Services Plan (ACSP). This plan is integral in establishing the future estates requirement of the Health Board and it is this which will inform ongoing strategy.	Executive Director of Finance	30.06.2025	15	30.06.2025	High	Overdue	July 2025 Update - The UHB are currently developing a Clinical Services Plan, the Estates Strategy will be developed following the completion of the Clinical Services Plan. Added to tracker May 2025
Internal Audit/2025/259	27/03/2025	Reasonable Assurance	Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28)	3.2 Snapshot audits should be undertaken as intended to verify that the data submitted to WG aligns with the number of breaches documented in the post-validation figures.	Internal Audit/2025/259/MD4/1	Informatics to run monthly reports as part of the submission to WG.	Chief Operating Officer	30.06.2025	15	30.06.2025	Medium	Overdue	July 2025 Update - The informatics team report monthly to WG as part of the Oversight and Assurance meetings, providing updates and actions against performance. Slides are available for viewing co-ordinated by the COO business team. Deputy COO signed off 14.07.25 Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28) was presented to the Audit, Risk & Assurance Committee on 22/05/2025. This recommendation action supersedes/replaces original recommendation action 5.1 of 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03).
Internal Audit/2025/259	27/03/2025	Reasonable Assurance	Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28)	3.3 A SOP in relation to the validation process should be developed to accurately reflect the recent changes in the process to ensure a consistent approach is in place across all sites. The SOP should include details of the snapshot audits process for verify data submitted to WG.	Internal Audit/2025/259/MD5/1	Standardised SOP to be develop for each site that includes breach data validation process.	Chief Operating Officer	31.05.2025	45	31.05.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28) was presented to the Audit, Risk & Assurance Committee on 22/05/2025. This recommendation action supersedes/replaces original recommendation action 5.3 of 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03).
Internal Audit/2025/259	27/03/2025	Reasonable Assurance	Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28)	4.1 Consideration should be given to undertaking more detailed reporting that provides analysis of the data currently presented, such as the proportion of non-breaches that are as a result of clinical exemptions, and the proportion of 'did not wait'. Analysis of the breach reason codes, should be undertaken with the aim of better understanding the causes of patients exceeding the 4-hour target.	Internal Audit/2025/259/MD6/1	Plan to recruit Patient Flow Coordinators to support real time data capture on WPAS. Until recruited on each site, the patient pathway information will be updated by PFCs (PCH x 2 WTE, RGH 1 WTE) consultants and NIC. Implementation date for patient tracking on WPAS as above – 14th May 2025. Snapshot audits to be undertaken against breach outcomes and patient notes during May – Action for Band 7 Ops Managers weekly commencing after rollout. Longer term, plan to introduce as part of the data set in the ED power BI app – Action ED clinical lead, Informatics and Directorate.	Chief Operating Officer	31.05.2025	45	31.05.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28) was presented to the Audit, Risk & Assurance Committee on 22/05/2025. This recommendation action supersedes/replaces original recommendation action 6.4 of 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03).
Internal Audit/2025/259	27/03/2025	Reasonable Assurance	Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28)	1.1 New and existing staff who are required to capture patient information in the updated WPAS tracker should be provided with training in relation to the WPAS and the new Standard Operating Procedures (SOPs). To ensure staff understand the importance of accurate data capture, the training should incorporate an overview of the rationale for capturing information.	Internal Audit/2025/259/MD1/1	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 to enable standardised breach reporting and as preparation for the merger of POW WPAS over to CTM and to ensure comparable data is available moving forward. This work has now been completed. The existing training SOPs are in the process of being updated – Date for completion 30 April 2025. Roll out training programme 1 May 2025 to align with the WPAS POW merger on 4 May 2025.	Chief Operating Officer	14.05.2025	62	14.05.2025	Medium	Overdue	July 2025 Update - the merger of POW WPAS over to CTM has been complete now enabling comparable data to be presented. The existing training SOPs have been complete and training programme was rolled out in May 2025. Standardisation of data capture across the 3 ED's has been completed. Next step - embedding a culture where clinicians update the system live to accurately report on ED activity. Development of Rapid Improvement Plan (30/60/90) - including sign off of internal professional standards. Care group continue to work towards their action plan and regularly update WG on their progress and performance. Signed off by Deputy COO 14.07.25 Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28) was presented to the Audit, Risk & Assurance Committee on 22/05/2025. This recommendation action supersedes/replaces original recommendation action 3.1 of 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03).
Internal Audit/2025/259	27/03/2025	Reasonable Assurance	Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28)	2.1 The criteria for determining the treatment complete time should be reviewed with a view to having a consistent definition in place across all sites. The agreed approach should be captured in a SOP.	Internal Audit/2025/259/MD2/1	The new sample card and standardisation of drop downs undertaken will ensure accurate data capture moving forward with a standardise approach and understanding of the data requirement / meaning being in place across CTM. The definitions on when and how this should be captured will be written into the updated SOP and will be discussed with staff during the training roll out.	Chief Operating Officer	14.05.2025	62	14.05.2025	Medium	Overdue	July 2025 Update - the merger of POW WPAS over to CTM has been complete now enabling comparable data to be presented. The existing training SOPs have been complete and training programme was rolled out in May 2025. Standardisation of data capture across the 3 ED's has been completed. Next step - embedding a culture where clinicians update the system live to accurately report on ED activity. Development of Rapid Improvement Plan (30/60/90) - including sign off of internal professional standards. Care group continue to work towards their action plan and regularly update WG on their progress and performance. Signed off by Deputy COO 14.07.25 Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28) was presented to the Audit, Risk & Assurance Committee on 22/05/2025. This recommendation action supersedes/replaces original recommendation action 4.2 of 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03).
Internal Audit/2025/259	27/03/2025	Reasonable Assurance	Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28)	3.1 A detailed record of any adjustments made following validation should be maintained, including the individual who initially entered the data and the specific error that was amended. This information should be utilised to determine the training needs of the staff.	Internal Audit/2025/259/MD3/1	WPAS team to run weekly report from system to identify where an adjustment(s) have been to a patients breach outcome. Plan to make automatically available the ED power BI app.	Chief Operating Officer	30.04.2025	76	30.04.2025	Medium	Overdue	June 2025 Update - An update against this recommendation has not been provided on this occasion. Follow-up: 4-hour Emergency Department Performance_March 2025 (Review reference: CTM-2425-28) was presented to the Audit, Risk & Assurance Committee on 22/05/2025. This recommendation action supersedes/replaces original recommendation action 5.2 of 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03).

Internal Audit/2025/260	22/05/2025	Reasonable Assurance	Follow-up: Arrangements for Financial Savings_May 2025 (Review reference: CTM-2425-31)	1. Before a savings scheme starts and depending on size, relevant control documentation including a project plan should be put in place and a quality impact assessment and risk assessment should be undertaken, together with an assessment of the resources that may be required to deliver the anticipated savings.	Internal Audit/2025/260/MD1/1	We will advise all care groups that the relevant documentation should be used for all the savings schemes identified. An email will be circulated from the COO office advising Care groups.	Chief Operating Officer	31.05.2025	45	31.05.2025	High	Overdue	July 2025 - an email was sent to all care directors on the 28th May 2025, reminding all of the importance of actions prior to commencing a savings scheme. Email included directing all to relevant documents for use. Evidence uploaded to COO file under AMAT UPDATES. Proposed for closure. Deputy COO sign off 10.07.25. May 2025 Update - Follow-up: Arrangements for Financial Savings May 2025 Review reference: CTM-2425-31 was presented to Audit, Risk & Assurance Committee 22/05/2025. This recommendation action superseded/replaces original recommendation 2.2b of Arrangements for Financial Savings Internal Audit Report_December 2023 (Review reference: CTMUH8-2223-07) as it is considered as not implemented

Cwm Taf Morgannwg University Health Board

Audit, Risk & Assurance Committee Internal Audit Progress Report

August 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 and Assurance 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 & Assurance Committee (the 'Committee') with the current position of the work undertaken by Internal Audit as at 5 August 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 both for the Health Board and Joint Commissioning Committee (JCC), along with details regarding the delivery of the plans and any required updates.

2 Reports Issued

- 2.1 Since the May meeting of the Committee seven reports have been finalised, including one for the JCC. We have two reports in draft (one for the JCC) and ongoing fieldwork in relation to two reviews. A summary of the position of the finalised reports, including a summary of number of recommendations, is provided in Table 1 below.

Table 1: Summary of finalised reports

Assignments	High	Medium	Total	Assurance rating
Financial systems	-	2	2	Substantial
Audit recommendations tracker	-	2	2	Reasonable
Welsh risk pool	-	6	6	Reasonable
Access to diagnostics criteria	-	5	5	Reasonable
JCC Financial arrangements	1	6	7	Reasonable
End of life care management	2	2	4	Limited
Decarbonisation – follow up	-	-	-	-

3 Delivering the Plan

- 3.1 The programme of work for 2025/26 that was agreed with the Committee in May 2025. We are in the process of agreeing our additional work programme for the Prince Charles Hospital redevelopment project.
- 3.2 In addition, we have agreed our programme of work for 2025/26 with the JCC. The detail of this 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. We also report performance during the year at Audit Committee. We will report the position for 2025/26 at the November meeting.

5 Feedback

- 5.1 We send a post audit questionnaire to the key health board staff that we have worked with on each audit. This is one way of getting feedback on the audit process so that we can look to make improvements. In 2024/25 we issued feedback questionnaires for all finalised report and received responses for 59% of the questionnaires that we had issued. This a great improvement on the number of responses that we received for our work in 2023/24.
- 5.2 We ask responders to score the audit process out of ten for five categories. The results for 2024/25 are summarised below:

Table 2

Category	Average score
Engagement and communication	9.25
Professionalism	9.17
Report	9.21
Impact	8.54
Overall satisfaction	9.04

6 Other activity

Joint Commissioning Committee (JCC)

- 6.1 We have agreed a programme of work for 2025/26 with officers of the JCC (Appendix A – Table 5). We have finalised two reports, have one report in draft and are concluding our fieldwork for our final review.

Meetings

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

Appendix A – Programme of work**Table 3: 2024/25 Programme of work not previously reported**

Plan Ref.	Review	Rating	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
T04	End of life care management	Limited	Final	Y	N	-
T21	Financial systems	Substantial	Final	Y	N	-
T26	Audit recommendations tracker	Reasonable	Final	Y	Y	-
T14	Welsh Risk Pool	Reasonable	Final	Y	Y	-
T03	Elective care criteria – access to diagnostics	Reasonable	Final	Y	Y	-
-	PCH Financial and Technical compliance	Reasonable	Draft	Y	-	Draft report issued 03.07.25

Table 4: Core programme of work for 2025/26 Q1-Q2

Plan Ref.	Review	Rating	Review period	Planned AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
30	Follow up - Decarbonisation	-	Q2	~~Nov~~ Aug	Final	Y	Y	-
N/A	Discharge planning	-	Q1	~~Aug~~ Nov	WIP			-
4	Operational response to critical incident	-	Q1	~~Aug~~ Nov	WIP			Fieldwork started w/c 14.07.25
16	Stroke	-	Q2	Nov	Planned			Brief agreed 06.06.25. Audit to start August
20	Estates assurance – Asbestos Management		Q2	Nov	Planned			Brief agreed.
1	Continuing Health Care	-	Q1	Nov	Planning			Scoping meeting 07.07.25
18	Savings	-	Q2	Nov	Planning			Draft brief issued 15.07.25.
9	Clinical coding	-	Q1	~~Aug~~ Nov	Planning			Scoping meeting held. Delay due to Auditor leave.

5	Medical sickness records	-	Q2	Nov	Planning			Awaiting response for initial meeting.

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

Ref.	Review	Rating	Status	Notes
3	Financial arrangements	Reasonable	Final	-
4	Traumatic stress Wales	Limited	Draft	Draft report re-issued 03.05.25

Table 6: Joint Commissioning Committee (JCC) 2025/26

Ref.	Review	Rating	Status	Notes
1	High cost drugs	-	Planning	Work planned for Q4. We have had initial planning meeting.
2	Individual Patient Funding Requests (IPFR)	-	Planning	Work planned for Q3. We have had initial planning meeting.
3	Strategic planning	-	Planning	Work planned for Q4. We have had initial planning meeting.
4	Budget management	-	-	Work planned for Q4.

End of Life Care Management

Final Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



Limited Assurance

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Review Reference

CTM-2425-04

Fieldwork

February – April 2025

Executive Sign Off

13 June 2025

Audit Committee

August 2025

Executive Lead

Gethin Hughes, Chief Operating Officer

Audit Team

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

To review the work that Cwm Taf Morgannwg University Health Board (the 'Health Board') is undertaking to enable the delivery of end of life care to patients.

Overview

End of life care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patients and families to be identified and met throughout the last phase of life and into bereavement.

In October 2022 the Welsh Government published its 'Quality statement for palliative and end of life care for Wales'. The statement sets out the vision for what good quality palliative and end of life care services should look like. The Quality Statement should be implemented through a series of health board enabling plans. The 2024-27 IMTP states that the Health Board's 'Palliative and End of Life Care Delivery Group' will coordinate local implementation of the Quality Statement.

The IMTP sets out the four key priorities of the group:

1. Relaunch of the NHS Executive care decisions guidance.
2. Bereavement services.
3. Education, training and information.
4. Patient feedback and communication.

The Health Board participates in the National Audit of Care at the End of Life (NACEL), which is an annual review and forms part of the clinical audit plan for the Health Board. Scores are provided over a number of component areas, which allows the Health Board to be benchmarked against other health boards and identify areas for improvement.

Following the completion of our work, we have concluded limited assurance for this review. The matters requiring management attention include:

- Lack of oversight of implementation of the 'End of Life Care Delivery Action Plan' since the Palliative and End of Life Care Delivery Group stopped meeting.
- Very little end of life care training.
- No information or signposting of information in relation to end of life care provision for the public.
- A lack of monitoring and reporting of end of life care provision.

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

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There are appropriate arrangements in place to facilitate the delivery of Health Board’s key priorities for end of life care and recommendations from national clinical audits. Consideration is given to the risk of non-delivery.	1	Limited
2	There are suitable training and awareness programmes for staff that allows the identification and management of patients approaching, or undertaking, end of life care.	2	Limited
3	Guidance documents and forms are readily available for use by staff and patients.	3	Reasonable
4	There are suitable monitoring and reporting arrangements in place across the Health Board.	4	Reasonable

Management Actions



High Priority



Medium Priority

Themes



- Performance Monitoring
- Communication & Engagement
- Governance
- Training & Development

Risk Type

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: There are appropriate arrangements in place to facilitate the delivery of Health Board’s key priorities for end of life care and recommendations from national clinical audits. Consideration is given to the risk of non-delivery.	Limited

Overview / Summary of Observations

Up until October 2023 the Palliative and End of Life Care (PEoLC) delivery group oversaw the delivery of the Health Board’s action plan in relation to end of life care services. The action plan aligned to the four key priorities set out in the 2024-27 IMTP. However, after October 2023 the group no longer met as an updated national service specification in relation to end of life care was due to be launched by the NHS Wales Executive. Management decided to review the end of life care governance arrangements to ensure they allowed for implementation of the specification and development of palliative and end of life care services. The launch of the national end of life care service specification has been delayed, and at the time of our review remained in consultation. In the interim period a proposed governance structure was developed and recently approved by the Health Board. This will see the formation of an End of life Care Strategic Implementation Group.

The action plans for two of the four key priorities set out in the IMTP have been monitored by the Bereavement Steering Group and the Specialist Palliative Care Business Planning Group, though services pressures has meant the latter group has not been able to meet as frequently as intended to discuss their actions.

Other actions recorded on the October 2023 PEoLC action plan have been implemented, such as the end of life companion service. However, in the absence of the delivery group we have been unable to confirm if there has been a co-ordinated approach to deliver the actions.

The Health Board participated in the 2024/25 NACEL review, and we understand that the outcomes are scheduled to be presented to the Clinical Effectiveness Committee in May 2025. Our review of the latest NACEL report received by the Health Board confirmed that many of the recommendations from that report aligned to the Health Board’s key priorities for end of life care.

Processes are in place whereby high scoring risks relating to end of life care provision have been identified within the Specialist Palliative Care Service and Bereavement Services departments, and these were reviewed and monitored. It is our understanding that the newly formed End of Life Care Strategic Implementation Group will maintain a risk register collating, and giving oversight to, all end of life and palliative care risks identified by departments.

Key Findings		Risk & Impact	Agreed Management Action
1	<u>Delivery of key priorities</u> The actions for delivering the key priorities for end of life care, were captured in an ‘End of Life Care Delivery Action Plan’ and progress was monitored by the Palliative and End of Life Care delivery group. The group stopped meeting in October 2023 in anticipation of a new governance structure linked to the expected launch of the NHS Wales Executive National Palliative and End of Life Care Programme All Wales Service Specification. Delays in release of the service specification meant the revised governance structure and a terms of reference for the	Lack of oversight meaning the Health Board’s key priorities in relation to end of life care may not be implemented.	Agreed Action: The Palliative and End of Life Care Strategic Implementation Group to be established as soon as practicable to ensure efficient and effective oversight to end of life care delivery across all Health Board Care Groups and all of their respective clinical and nursing areas. The Group will also be central to the coordination and implementation of the forthcoming NHS Wales Executive National Palliative and End of Life Care Programme All Wales Service Specification across the Health Board.

	replacement group have only recently been agreed. As such, there has been no overarching monitoring against the 'End of Life Care Delivery Action Plan' for over a year. We acknowledge that other groups linked to end of life care have remained in existence and have had some oversight of parts of the delivery action plan. However, there have been occasions when these groups have not been able to meet as frequently as intended. For example, due to service pressures the Specialist Palliative Care Business Planning Group has not met formally since September 2024 to discuss its elements of the delivery action plan. However, the Group has met in this period to discuss specific high risk issues relating to the department such as medical staffing issues.		The group will ensure that the 2024-27 IMTP objectives tasked to the legacy PEOLC Delivery Group are met and implemented along with residual actions from the End of Life Care Delivery Action Plan, subject to review in light of receipt of the all Wales Service Specification. Specialist Palliative Care Service Business meetings to continue to ensure local governance arrangements and oversight in respect of its palliative end of life care delivery issues, and also to ensure ongoing implementation of its applicable End of life Care Delivery and Action Plan objectives.
	Theme: Governance	High Priority Control Operation	Expected Evidence of Implementation: Palliative and End of Life Care Strategic Implementation Group meeting minutes / records. Officers: Kevin Duff, Head of Strategic Planning and Commissioning – Aging Well Paul Williams, Head of Strategic Planning and Commissioning – Dying Well Victoria Oxley, Deputy Director of Strategy and Partnerships Target Implementation Date: June 2026

Overview / Summary of Observations

We understand that previous Welsh Government funding allowed a senior nurse for palliative care and advance & future care planning to be employed. Part of this role involved the provision of training in relation to end of life care. The training was undertaken with nursing staff from a number of wards across the Health Board’s various sites. Those that were trained became end of life care champions with the aim of passing knowledge on to other staff on wards. However, this funding stopped in 2023, which meant that the training of champions also ceased. We understand that the new appointment to the role of clinical lead nurse for palliative care may allow some elements of training provision to restart.

We are aware that the current bereavement clinical lead delivers bereavement specific awareness sessions to staff for which attendance is voluntary. There is no other formal end of life care training available to staff.

Key Findings		Risk & Impact	Agreed Management Action
2	<u>End of Life Care training and awareness</u> The Health Board does not provide formalised specific training or awareness exercises in respect of end of life care provision for nursing or medical staff.	Poor patient experience if staff are unaware on how to deal with patient and family end of life care wishes.	Agreed Action: Liaise with the Clinical Education team to identify a suitable representative to work with the strategic implementation group in implementing a training programme. The Health Board to explore the possibility of introducing a training programme to deliver generic and/or specific training in respect of end of life care management for nursing and clinical staff across all Care Group specialities. Delivery progress in respect of the implementation of this training is monitored by the Palliative and End of Life Care Strategic Implementation Group though Care Groups will need to be accountable for their respective compliance. Training for carers to prepare and equip them with the skills to support patients in the best way possible to also be considered. Consideration is given to the reintroduction of end of life care champions at all wards who can train and raise awareness amongst colleagues, and also via the Health Board Induction process. Expected Evidence of Implementation: Care Group wide training programme of generic and/or specific training for end of life care management for all nursing and clinical staff.

		High Priority	Officers: Richard Hughes, Deputy Executive Director of Nursing Kevin Duff, Head of Strategic Planning and Commissioning – Aging Well
	Theme: Training & Development	Control Operation	Target Implementation Date: December 2026

Overview / Summary of Observations

Our review identified that the Specialist Palliative Care and Bereavement Support Services departments have both internet and intranet SharePoint pages that provide a wide range of information and documentation to staff and the public relating to end of life care within the context of their areas.

Additionally, the Health Board has a SharePoint site relating to All Wales 'Care Decisions Guidance for the Last Days of Life', which provides information and documentation for nursing staff and clinicians. The site also provides training materials and a video about the care decisions guidance. However, there are no corporate or overarching Health Board internet pages to provide advice and support to the public and external stakeholders in relation to end of life care.

Key Findings		Risk & Impact	Agreed Management Action
3	<u>Public awareness of end-of life care provision</u> Whilst the Health Board’s website contains information on palliative care and bereavement support, it does not have information relating to generic end of life care guidance and advice documentation, or information signposting the public to other support services such as charity websites.	Reputational damage if the Health Board does not have clear approach for capturing and managing patient’s end of life wishes.	Agreed Action: End of Life Care Strategic Implementation Group to ensure that the Health Board’s internet site includes up to date information for families, carers and external stakeholders on end of life care guidance and advice documentation, as well as signposting to relevant third sector and charities resources.
	Theme: Communication & Engagement	Medium Priority Control Operation	Expected Evidence of Implementation: A Health Board internet site for end of life care awareness and signposting to all relevant services and third sector and charity websites. Officers: Kevin Duff, Head of Strategic Planning and Commissioning – Aging Well Paul Williams, Head of Strategic Planning and Commissioning – Dying Well Victoria Oxley, Deputy Director of Strategy and Partnerships Target Implementation Date: June 2026

Overview / Summary of Observations

Monitoring in relation to the ‘End of Life Care Delivery Action Plan’ was previously undertaken by the Palliative and End of Life Care Delivery Group. The group stopped meeting in October 2023 and its replacement, the End of Life Care Strategic Implementation Group is yet to meet. Once operational, the strategic group will report to the Improving Care Board and will provide a strategic oversight on the development and implementation of comprehensive palliative and end of life care services across the Health Board.

In the interim period, at an operational level we have seen elements of the action plan being monitored at the Bereavement Steering Group and the Specialist Palliative Care Business Planning Group. We have also seen the Primary Care and Community Care Group has continued to monitor and report on aspects of palliative and end of life care through the care group governance arrangements and escalating to the Executive Leadership Group where appropriate. Regular updates on palliative and end of life care are also provided to the Improving Care Board as part of the Primary Care and Community Care Group transformation highlight reports.

Key Findings		Risk & Impact	Agreed Management Action
4	There are no reporting lines between care groups, or between care groups and the Board in respect of end of life activity. Additionally, as previously stated above, given that the Palliative and End of Life Care Delivery Group has not met since October 2023, there has been no formal monitoring of actions at a strategic level.	Reputational damage if the Health Board does not have clear approach for capturing and managing patient’s end of life wishes.	Agreed Action: Upon the introduction of the Palliative and End of Life Care Strategic Implementation Group, reporting lines between Care Groups and the Improving Care Board will be introduced for end of life activity reporting and sharing of good practice. Expected Evidence of Implementation: Reports of monitoring activity presented at relevant groups or committees.
		Medium Priority	Officers: Kevin Duff, Head of Strategic Planning and Commissioning – Aging Well Paul Williams, Head of Strategic Planning and Commissioning – Dying Well Victoria Oxley, Deputy Director of Strategy and Partnerships Target Implementation Date: June 2026
	Theme: Performance Monitoring	Control Design	

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](#)

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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.



Welsh Risk Pool

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

CM-2425-14

May - June 2025

June 2025

August 2025

Greg Dix, Executive Director of Nursing,
Midwifery & Patient Care

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal
Audit



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CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
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Executive Summary

Purpose

Our review of Welsh Risk Pool concerns and compensation claims was completed in line with the 2024/25 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board'). We sought to provide assurance that the correct processes have been followed, reimbursements are compliant with the Welsh Risk Pool standard, and claims are accurate.

Overview

Compensation claims usually take a number of years from receipt of claim to settlement and can involve a large number of payments and repayments; this gives rise to the potential for mistakes to occur. Welsh Risk Pool Services (WRPS) require claims for reimbursement and repayment to be made within specific timescales. The WRP standard requires Internal Audit to review the accuracy of a representative sample of compensation claims for reimbursement, made on Welsh Risk Pool Services.

During 2024 management have provided update reports to the Audit and Risk Committee and the Quality and Safety Committee on the actions taken to address the ongoing issue of outstanding Learning From Events Reports (LFER).

In 2024/25 there were 157 reimbursable closed Clinical Negligence (CN), Personal Injury (PI) and Redress cases in total. We tested a sample of 25 cases from across the three claim types to provide assurance that the claims were submitted to WRPS within the specified timeframes, and to verify the accuracy of the data. Five of 13 Redress cases were later excluded from the sample as either the claim was withdrawn or there was no qualifying liability.

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

- Accuracy and completeness of information captured in Datix, especially in relation to key dates and evidence to support costs.
- Timeliness of submissions to WRPS.
- Appropriate processing of invoices received after claims to WRPS have been made.
- Appropriate completion and authorisation of claim management forms for reimbursement.
- Completion of the draft standard operating procedures.

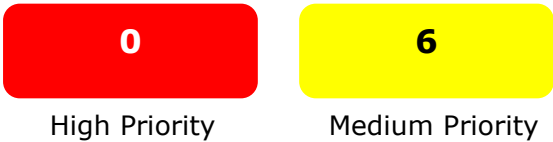
Full details of matters arising are within the Findings & Agreed Action Plan. We also identified the following opportunities for enhancement that do not impact the overall opinion and are highlighted for management information:

- As cases progress through the claims process, their status on Datix should be updated. While recording the 'current stage' had improved since our previous audit, there were still some closed cases that were incorrectly categorised.
- Monitoring of progress against the 2023/24 WRPS action plan should continue through the Patient Safety Team assurance meetings.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	An appropriately completed learning from events report, case management report, case financial record and a schedule of costs has been completed for each reimbursement claim within set timescales	1,2	Reasonable
2	There is appropriate evidence to support the costs incurred.	3,4	Reasonable
3	Forms have been appropriately authorised aligning with delegated limits within the organisation.	5	Reasonable
4	Claims submitted are accurately entered onto the Datix risk management database.	-	Substantial
5	An action plan has been developed to address issues highlighted in the 2023/24 WRP Annual Report in relation to timeliness and approval of LFER submissions. Monitoring against the action plan takes place.	6	Reasonable

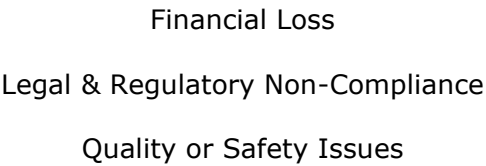
Management Actions



Themes



Risk Types



Findings & Agreed Action Plan

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

Reasonable

Overview

We reviewed Datix reports of closed Clinical Negligence (CN), Personal Injury (PI) and Redress cases for 2024/25. Of the 157 reimbursable cases, 49 were CN, 3 were PI and 105 were Redress. Whilst all cases had been closed in Datix, the 'current stage' field was not always accurately updated to show 'Final Reimbursement from WRP received'. We note that 48/105 closed Redress claims were identified as 'QL Being Investigated'. We understand that the majority of these are linked to a cleansing exercise conducted prior to the previous Head of Claims and Inquests leaving post. Some incorrect stages were also identified for CN and PI cases, but we acknowledge an improvement compared to our 2023/24 audit.

Our testing of a sample of closed claims revealed some issues with the accuracy of dates recorded in Datix, delays in submitting Learning from Event Reports (LFERs) and Case Management Reports (CMRs) within required timeframes, and in some instances, we were unable to retrieve the original submission emails to WRPS. We acknowledge that the team have faced a number of resource issues during the year, which is likely to have had a detrimental impact on the ability to meet the WRPS required timeframes.

We saw evidence of the Health Board submitting the Redress forecasting checklist, RF1, to WRPS each quarter, with manual adjustments to incorporate report data into the WRPS template.

Key Findings		Risk & Impact	Agreed Management Action
1	Accuracy of information We tested a sample of 20 cases to confirm if key milestone dates recorded on the LFER, CMRs and U1/U2 finance checklist forms agreed to the dates captured in Datix. We identified: <u>LFERs</u> 5/11 CN cases and 3/8 Redress cases there was inconsistent or missing date information in relation to the LFER document and Datix records. 1/11 CN cases and 6/8 Redress cases there was inconsistent date information in relation to the CMR and U1/U2 checklist, invoice information and Datix records.	Incorrect reporting of data could impact on decision making and statutory reporting requirements.	Agreed Management Action: Emphasising to staff the criticality of inputting comprehensive and precise data into Datix is essential. Ongoing monitoring processes will be implemented to assess adherence to these data accuracy standards. Efforts to revise the draft Standard Operating Procedures will focus on incorporating detailed guidelines regarding the accuracy and completeness of Datix records. Expected Evidence of Implementation: A communication will be distributed to all staff emphasising the critical importance of accurately documenting details in Datix. Additionally, approval has been granted to designate this system as the exclusive platform for case recording. This consolidation will facilitate secure and centralised data storage, enhancing visibility and accessibility for all relevant stakeholders involved in case management. Furthermore, it will enable the generation of data reports to monitor compliance effectively.

			Draft SOP to be reviewed and updated, ensuring that there is clear information on the accuracy and completeness of recording all relevant information/narrative/progress note updates, and supporting documentation on each of the Datix record(s) /case(s). Ensure the final draft SOP is presented for approval at the Executive Director's weekly meeting on Monday, 22nd August 2025. Following this, a soft launch will take place, with full implementation starting on 1 September 2025. Cleansing of Datix system to ensure all cases are relevant and current. Access to the relevant Datix modules has been provided to the Senior Finance Officer – Losses to reconcile payment/financial details and record the same.
		Medium Priority	Officer: Assistant Director of Patient Care & Safety Target Implementation Date: 31 August 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
2	Timeliness of submissions to WRPS LFERs must be completed within 60 working days of the decision to settle for CN & PI cases, or the Health Board's Qualify Liability (QL) confirmation date for Redress cases. For cases after September 2023, the deadline changed to 4 months. <u>LFERs</u> 8/11 CN cases the LFER was not submitted within 60 working days. The lengthiest time being 846 days. - For the one PI case, the LFER due date had been incorrectly input in Datix and was showing as due 736 days after the decision to settle date, as opposed to 60 days. There was also a difference of 968 days between the decision to settle date and the date the LFER was sent to WRP. 2/8 Redress cases, the LFER was not submitted within 60 working days. One took up to 158 days from the QL date before it was submitted to WRP. CMR and U1/U2 checklists should be submitted to WRP within four months of the final payment date. <u>CMR and U1/U2 checklist:</u>	Financial loss to the Health Board if WRP fail to reimburse untimely claims.	Agreed Management Action: All staff members will receive a reminder about the critical importance of adhering to the timeframes outlined by the WRPS. It is essential that everyone understands how meeting these deadlines contributes to the overall success of our initiatives. Furthermore, we will implement a monitoring process to track submissions related to the WRP. This will involve regular assessments to ensure compliance with the specified timelines and to identify any areas where support may be needed to improve timely submissions. This initiative aims to enhance our efficiency and effectiveness in achieving the standard. Expected Evidence of Implementation: Staff must adhere to the timeframes set by WRPS to ensure compliance with regulatory standards. An internal audit plan will be formulated to systematically monitor compliance with WRP submissions. Findings from these audits will be communicated during Legal Team meetings and

4/11 CN cases the CMR and U1 checklist did not meet the submission deadline date.		weekly LFER data review sessions, and significant issues will be escalated to the Executive Directors as necessary. A thorough cleanse of all records in the Datix system will be undertaken to ensure that the current caseload is accurately reported and monitored. Particular emphasis will be placed on addressing legacy cases identified during this process. The Head of Quality & Patient Safety from each Care Group will participate in weekly LFER data review meetings. These sessions will facilitate discussion and updates to ensure all LFER spreadsheets are reconciled. They will also provide a comprehensive weekly update on deferred LFER cases, specifically highlighting any that require escalation to the Executive Director. Senior Finance Officer - Losses is now included as a member of the weekly LFER data review meeting. WRP activity to be coordinated by named individuals from within the Legal Services team. SOP to be developed with KPIs and timelines for compliance. NEW PI process approved and implemented from July 2025 (action links with Obj 5, key finding 6)-full launch from 1 August 2025.
		Officer: Assistant Director-Patient Care & Safety Target Implementation Date: 22 August 2025
Theme: Planning, Delivery & Deadline Management	Control Operation	

Overview

From our sample of 20 CN, PI and redress cases, total payments just below £950,000 were made in relation to costs such as court fees, medical reports and solicitor fees. Our review of the Datix files identified that not all supporting information had been saved. This included missing invoices relating to a small number of cases, and a missing Losses and Special Payments Register (LaSPAR) schedule.

We also found one instance where an invoice in excess of £10,000 for defence solicitor fees, was received after the WRPS reimbursement had been submitted and paid. As such, this amount has not been re-claimed from WRPS.

Key Findings		Risk & Impact	Agreed Management Action
3	Completeness of information We were unable to locate all of the financial documentation relating to the 20 cases in our sample. - One sampled case did not have a Losses and Special Payments Register (LaSPAR) schedule attached within Datix, therefore an accurate reconciliation of costs could not be carried out for the case. - Three court fees invoices totalling £550 relating to one CN cases were not on file. Although we note that other information on file confirmed that an appropriate payment had been made. - Six invoices related to counsel fees and expert fees for one PI case were not available on file. The total value of these invoices was less than £5,000.	Financial loss to the Health Board if an appropriate evidence trail is not available.	Agreed Management Action: Staff must save all case-related documentation in the Datix file.
			Expected Evidence of Implementation: Correspondence will be sent to the Legal Services team, informing the team of the expectations in processing all documentation through Datix. This system will be the single point of recording per case, ensuring accurate, up-to-date progression of each case and clear visibility during all stages of the case. Closer links will be made with the Senior Finance Officer—Losses to ensure cost reconciliation and appropriate recording of all payment activity on Datix. Meetings with Senior Finance Officer – Losses to be established with individual Case Handlers as required. The Senior Finance Officer – Losses has been invited and attends the weekly data review meetings.
	Theme: Information, Data Quality & Data Accuracy	Medium Priority Control Operation	Officer: Assistant Director – Patient Care & Safety Target Implementation Date: 8 August 2025

4	Delay in processing invoice A £12,000 solicitor fee invoice for the PI case sampled was not captured on the U1 checklist submitted to WRP despite it being received prior to submission. When the invoice was processed, four months later, it was not identified that it related to a closed case. Consequently, no claim was made to the WRP to reimburse this amount.	Financial loss to the Health Board if invoices are not processed correctly.	Agreed Management Action: To recover the missed payment for the PI case of £12k invoice, Claims Handler to submit a request for additional reimbursement to WRP, with the necessary U5 documentation, in accordance with WRP reimbursement guidelines. Staff must confirm with Legal and Risk that all costs are accounted for and reconciled with the financial lead before submitting reimbursement requests to WRP. All records should be documented on Datix. The process for submitting and claiming missed invoices will be reviewed and included in the newly developed PI SOP.
	Expected Evidence of Implementation: Email for Executive approval to submit late U5. Email request and Exec Approval. Email submission and U5 to WRP (outcome of reimbursement claim awaited).		
	Medium Priority		Officer: Business Manager Quality & Safety, Patient Care & Safety team
	Theme: Finance Management & Control	Control Operation	Target Implementation Date: 15 August 2025

Overview

Each case should have a CMR form on file. The CMR form should be signed by the claims manager and two senior officers of the 'responsible body': one being the Chief Executive; and the other a person aligned to the Health Board's scheme of delegation.

All PI and redress cases that we tested had appropriate 'Responsible Body' declarations on the CMR. However, in a small number of CN cases, the forms were not completed or authorised in line with requirements.

Key Findings		Risk & Impact	Agreed Management Action
5	Authorisation of forms Our testing of 13 CMR forms relating to CN cases identified: 1/13 the form was only signed by the CEO, with the Claims Manager Declaration and Governance Declaration left blank. 1/12 one of the signatories on the governance declaration was the Board Secretary, who is not listed in the scheme of delegation as able to authorise these forms. 1/12 was signed by the Deputy Executive Director of Nursing and the Executive Nurse Director. Although both are authorised signatories, the CMR form states that one of the signatories should be the CEO. 1/11 the CMR had been signed by the Executive Director of Nursing twice. This was also a finding in last year's audit.	Inappropriately authorised documentation submitted causing delays in reimbursement.	Agreed Management Action: The Legal Services team lead will emphasise that Case Management Review forms must be: a. Fully completed before authorisation. b. Authorised according to the scheme of delegation. c. Authorised by two different individuals; one person cannot sign in different capacities. Updates to the draft Standard Operating Procedures will provide clear guidance on completing and authorizing CMR forms. Expected Evidence of Implementation: To ensure adherence to CMR requirements, the necessity of comprehensive form completion must be reiterated. This includes confirming that all declarations are duly signed and that two distinct individuals are responsible for signing off on the forms. These requirements will be incorporated into the revised Standard Operating Procedure (SOP). Additionally, we must review signatory roles to ensure they align with the current Scheme of Delegation established by the health board. The updated SOP will be presented for approval at the upcoming weekly Executive meeting, facilitating clear directives regarding the authorisation process for CMR forms. Upon approval, the SOP will be disseminated via email and during Legal Services team meetings with all Case Handlers. There will also be discussions to ensure awareness and understanding at the weekly data review meeting, which includes all Legal Services

			Officers, Heads of Quality & Patient Safety, and finance colleagues, coordinated by the Assistant Director.
		Medium Priority	Officer: Assistant Director-Patient Care & Safety Target Implementation Date: 31 August 2025
	Theme: Approvals	Control Operation	

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

Substantial

Overview

All of the 20 reimbursements that we tested were appropriately approved by WRPS. The U1 /U2 checklists ensure accurate recording and appropriate authorisation of claim costs reimbursed by the WRP. The amounts received reconciled to the U1 /U2 checklists and the finance schedules that were submitted to WRPS.

Overview

For a number of years, the Health Board has struggled to submit LFER to WRPS in line with their required timeframes. During our previous WRP audits we have seen work undertaken to improve the LFER submissions to ensure they are more timely and comprehensive. However, the WRP 2023/24 annual report identified that the Health Board was still struggling in relation to these matters. In October 2024 the Audit and Risk Committee were made aware of the WRP report and were informed of the Patient Care and Safety team planned to develop an action plan to address the matters raised in the report.

The action plan is comprehensive and sets out the WRP recommendations, the actions to be taken, responsible officers, and timeframes for completion. We understand that the action plan has been provided to the Head of Safety and Learning in WRPS, and we understand that the Patient Care and Safety team assurance meetings monitor progress against the action plan.

At the time of our 2023/24 internal audit, the Standard Operating Procedures (SOPs) for managing CN, PI and Redress claims were being updated. At the time of our fieldwork this year the SOPs remain in draft. We acknowledge that the department has experienced significant staffing issues and has lost key team members, which may have impacted on the ability to update these documents.

Key Findings		Risk & Impact	Agreed Management Action
6	Standing Operating Procedures Over a number of years, the claims management team have been working to update their SOPs to reflect changes brought in by WRPS, and to reflect recommendations made in our previous audit reports. The SOPs remain in draft.	Inconsistent approaches are in place to recording and capturing information meaning inaccurate reporting.	Agreed Management Action: The Standard Operating Procedure (SOP) section will be reviewed to ensure that previous recommendations have been addressed and implemented. 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. Expected Evidence of Implementation: Draft SOP to be reviewed and updated to ensure a standardised and consistent approach to recording and capturing of information. Present draft SOP for approval by Executive Directors at the weekly Executive Director Quality & Safety meeting on 25th August 2025. Evidence of training sessions delivered to all Case Handlers will be undertaken; however, this will be in line with the All-Wales approach, and therefore, the completion date for this action is dependent on it. PI SOP revised process, updated, consulted on with key stakeholders, feedback received, reviewed and where appropriate

			included. SOP presented to Exec weekly meeting on 21 July 2025 for approval.
		Medium Priority	Officer: Assistant Director-Patient Care & Safety
	Theme: Policies & Procedures	Control Operation	Target Implementation Date: 31 August 2025, with acknowledgement that compliance with the training sessions is dependent on the release of the All-Wales approach.

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.

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Audit recommendations tracker review

Final Internal Audit Report

2024/25

Cwm Taf Morgannwg University Health Board



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Review Reference

CTM-2425-26

Fieldwork

May - June 2025

Executive Sign Off

12 June 2025

Audit Committee

August 2025

Executive Lead

Gareth Watts, Director of Governance/Board Secretary

Audit Team

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



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Executive Summary

Purpose

To review the process that Cwm Taf Morgannwg University Health Board (the 'Health Board') has in place in relation to its audit recommendations tracker process. We have also considered how the Health Board's new tracker system is embedding.

Overview

The Health Board maintains a tracker of all recommendations made in internal and external audit reports, and Health Inspectorate Wales (HIW) reviews. Responsible officers are required to provide updates to the tracker on the progress that has been made in implementing agreed recommendations, to the point recommendations are deemed completed, closed and removed from the tracker. The tracker and update reports are included on the agenda for each meeting of the Audit, Risk and Assurance Committee (ARAC) for scrutiny by members.

In early 2024 the Health Board switched from using a spreadsheet tracker, to using the Audit Management and Tracking (AMaT) system. The AMaT system was designed for capturing information in relation to clinical audit activity. The Health Board is adapting AMaT to meet its needs in relation to a more general audit tracker system. The Health Board is also working to refresh and cleanse the data transferred from the spreadsheet tracker and refining the tracker dashboard presented to the ARAC. This work includes identifying historical actions where the current process may differ to that which was considered during the original audit fieldwork, meaning that the risks originally identified may have been mitigated through a change in process.

We have concluded reasonable assurance on this area and have highlighted some areas which require management attention. These are:

- The process ahead of for closing recommendations needs to be further embedded to ensure appropriate scrutiny before removal from the tracker.
- Undertaking more in-depth monitoring and allowing greater challenge of actions where target implementation dates are extended.
- Full details of matters arising are detailed within the Findings & Agreed Action Plan.

The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- Monitoring should take place of the number of actions where no updated are provided for the ARAC meeting. Should the number increase, the data should be reviewed to identify common areas and the lack of updates raised with relevant executive leads.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	There is a process for ensuring the completeness of the tracker with all agreed recommendations made in Internal Audit, External Audit and HIW reports.	-	Substantial
2	There is a robust process for closing recommendations and removing them from the tracker once management believe they have been implemented or superseded.	1	Reasonable
3	Where management updates to open recommendations are not provided, these are highlighted to the Executive Leadership Group.	-	Substantial
4	Where implementation dates for open recommendations are put back, appropriate scrutiny, explanation and consideration is given to the associated risk of delayed implementation.	2	Reasonable

Management Actions



High Priority



Medium Priority

Themes



■ Governance

Risk Types

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: There is a process for ensuring the completeness of the tracker with all agreed recommendations made in Internal Audit, External Audit and HIW reports

Substantial

Overview / Summary of Observations

Following each ARAC meeting, the recommendations, management actions and other relevant information from the Internal and External Audit reports presented at the meeting are captured in the AMaT database by the Quality Assurance & Compliance. The team have developed a guidance document that explains the process to be followed when recording audit information in AMaT.

The Quality Assurance & Compliance Team have also developed a 'Tracker User Guide'. This is for AMaT users within care groups and central corporate departments and sets out the process to follow when providing updates to open actions. New users of the AMaT system area provided with training by the Quality Assurance & Compliance Team.

We tested a sample of Internal Audit, Audit Wales and Health Inspectorate Wales (HIW) reports that had been presented ARAC, or in the case of HIW reports, the Quality, Safety & Experience Committee, over the past year. Our testing confirmed that all recommendations and actions from the sampled reports had been accurately transferred to the AMaT system for inclusion on the Health Board's audit tracker.

Overview / Summary of Observations

Within the tracker user guide there is a timetabled process that outlines the criteria relating to the close down and removal of implemented recommendations from the audit tracker. Automated emails from the AMaT system to assigned management leads prompt the lead to provide updates for their actions. Regular reminders are also sent to business managers by the Quality Assurance & Compliance Team in relation to the open actions for their area of the Health Board.

Where actions are marked for closure, the user guide sets out the information that assigned management leads should record in AMaT to confirm that there has been appropriate oversight ahead of closure. We note that this part of the process is not yet carried out in its entirety by care groups /central corporate departments. We are aware that the COO’s business management team are in the process of developing their own guidance notes to ensure this element of the process is taking place and that there is a review of those actions marked for closure.

Once the timeframes for updates have passed, the tracker report is generated from the AMaT system, and a dashboard is produced. The tracker report lists the current status of all actions. This will include those recommendations marked for closure as assigned management leads believe the actions to implement the recommendation have been completed. The tracker report and dashboard are presented at an Executive Leadership Group (ELG) and/or Executive Management Board (EMB) meeting ahead of being presented at an ARAC meeting. We understand that whilst the tracker information is discussed at ELG/EMB, there is no detailed discussion around the recommendations proposed for closure at each meeting, however, the need for timelier review of overdue actions has been noted.

We reviewed a sample of actions that had been marked as completed and removed from the tracker since April 2024. In the majority of cases, we were able to confirm that it was appropriate to close the actions, however we identified a small number of cases where it appeared that the action had been closed in error or too soon.

Key Findings		Risk & Impact	Agreed Management Action
1	<u>Actions closure process</u> We reviewed a sample of 53 high and medium priority actions that had been marked as closed from seven internal audit reports and obtained evidence from the assigned leads to support the closure of those actions. We identified one report that contained four actions that were closed in error. We also identified two closed actions from another report, where the narrative of the action taken did not correspond to the agreed management action stated to address the recommendation. We therefore felt these actions should not have been closed. The user guide states, 'As part of closure assurance when you mark your action to "Fully Complete (Awaiting Approval)" we will be seeking confirmation of appropriate oversight of closure i.e. by your Directorate Team Meetings / Senior Management Teams	Failure to have an effective system in place to provide assurance that recommendations are tracked, progressed and monitored.	Agreed Action: In accordance with the Audit Tracker User Guide: 1. The Quality Assurance & Compliance Team in its next routine call for updates will reiterate the requirement to ensure that audit action leads provide a narrative update confirming where 'sign off' has been received and this will be captured in the "Comments/Updates" box for each individual action. 2. The Quality Assurance & Compliance Team will update the User Guide to reflect the change in location for the 'sign off' narrative and circulate this with the next routine call for updates.

<i>so please add this to your update.</i> For the sample we selected, we did not see notes added to the AMaT system in line with the guidance. We understand that as the AMaT system and associated processes are still relatively new, the requirement to seek and record the oversight of closure is yet to embed. Our testing shows some actions have been closed when they should not have been.		Expected Evidence of Implementation: Comments/updates function in AMaT being used to record confirmation that actions have been agreed for closure.
Theme: Governance	Medium Priority Control Operation	Officer: Assistant Director of Governance & Risk and Head of Quality Assurance & Compliance Target Implementation Date: 31 August 2025

Objective 3: Where management updates to open recommendations are not provided, these are highlighted to the Executive Leadership Group.

Substantial

Overview / Summary of Observations

As part of the process followed prior to each ARAC meeting, assigned management leads are required to provide a narrative update for each of their actions. This process continues until actions are marked as completed and are then removed from the tracker. Where the management leads fail to provide an update, this is highlighted in the tracker to say that no update was provided in that period.

Our review of the tracker reported to the February 2025 ARAC identified there were 192 open management actions. For seven, no update was provided. This is an improvement from previous tracker reports where we saw more actions with missing updates, including some with no updates for consecutive meetings.

Whilst the tracker is reported at ELG/EMB ahead of ARAC, detailed discussion is not held on those actions where no update has been provided. Given the current improved position in relation to missing updates, we have not raised a key finding at this time, although the lack of updates is something that should be monitoring going forward.

Objective 4: Where implementation dates for open recommendations are put back, appropriate scrutiny, explanation and consideration is given to the associated risk of delayed implementation.

Reasonable

Overview / Summary of Observations

In addition to the tracker, listing all open actions, a tracker dashboard is presented to each ARAC meeting. The dashboard includes information on the number of open recommendations that have passed their original due date. The information is categorised by priority rating and by length of time they are overdue. The dashboard does not give any breakdown for example by care group/central corporate department, or if the overdue actions mostly relate to certain audit reports, although this information can be obtained from the tracker.

We are aware of the work that is being carried out to cleanse the tracker and to allow more refined data to be captured in the dashboard. Through our attendance at ARAC meetings we are aware that during this period there has been less discussion in relation to the dashboard and its contents. Once work to cleanse the tracker has been completed, there can be more detailed analysis and more meaningful discussions at ARAC meetings. Members will be able to better scrutinise the data and hold management to account where dates are extended and the impact of the risk of date changes / inactions on the Health Board.

The tracker dashboard is also presented at the ELG / EMB meetings. We understand that whilst the report is reviewed, there is not always detailed discussion around areas where there are a higher number of overdue actions.

Key Findings		Risk & Impact	Agreed Management Action
2	<u>Analysis of overdue actions</u> The February 2025 tracker identified 192 open actions, of which 128 were overdue, although 30 were marked for closure at that meeting. Our analysis of the remaining 98 actions identified: 40/98 (41%) had no revised target implementation date, despite the original target date being in 2023 or 2024. Whilst most had narrative updates, it appears the 'revised target date' had been missed. We note that 14/40 were high priority findings. 26/98 (27%) had target implementation dates that were a year later than their original target date. Some target dates were up to three years after the original target date (7 high, 17 medium, 2 low priority recommendations). Whilst information on the status of overdue actions is captured in the tracker dashboard, there is no breakdown by care group or central corporate department. Though the narrative report accompanying the dashboard gives an overview of the change in position from the previous ARAC meeting.	Unreliable assurance provision and inaccurate reporting of the Tracker within the Health Board.	Agreed Action: 1. A review of the Tracker Report submitted to ARAC meetings is underway following discussion with ARAC Members. The review will capture a renewed emphasis on overdue actions and the performance dashboards within the cover paper will provide a more detailed status trajectory. 2. The performance dashboard data captured within the cover paper of the tracker report is and will continue to be derived from the original implementation date and not the revised implementation date(s). The revised report will identify the number of days overdue from the original date allowing more focus on those actions with continuous extensions and areas of concern where pace of progress is slow.
			Expected Evidence of Implementation: A more refined tracker that allows better scrutiny and challenge to take place.
	Theme: Governance	Medium Priority	Control Operation

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.

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Decarbonisation (follow up)

Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board

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Status of Previously Agreed Recommendation 2

Appendix A 5



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Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services



Review Reference

CTM-2526-30

Fieldwork

July 2025

Executive Sign Off

August 2025

Audit Committee

August 2025

Executive Lead

Claire Thompson – Executive Director of
Strategy and Transformation

Audit Team

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal
Audit

Executive Summary

Purpose

We completed a follow-up review of the implementation of the agreed management actions from our decarbonisation audit that was issued in May 2024. This follow up review was completed in line with the 2025/26 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

In our original report we issued a 'limited' assurance¹ opinion and identified five high or medium priority matters arising. Management agreed eight actions to address the matters arising and the associated recommendations. The Audit, Risk and Assurance Committee has monitored the progress being made in implementing the management actions, via the internal audit tracker.

Overview

We identified five overarching high and medium priority matters arising, three of these matters had a number of parts, meaning that there were eight agreed actions to follow up. Our review has identified the following:

Original Priority Rating	Number of Recommendations/ agreed actions	Implemented/ obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented/ Not due (Further action required)
High	5	4	1	-
Medium	3	-	1	2
Total	8	4	2	2

Full details of agreed actions requiring further work are provided in the table below. Where work is ongoing, we have re-assessed the priority rating for the recommendation and revised these where appropriate.

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:

- Updating the terms of reference for the Environmental Sustainability Group (ESG) to reflect current membership requirements to ensure representation from each work stream.
- More comprehensive ESG minutes capturing the department or workstream that members are representing.
- A Sustainability Manager commencing in post in June 2024 with responsibility for developing and implementing the decarbonisation strategy and action plan.
- Update reports from each of the workstreams are now received at ESG meetings, allowing more meaningful updates on progress in implementing the Decarbonisation Action Plan (DAP).

¹ Limited Assurance definition 'More significant matters require management attention. There will be moderate impact on residual risk exposure until resolved'.

Progress of Agreed Recommendations Not Fully Implemented

Ref	Previous Recommendation and Action	Original Responsibility, Timescale	Priority Rating	Status, Updated Action, Responsibility and Timescale	Revised Priority Rating
4.1	Costed plan and funding strategy <u>Recommendation:</u> 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. <u>Agreed Action:</u> 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.	Vicki Oxley – Deputy Director of Strategy and Partnerships March 2025	High Priority	Status: Partially Implemented Since the Sustainability Manager commenced post, some work has taken place to populate investment requirements against the initiatives listed in the Decarbonisation Action Plan. We understand the difficulty in developing a fully costed plan, hence our previous recommendation to only cost those initiatives that can be quantified and to note those that are unquantifiable. We also acknowledged that whilst the costs associated with delivery of an initiative may be identified, this does not mean the funding is then available to support delivery of the initiative. Agreed Action: Work will continue to identify the potential costs of undertaking the initiatives set out in the Decarbonisation Action Plan, with a view to being able to develop a longer-term model for funding. Those initiatives that cannot be quantified will be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not. Given the changes to the SDP this will be reviewed following its publication in 'Autumn' to avoid duplication of work. Officer: Calum Shaw – Sustainability Manager Target Implementation Date: March 2026	High Priority
4.2	<u>Recommendation:</u> For those initiatives that can be quantified, a long-term model for the funding required to support the	Claire Thompson – Executive Director of Strategy and Transformation	High Priority	Status: Not due We note that this action is not due for implementation until March 2026. Though we understand information has started to be gathered as part of the longer-term investment requirements.	High Priority

Ref	Previous Recommendation and Action	Original Responsibility, Timescale	Priority Rating	Status, Updated Action, Responsibility and Timescale	Revised Priority Rating
	decarbonisation programme should be developed. <u>Agreed Action:</u> This recommendation needs to be undertaken in partnership with Welsh Government (through Directors of Planning/Directors of Finance channels) as the UHB works within its revenue and capital resource limits. For example, a key component of the UHB's capital planning is maximising access to funds available from Estates Funding Advisory Board for decarbonisation (which provided £0.9m in 23/24).	March 2026		Agreed Action: <i>Where initiatives to aid the achievement of the WG Decarbonisation target can be quantified, a long-term model for the funding required to support the decarbonisation programme should be developed.</i> Officer: Calum Shaw– Sustainability Manager Target Implementation Date: March 2026	
5	Carbon consideration in decision making <u>Recommendation:</u> Carbon impact assessments should form part of the decisions made and actions taken by the Health Board, especially in larger scale transformational projects. <u>Agreed Action:</u> 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.	Vicki Oxley – Deputy Director of Strategy and Partnerships March 2025	Medium Priority	Status: Partially Implemented Reports taken to the Board and its committees require the environmental sustainability impact to have been considered and captured in the cover report. Reference to this revised process is mentioned in the 2025/28 IMTP and we understand there have been Board briefing sessions to raise awareness further. However, we did not see evidence that in larger scale transformational projects due consideration has been given to environmental sustainability and the carbon impact. We note that the May 2025 updated audit tracker - acknowledges that 'more work is required to ensure decarbonisation and climate adaptation forms part of decision making'. Agreed Action: Where larger scale projects take place, mechanisms will be put in place to ensure the carbon impact / environmental sustainability impact is assessed and captured as part of the decision-making processes.	Medium Priority

Ref	Previous Recommendation and Action	Original Responsibility, Timescale	Priority Rating	Status, Updated Action, Responsibility and Timescale	Revised Priority Rating
				Officer: Calum Shaw– Sustainability Manager Target Implementation Date: December 2025	
6.2	Monitoring and reporting <u>Recommendation:</u> The reporting format (to Board / Committee) should be supplemented to include a narrative report that allows readers to gain a clear understanding of the current position of the Health Board in achieving the initiatives in place for each workstream and the overall position against the Welsh Government targets. Reporting on progress in implementation of the DAP to the Population Health and Partnership Committee should take place at regular intervals, as set out in the ESG terms of reference. <u>Agreed Action:</u> The Health Board accepts this recommendation and the reporting arrangements for the Environmental Sustainability Group will be reviewed.	Vicki Oxley – Deputy Director of Strategy and Partnerships September 2024	High Priority	Status: Not implemented The updated terms of reference for the ESG set out that it now reports to the Strategic Development Committee (SDC). The requirement for bi-annual reporting remains unchanged. Whilst a report was produced for November 2024 committee, it was not presented at the committee and the subsequent agenda item for the April meeting was deferred until October 2025. Agreed Action: In line with the terms of reference for the ESG, bi-annual update reports will be provided to the Strategic Development Committee. Reports will be in a format that allows readers to gain a clear understanding of the current position of the Health Board in achieving the initiatives in place for each workstream and the overall position against the Welsh Government targets. Officer: Calum Shaw – Sustainability Manager Target Implementation Date: October 2025	High Priority

Appendix A

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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.
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Financial systems

Internal Audit Report 2024/25

Cwm Taf Morgannwg University Health Board



Substantial Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-2425-21

February - April 2025

17 June 2025

14 August 2025

Sally May, Director of Finance

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



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Executive Summary

Purpose

Our review of the petty cash and losses and special payments elements of Cwm Taf Morgannwg University Health Board’s (the ‘Health Board’) financial systems was completed in line with the 2024/25 Internal Audit Plan.

Overview

The Health Board has a number of Financial Control Procedures (FCPs) that set out the procedures and processes that should be followed to ensure appropriate controls in relation to the use of financial resources. Our review focussed on the FCPs for petty cash and losses and special payments.

Petty cash is used to reimburse low value purchases where it would not be appropriate to raise an official order. Petty cash may also be used for refunding of patient travel expenses and patient money withdrawals.

Losses relate to the loss of cash or property, whereas special payments are payments that fall outside of the normal day to day business of the Health Board and for which no statutory authority to pay exists, for example voucher payments to staff on retirement.

We have concluded substantial assurance on this area. The matters requiring management attention include:

- Better completion of the documentation used to request reimbursement from petty cash floats, especially in relation to financial coding.
- Better completion and submission of ex-gratia claim forms, especially ensuring approval and segregation of duties.

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:

- Regular reconciliations of petty cash floats should be undertaken and petty cash holders should be reminded of the requirement to notify the cashier when a discrepancy is identified with a cash float.
- Petty cash holders should be reminded that all replenishment documentation must be fully completed and signed.
- Consideration should be given to providing a copy of the Losses and Special Payments Schedules to the Audit, Risk & Assurance Committee at least once a year.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Petty Cash	1	Substantial
2	Losses and Special Payments	2	Substantial

Management Actions

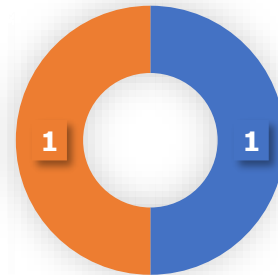


High Priority



Medium Priority

Themes



■ Finance Management & Control

■ Governance

Risk Types

Public Perception & Reputational Risk

Financial Loss

Findings & Agreed Action Plan

Objective 1: Petty Cash	Substantial

Overview / Summary of Observations

Policies and Procedures

The Petty Cash FCP sets out responsibilities in relation to petty cash and provides guidance on reimbursements and reconciliations. The FCP has recently been updated and is accessible to staff via the Health Board intranet. Training is provided to relevant staff on commencement of employment. The Finance Department maintains a schedule detailing the value and location of all petty cash floats.

Petty Cash Expenditure

Our testing of a sample of petty cash transactions established that the process for reimbursing expenditure is generally well managed. However, we identified instances inaccuracies and inconsistencies in relation to the financial coding of expenditure on some documents. We also saw different versions of the petty cash voucher being used.

New Funds & Increase in Floats Balance

We confirmed that no new petty cash floats were set up in 2024/25. Where there were increases to existing floats, these were approved by the Head of Corporate Finance, in accordance with the FCP.

Security Arrangements

Our testing of a sample of petty cash floats established that the security arrangements were appropriate. All floats were held in a safe or locked drawer with access restricted to relevant staff.

Reconciliations

The FCP requires petty cash float holders to perform a weekly reconciliation of their float. Most of the areas we visited undertake these reconciliations as it forms part of the cash replenishment process. However, this is not the case for all.

Our checks on a sample of petty cash floats identified minor discrepancies in relation to two floats. These discrepancies had not been notified to the cashier which is not in line with the FCP.

We understand that due to staff resource constraints, it has not been possible for the central monthly reconciliations between the general ledger petty cash balance and total of individual floats to be carried out.

Replenishments

For the sample of petty cash floats that we tested, the replenishment interval was appropriate. We identified some minor issues where some supporting documentation not always fully complete. All replenishment requests were accounted for correctly within the financial ledger.

Monitoring of Floats

During 2024/25 finance staff have reviewed the petty cash floats to determine if they are still required or if cash levels can be lowered. We understand that during 2025/26 it is the intention to undertake monitoring on more regular and formal basis.

Key Findings		Risk & Impact	Agreed Management Action
1	<u>Petty Cash Expenditure</u> Our testing of a sample of 33 transactions from 11 petty cash funds to ensure compliance with the process detailed in the FCP identified the following: • 2/33 failure to record the financial code on the petty cash voucher. • 21/33 where the incorrect financial code (specifically subjective code) had been used in relation the type of item purchased. • 7/33 where there was inconsistency in the financial code used to record patients travelling expenses. • 2/33 the approval officer details were illegible. • Different versions of the petty cash vouchers in use.	Inaccurate reporting due to expenditure being miscoded.	We will issue a reminder to all staff that all petty cash vouchers must include a valid and appropriate financial code. We will liaise with Financial Management colleagues to ensure that they provide budget holders/managers with appropriate financial codes for their areas. We will review the reporting requirements for patients travelling expenses to determine the correct financial code to be used and then inform all relevant staff. We will ensure that the correct version of the petty cash voucher is provided to relevant staff. We will consider including the voucher within the FCP when it is next reviewed, so staff can access the correct version. We will also consider amending the voucher to allow for the 'approver' to print their details.
		Medium Priority	Expected Evidence of Implementation: Copies of emails issued to staff to be kept.
	Theme: Finance Management & Control	Control Operation	Officer: Adele Lewis, Senior Finance Manager - Financial Accounting Target Implementation Date: August 2025

Overview / Summary of ObservationsPolicies and Procedures

There is a losses and special payments FCP in place that details the processes and responsibilities for reporting of losses and special payments. The FCP has recently been updated and is accessible to staff via the intranet. In addition, the finance department have developed local guidance to be followed for the monthly and annual 'tasks' to be completed.

Losses and Special Payments Process

Whilst there is a defined process for the reporting of losses and claiming of ex-gratia payments our testing to ensure compliance with this process identified some issues including the use of incorrect forms, forms not fully completed, including a number of cases where the approval section had not been completed, illegible signatures and lack of segregation of duties.

Approval of Losses and Special Payments

The FCP and Health Board's Standing Financial Instructions (SFIs) sets out which members of staff can approve losses and special payments, and their financial limits. We identified instances where there was a lack of segregation of duties between payment requestor and approver. We also note that the approval section of the ex-gratia claim form was not completed in a small number of cases. Where forms were completed, we confirmed that the payments were within delegated financial limits.

Losses and Special Payments Register (LaSPaR)

The Health Board maintains a register of losses and special payments that is updated monthly. Our review of a sample of entries confirmed that all payments had been correctly classified according to the type of loss or special payment that they were. However, our testing identified a duplicate entry on the register although we confirmed that a duplicate payment was not made. We also note that the finance section of the ex-gratia payment form, to confirm that the register had been updated, had not been completed for the sample we tested.

Health Board Reporting

In accordance with the Audit, Risk & Assurance Committee's terms of reference and the FCP, we confirmed that a report on losses and special payments is submitted to the Committee for formal approval on a quarterly basis. The report provides details of the previous quarterly activity as well as the year to date. At the Committee's request, the format and contents of the information captured in the report changed during 2024/25. The Committee now receives a written report as opposed to detailed information on all payments made. Committee members can request the detailed information at any time from the finance team. Whilst we have been informed that this change is working well, as good practice it may be beneficial for the Audit, Risk & Assurance Committee to be provided with the more detailed breakdown once a year, at year end.

Key Findings		Risk & Impact	Agreed Management Action
2	<u>Special Payments</u> Our testing on a sample of 20 special payments relating to ex-gratia payments, ombudsman payments and retirement vouchers identified the following issues: Process For 2/8 ex-gratia payments an incorrect form was submitted in addition to the correct ex-gratia claim form. The additional form submitted should only be completed for claims relating to the loss of Health Board property. There were seven instances where not all sections of the form had been completed, or signatures were illegible. There was a lack of segregation of duty for one payment as it was requested, endorsed and approved by the same person. We also identified a duplicate entry on the register that related to a replacement cheque for a previous payment. Approval All six ombudsman payments had been requested and approved by the same person. We acknowledge that all payments were less than £500 and had been made at the request of the ombudsman. For 2/8 ex-gratia payments the approval section of the form had not been completed. Finance Section / Register None of the ex-gratia payments forms had the finance section of the form completed, confirming that the LaSPaR had been updated.	Reputational damage if payments are deemed inappropriate or transactions are fraudulent	We will remind all appropriate staff that all sections of the Ex-Gratia Claim form must be completed. We will also advise staff to print their name alongside their signature. We will review the training arrangements for Losses and Special Payments to ensure that staff are aware of the correct form to be completed. We will implement checks to ensure that Ex-Gratia claims are appropriately authorised before payment is made. We will also ensure that any future payments as a result of Ombudsman resolution are subject to an appropriate segregation of duties.
			Expected Evidence of Implementation: Copies of emails issued to staff to be kept. Appropriately authorised and completed Ex-Gratia forms available for review.
	Theme: Governance	Medium Priority Control Operation	Officer: Sion Waterworth, Senior Finance Officer – Losses Target Implementation Date: Immediate

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 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.



Access to Diagnostics Criteria

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

CTMUHB-2425-03

March - June 2025

August 2025

August 2025

Gethin Hughes, Chief Operating Officer

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

Our audit review of access to diagnostics was undertaken in line with the 2024/25 internal audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

Patient access to diagnostics in NHS Wales has been a focus of recent efforts to improve healthcare services. Diagnostics are a critical component of most patient pathways, forming the evidence base for clinical decision-making. Therefore, prompt access plays a key role in achieving timely care for patients and in doing so, helps the Health Board improve its referral to treatment times. The Welsh Government's performance framework for NHS Wales sets out the expectation that no patient should wait more than eight weeks, from the time of referral, to receive their diagnostic test.

The term diagnostic modality refers to a specific method or technology used to diagnose diseases and medical conditions and are grouped within the Health Board by areas of clinical specialty. Each modality supports a range of diagnostic tests, typically governed by standardised administrative processes implemented by the relevant departments or directorates. Our review encompasses an element of testing linked to all diagnostic modalities across the Health Board and more detailed testing within the Radiology department. Whilst this focus of testing related to Non-Obstetric Ultrasound (NOUS) and Non-Cardiac Computed Tomography (CT) patients, the findings which relate to the general administrative processes, apply to all diagnostic modalities administered by the Radiology department.

Overview

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

- Production of referral guidelines for most diagnostic modalities.
- Documentation of referral checking guidance for most diagnostic modalities.
- Improvements to the clarity of information recorded on test request forms (Radiology).
- The implementation of a planned audit of duplicate referrals (Radiology).

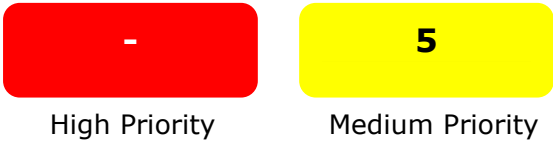
Full details of the matters arising are detailed within the Findings & Agreed Action Plan. We identified the following opportunities for enhancement that do not affect the overall opinion and are highlighted for management information:

- A significant proportion of the referral administrative process is paper based. While efforts are underway to transition to electronic systems, until this is achieved, inherent inefficiencies and the increased potential for delays caused by paper-based systems cannot be eliminated.
- Delays in the receipt of referrals, which originate from sources outside the Health Board or the main health board sites, could be monitored and remedial action implemented where excessive or unexplained delays are identified.

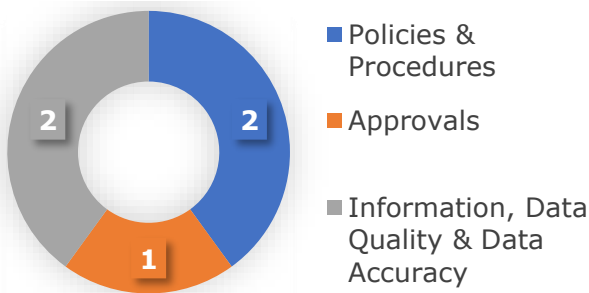
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
All Diagnostic Modalities:			
1	Each modality of diagnostic has clear referral guidance in place and reviews are undertaken to ensure referrals are in compliance with the guidance.	1, 2	Reasonable
Specifically in relation to Non-Obstetric Ultrasound (NOUS) and Non-Cardiac CT:			
2	There is clear guidance in place setting out the when and how referrals should be made.	-	Substantial
3	There is a suitable system in place for capturing referrals and there are adequate procedures/guidance notes in place detailing the process to follow on receipt of referrals.	-	Reasonable
4	Referrals are appropriately vetted and prioritised. There is a process to amend referral priorities where necessary.	3	Reasonable
5	Mechanisms to ensure the waiting lists are validated and checked to ensure accurate and complete.	4	Reasonable
6	There is an appropriate mechanism in place to manage the diagnostic waiting list for 'did not attend' (DNAs) and cancellations (both patient and Health Board).	5	Reasonable
7	There is an appropriate mechanism in place to manage the diagnostic waiting list for 'did not attend' (DNAs) and cancellations (both patient and Health Board).	-	Substantial

Management Actions



Themes



Risk Types

Quality or Safety Issues
Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Each modality of diagnostic has clear referral guidance in place and reviews are undertaken to ensure referrals are in compliance with the guidance. *(All diagnostic modalities).*

Reasonable

We considered three components of referral guidance relating to each diagnostic modality. We ensured clinical guidelines are in place (these are generally published by the National Institute for Health and Care Excellence (NICE), or other recognised institutions), and that they are supported by procedural guidance produced by the Health Board itself. Furthermore, we made enquiries and examined documentation to evaluate the processes in place for checking referrals when they are received.

We requested directorate managers provide details of the referral criteria in place for the diagnostic tests they manage. Responses were received from most areas confirming that clinical guidelines were in place. Where no responses were received, we confirmed that there were NICE or national guidelines. In terms of the comprehensiveness of the Health Board’s own procedural guidance for referrals, this was in place for most modalities. Some services had detailed guidelines, especially where this is explicitly required by regulatory specifications such as within Radiology and Microbiology, but others had less comprehensive guidance in place.

From the responses that we received we note that one procedure, Radiology, included a referral checking process for ensuring referrals follow the guidance. The other diagnostic modalities did not have a checking process included within their procedures.

Key Findings		Risk & Impact	Agreed Management Action
1	Referral guidelines Clinical guidelines are in place for all diagnostic modalities, but Health Board guidance in the use of these guidelines, or in the administration of referrals, has not been produced for all modalities. We contacted directorate managers, with a collective responsibility for 30 diagnostic modalities. We did not receive responses in relation to eight modalities. In relation to the remaining 22 modalities, comprehensive referral guidelines were provided in relation to nine, all of which were operated by the Radiology and Pathology directorates. We obtained guidance for the remaining 13 modalities within Cardiology and Neurophysiology, but these were not comprehensive. The directorate manager’s response in relation to endoscopy examinations indicated that documented guidance was limited or had not been produced.	Inappropriate referrals for diagnostic testing leading to increased diagnostic waiting times and inability to meet WG targets. Failure to deliver efficient services potentially resulting in patient harm and associated financial and reputational implications.	Care Group teams will be instructed to ensure that appropriate referral guidance is produced in relation to all diagnostic modalities and that suitable authorisation and review process are implemented and cascaded.
			Expected Evidence of Implementation: Communications with Care Group Medical Directors and Service directors via email referencing Referral guidance (iRefer guidelines). Also to be discussed through Operational Management Board on 6 August 2025. Will also be added to Diagnostic SIG agenda for 12 August 2025
		Medium Priority	Officer: Carl Verrecchia, Care Group Service Director / Sally Bolt, Care Group Medical Director Target Implementation Date: 14 August 2025
Theme: Policies & Procedures		Control Design	

2	Referral checks There is variation in the referral checking process across the Health Board, and not all processes have been documented. Checking processes for Radiology have been documented, but responses indicated guidance is limited or non-existent in other areas.	Inappropriate referrals for diagnostic testing leading to increased diagnostic waiting times and inability to meet WG targets. Failure to deliver efficiently services potentially resulting in patient harm and associated financial and reputational implications.	Directorate managers should ensure that appropriate referral checking guidance against referral criteria in relation to all diagnostic modalities and that suitable authorisation and review processes are implemented.
		Medium Priority	Expected Evidence of Implementation: Communications with Care Groups and other Service Directors where direct responsibility sits through Operational Management Board. Reported through Diagnostic SIG through to PIT board.
	Theme: Policies & Procedures	Control Design	Officer: Carl Verrecchia, Care Group Service Director / Sally Bolt, Care Group Medical Director Target Implementation Date: Communicated by 14 August to be followed up through PIT programme / diagnostic SIG through 2025 until complete.

Objective 2: There is clear guidance in place setting out the when and how referrals should be made. (*Non-Obstetric Ultrasound and Non-Cardiac CT*).

Substantial

Clinical referral guidelines are in place with respect to Non-Obstetric Ultrasound (NOUS) and Non-Cardiac Computed Tomography (CT) diagnostic examinations. 'Guidelines for Professional Ultrasound Practice' are published by The Society of Radiographers, with the most recent available issued in December 2023, and reference is made to relevant NICE Guidelines in relation to CT referrals.

Further guidelines exist within iRefer, an online repository for referral guidance produced by the Royal College of Radiologists, which is used by health organisations across the UK.

The Health Board's Ionising Radiation Protection Policy (IRPP) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Employers Procedures include additional referral guidelines which relate to all diagnostic modalities operated by the Radiology department.

Between January and December 2024, the Radiology department received over 279,000 test requests, with 93,800 related to Non-Obstetric Ultrasound and Non-Cardiac CT examinations. The supporting guidance is comprehensive and clearly defines roles and responsibilities and the referral processes which may be paper-based or electronic systems. Electronic referrals are received via the Welsh Clinical Portal (WCP) into the Radiology Information System (Radis). Paper referrals are manually transcribed into Radis, and a scanned copy of the original form is kept.

Procedures are in place to ensure that referring clinicians are notified once examinations are completed and the corresponding reports are available for them to view.

We analysed the 2024 incoming referrals for NOUS and Non-Cardiac CT. We found that most referrals were administered promptly. The overall average number of days between a recorded referral date and the date the associated request for a diagnostic is received by the Health Board, irrespective of the urgency of the referral is less than one day. However, from our analysis of average number days based on referral source we saw delays from some referral sources.

Referral source	Number of referrals / requests	Avg. Days – Referral to request received
RGH Psychology OPD	39	9.9
Ysbyty Cwm Rhondda Fracture Clinic	42	8.8
University Hospital of Wales	377	4.9
Breconshire War Memorial Hospital	152	4.3
GP referral	18,015	3.4

Referrals from some sources, specifically those from outside the Health Board are more frequently delayed. The reasons for this are unlikely to be in the direct control of the Health Board, nonetheless, these delays could be monitored and queried with the referral source should they become excessive. We also noted that two of the referral sources with longer average days were internal departments. Again, these referrals could be monitored and action taken if they become excessive, though we understand work is already underway to ensure internal referrals are processed electronically.

Furthermore, the average of 3.4 days between the referral date and the request date for referrals originating from GPs, is a substantial delay compared to the average, and represents the only major source of referrals that significantly deviates from the overall average. We acknowledge that GP referrals are paper based, thus contributing to the time delay between referral date and date received by the Health Board.

Follow up-actions are limited to ensuring that the appropriate reports are uploaded to Radis. A notification is provided to the referrer that the test has been completed, and the report is available, it is the referrers responsibility to take any further follow up actions. In cases where testing has been outsourced, the referrer is contacted by telephone to confirm the completion of the test and availability of the related report.

Although we have not raised a finding in this area, we have rated this objective as 'reasonable assurance'. This is due to variations in average number of days for referrals being received and the opportunity for monitoring and better understanding of these variations.

Objective 4: Referrals are appropriately vetted and prioritised. There is a process to amend referral priorities where necessary.
(Non-Obstetric Ultrasound and Non-Cardiac CT).

Reasonable

Referrals are assigned to appropriate clinicians based on a roster. Referrals are initially prioritised by the referrer, but administrative processes allow clinicians can modify the priority as needed. Any changes made trigger a notification to inform the referrer. Both the original and updated referral details are retained within Radis, ensuring an audit trail of the changes.

We tested a sample of test request forms which showed correct completion by referrers, but inconsistencies in the completion of the review section of the form, such as illegible signatures and missing dates.

The Health Board's IRPP includes several references to the appropriateness of referrals, and Procedure A, which is appended to the IRPP, contains the following provision: *'Where an entitled Practitioner recognises that an entitled Referrer has provided a referral that does not accord with this policy, they shall advise the Referrer directly. Where a Practitioner recognises consistent failures by a particular Referrer, they shall advise the Clinical Director Radiology who may revoke or further limit the entitlement of any Referrer at his discretion'*. This indicates there is process in place to deal with inappropriate referrals.

Key Findings		Risk & Impact	Agreed Management Action
3	Completion of Clinician Details Whilst referral details were correctly recorded on test request forms, further details relating to the examination had not always been recorded or were not easily legible. These details included 'Practitioner's comments / protocol, and the 'Examination Justified By' fields, the pregnancy check, patient ID check, and operator's name.	Inappropriate referrals for diagnostic testing leading to increased diagnostic waiting times and inability to meet WG targets. Failure to deliver efficiently services potentially resulting in patient harm and associated financial and reputational implications.	An email will be issued to all referring teams to reinforce the importance of accurately completing request forms and to remind them of their responsibilities under the employer's procedures in accordance with IR(ME)R. This process is continuously monitored as part of the established IR(ME)R audit schedule within Radiology.
		Medium Priority	Expected Evidence of Implementation: Provide supporting evidence of the email notification and corresponding audit outcomes.
	Theme: Approvals	Control Operation	Officer: Alex Wallace, Radiographer Target Implementation Date: October 2025

Waiting list validation processes are prescribed by IR(ME)R and an audit schedule has been formulated in compliance with IR(ME)R specifications, which incorporates waiting list validation exercises.

Audits included in the schedule that are directly relevant to the validation of waiting lists include a 'Completion of Radiology Referral Form Audit', and an 'IR(ME)R Operator/Practitioner Entitlement' review.

At the time of our fieldwork, we understand that an audit of duplicate test requests was being undertaken at Prince Charles Hospital as an addition to the planned schedule. However, limited evidence was available to show that waiting list validation exercises are routinely undertaken. Our testing identified some instances whereby the status of test requests had not been updated correctly.

Key Findings		Risk & Impact	Agreed Management Action
4	Status errors Out of approximately 90k test requests for NOUS and Non-Cardiac CT examinations received between January and December 2024, 169 cases were identified whereby the status was recorded as 'visit', meaning the patient was listed as currently 'in attendance' at a Health Board facility. We tested a sample of ten request records and in all cases, we found that the status had not been updated correctly following the visit.	Incomplete/inaccurate data leading to an increase in the diagnostic waiting time and potential deterioration of the patient's condition.	Radiographers will be reminded to cancel examinations listed as 'visit' in RADIS when they are no longer required, such as when a subsequent imaging request supersedes the original (e.g., a CT thorax replacing a chest X-ray). This action will be reinforced through targeted communication and monitored through ongoing audit processes.
			Expected Evidence of Implementation: Email alert reminding staff of the importance of cancelling radiology visits that are no longer required. Evidence of an audit identifying any themes or trends as to why examinations haven't been cancelled.
		Medium Priority	Officer: Alex Wallace, Radiographer / Christopher Griffiths, Radiology Clinical Architect Target Implementation Date: September 2025
Theme: Information, Data Quality & Data Accuracy		Control Operation	

Guidelines in relation to the administration of 'Did Not Attend' cases and cancellations have been documented within the Radiology department's Employers Procedures along with a detailed process flowchart.

Our testing confirmed that 'Did Not Attend' cases and cancellations are generally administered in accordance with established guidelines, but controls to prevent and detect duplicate test requests entries have not been adequate.

Key Findings		Risk & Impact	Agreed Management Action
5	Duplicate entries audit We identified cases where duplicate entries had been input to the Radis system. We tested a sample of twenty test request records where the recorded status showed that the requested test had not taken place, eight of these records related to test requests that had been input twice and were therefore duplicate entries.	Incomplete/inaccurate data leading to an increase in the diagnostic waiting time and potential deterioration of the patient's condition.	An audit of duplicate entries has recently been incorporated into the IR(ME)R audit schedule. This will be carried out and programmed to be repeated on an annual basis.
		Medium Priority	Expected Evidence of Implementation: Evidence of audit identifying any themes or trends as to why duplicate referrals have been received.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Alex Wallace, Radiographer / Alyson Berbillion, Radiology Admin Manager Target Implementation Date: October 2025

Objective 7: Regular monitoring of waiting lists with action plans to tackle where waiting time targets are not being achieved. (Specifically in relation to Non-Obstetric Ultrasound and Non-Cardiac CT)

Substantial

The Radiology Directorate Manager oversees the waiting lists for NOUS and Non-Cardiac CT patients. Weekly reports are produced, detailing total waiting list numbers and providing analysis on key metrics such as breaches over 8 weeks, longest waits and the breakdown of urgent versus routine referrals. When delays in diagnostics occur, we understand that they are typically due to resource constraints within the Directorate. As such, decisions on remedial actions are escalated to senior Health Board leadership.

Bi-monthly diagnostic performance reports are presented to the Operational Delivery Committee (and previously presented to the Planning, Performance and Finance Committee). The March 2025 report highlighted significant progress in reducing the number of NOUS patients waiting more than 8 weeks for their diagnostic, with just one breaching patient remaining. However, concerns have emerged about potential shortfalls in scanning capacity which will have an impact on waiting times. The high demand for CT scans has been raised as a concern in the highlight reports presented at the Health Board's Quality, Safety, and Experience Committee meetings of September and November 2024.

Effective reporting mechanisms have historically enabled timely allocation of additional resources in response to rising demand. For instance, mobile CT units were deployed in October 2024 to address increased waiting list pressures. Monitoring reports continue to track the implementation of such remedial actions.

A Diagnostics Service Improvement Group (SIG) is in place and meets each month. The group is responsible for overseeing and enhancing the performance and quality of diagnostic services within the Health Board, it is attended by the Care Group Service Director and relevant Directorate Managers. Action logs are produced to record relevant actions arising from the Group's discussions.

Overall, robust monitoring and reporting arrangements in relation to waiting lists for NPUS and Non-Cardiac CT examinations are in place, and processes ensure remedial actions are identified and implemented where appropriate.

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

Date issued: August 2025

Document reference: 4695A2025

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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 2024-25 Charitable Funds Annual Report and Accounts	Executive Director of Finance	To provide an audit and opinion on the Charity's 2024-25 Annual Report and Accounts.	Yet to commence.	The audit is scheduled to commence in the autumn, with certification by January. The Charity Commission's deadline is 31 January 2026.

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.	Completed.	The Auditor General certified the Annual Report and Accounts on 27 June; and that day he instructed the Senedd to lay the document on its website.

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
All-Wales thematic review of planned care	Chief Operating Officer	This work followed on from the national report on <u>tackling the planned care backlog</u> and considered: • 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. • Use of the additional Welsh Government financial allocations to improve waiting lists.	Completed and included in today's meeting papers	August 2025
Structured Assessment 2025	Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of	Fieldwork underway	February 2026

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		resources. Our 2025 Structured Assessment will review: • Board and committee cohesion and effectiveness. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning and management arrangements.		
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.	Fieldwork underway	February 2026
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	Part 1 – Report being drafted	November 2025

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		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 2 – Report being drafted	November 2025
Review of Eye Care Services	Chief Operating Officer	This work will assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.	Report being drafted	November 2025

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		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.		
Structured Assessment 2024 – Deep Dive – Estates	Chief Executive Officer	This work will examine the effectiveness of corporate arrangements to manage the SHA's estate with a particular focus on ensuring the current estate is fit for purpose, represents value for money and supports organisation's wider strategic priorities	Scoping	To be confirmed
Review of cancer services	Chief Operating Officer	This work will follow on from the <u>review of national leadership arrangements for cancer services</u> . Whilst the exact focus of this work is to be determined, it is likely to consider:	Scoping	To be confirmed

Area of work	Executive Lead	Focus of the Work	Current Status	Planned Date for consideration
		• The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services.		
Local project work – Follow-Up Outpatients	Chief Operating Officer	This work will examine the Health Board's arrangements to follow-up outpatient appointments, with the option to follow-up recommendations made in our 2015 and 2017 reviews of follow-up outpatient appointments.	Scoping	To be confirmed

Other relevant publications

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

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

Title	Publication Date
<u>Temporary Accommodation, long-term crisis?</u>	July 2025
<u>Cost Savings Arrangements – A checklist for NHS Board Members</u>	June 2025
<u>The Wales Infrastructure Investment Strategy</u>	May 2025
<u>Lessons from our work under the Wellbeing of Future Generations Act</u>	April 2025
<u>The Biodiversity and Resilience of Ecosystems Duty</u>	March 2025

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.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Annual Report and Accounts 2024-25</u>	June 2025



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Rydym yn croesawu gohebiaeth a
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Tackling the Planned Care Challenges – Cwm Taf Morgannwg University Health Board

Date issued: June 2025

Document reference: 4666A2025

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Summary report

About this report

- 1 This report sets out the findings of work on planned care recovery that we have undertaken at Cwm Taf Morgannwg University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with INTOSAI¹ audit standards. This report excludes any examination of waits relating to cancer diagnosis and treatment, which are the subject of a separate examination by the Auditor General.
- 2 Tackling the planned care waiting list backlog is one of the biggest challenges facing the NHS in Wales. NHS waiting time targets in Wales have not been met for many years and the COVID-19 pandemic made an already challenging situation considerably worse as planned care services were initially postponed and then slowly re-started to allow the NHS to focus its attention on dealing with those seriously ill with the virus. Since the onset of the pandemic, the overall size of the NHS waiting list has grown significantly and at the end of February 2025 there were 614,150 individual patients waiting for treatment.
- 3 In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme includes £170 million recurring funding to support planned care recovery, together with an additional £15 million funding per year over four years to support planned care transformation. Welsh Government subsequently allocated a further £50 million between September and October 2024 to reduce the longest waiting times². The programme includes specific targets and Ministerial priorities:
 - that no one should wait longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023³**);
 - to eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**);
 - people should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024; and
 - to eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

¹ INTOSAI is the International Organization of Supreme Audit Institutions

² Health Secretary response to latest NHS Wales performance data. The £50 million additional allocation comprised £28 million in September and £22 million in October 2024.

³ Health Boards did not achieve the original targets for first outpatient appointment and number of people waiting longer than two years for treatment. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

- 4 In May 2022, the Auditor General for Wales published a commentary on "[Tackling the Planned Care Backlog in Wales](#)" which estimated that it could take up to seven years for the overall waiting list in Wales to return to pre-pandemic level. The commentary highlighted key areas for action, including:
- having strong and aligned local leadership to deliver the national vision for recovering planned care services;
 - having a renewed focus on system efficiencies and new technologies;
 - building and protecting planned care capacity; and
 - communicating effectively with patients who are waiting for treatment and having systems in place to manage the clinical risks to those patients while they are waiting.
- 5 Our work has considered the progress Health Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on:
- action that the Health Board has taken to tackle the planned care backlog;
 - waiting list performance; and
 - understanding and overcoming the barriers to improvement.
- 6 We undertook our work between December 2024 and March 2025. The methods we used are summarised in **Appendices 1 and 2**. **Appendix 3** provides some additional data analysis on planned care services and **Appendix 4** contains the Health Board's response to any recommendations arising from our work.
- 7 The Health Board is facing some significant challenges. It is currently at Level 3 escalation status for finance, strategy and planning, and performance outcomes relating to cancer and planned care. It is at Level 4 escalation for performance and outcomes relating to urgent and emergency care under the [NHS Wales escalation and oversight framework](#). In addition, during October 2024, the roof at Princess of Wales Hospital was declared unsafe, and a critical incident was declared. This led to the immediate closure of ten wards, eight theatres and the immediate relocation of the Intensive Care Unit. The impact of this was felt across the Health Board and plans were rapidly developed to redistribute services across to protect both unscheduled and elective care and mitigate shortfalls.

Key facts

£80.8m	the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.
111,179	the overall size of the waiting list at February 2025.
182%	the percentage growth in the overall waiting list between April 2019 and February 2025.
14,823	the number of patient pathways waiting more than 1 year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of 1 year waits for an outpatient appointment has reduced by 20%, since April 2022.
2,347	the number of patient pathways waiting more than 2 years for treatment at February 2025 against a national target of zero waiting. The number of 2-year waits has reduced by 82% since April 2022.
79%	the percentage diagnostic test waits that are within 8 weeks at February 2025 against a national target of 100%. The Health Board has achieved a significant 80% reduction of 'over 8 weeks' diagnostic waits since April 2022.
98%	the percentage of therapy waits that are within 14 weeks at February 2025 against a national target of 100%. The Health Board has achieved an 93% reduction of 'over 14 week' therapy waits since April 2022.
25,421	number waiting more than one year for treatment at February 2025 against a national target of zero for most specialties by Spring 2025. This has reduced by 20% since April 2022.

Key messages

Overall conclusion

- 8 Overall, we found that **the Health Board is reducing the numbers of very long waits, although the October 2024 critical incident affected waiting list recovery. It has good short-term plans, but it needs to develop its clinical services plan to help shape services that can sustainably meet expected growth in demand in the longer-term. It also needs to improve how it reports on harm resulting from planned care delays.**

Key findings

Action that the Health Board is taking to tackle the planned care challenge

- The Health Board has had some success protecting planned care capacity from wider unscheduled care pressures. However, the Princess of Wales critical incident impacted the Health Board's ability to sustain the required level of elective services. To mitigate this, it has increased short-term planned care capacity through insourcing, outsourcing, waiting list initiatives and regional working.
- The Health Board is spending its additional Welsh Government planned care allocation in line with its plans. However, most of these funds have been aimed at short-term improvements with only some investment in sustainable service transformation.
- Plans set out clear actions for securing short-term waiting list improvements, but these plans do not yet sufficiently describe actions that can secure more sustainable improvements to planned care services.
- The Health Board has started to deliver efficiencies but there remains scope to maximise outpatient capacity, increase theatre utilisation and improve job planning.
- The Health Board has implemented Welsh Government's Promote, Prevent and Prepare policy, and has a dedicated keeping in touch team for patients.
- The Health Board needs to strengthen reporting on actual harm resulting from long planned care waits.

Waiting list performance – is the action taken resulting in improvement?

- In overall terms, the Health Board has marginally reduced its overall waiting list, but the numbers waiting continue to present a substantial challenge for the Health Board. There are over 110,000 open treatment pathways.
- The Health Board made some good early progress to reduce its long waits but struggled to meet Welsh Government targets. Whilst the Health Board has not met the majority of the recent national planned care recovery targets in absolute terms:
 - the number waiting over a year for their first outpatient appointment has decreased from 20,975 patient pathways in April 2022 to 14,823 in February 2025; and
 - the numbers waiting over 2 years for treatment reduced from 12,046 patient pathways in April 2022 to 2,347 in February 2025.
- The Health Board is also performing well on its therapies waits and made significant and notable improvement in addressing long diagnostic waits.

Barriers to improvement and action being taken to overcome them

- There are a number of barriers to further planned care improvement. These include growing and competing service demands, continued recovery from the impact of the Princess of Wales critical incident, financial pressures and workforce shortfalls.
- The Health Board recognises these challenges and is introducing a number of actions to help address these issues. The Health Board needs to continue to embed these arrangements and develop its clinical services plan alongside securing the required pace of delivery from wider regional developments.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**.

Exhibit 1: recommendations

Recommendations	
Planning	
R1	The Health Board need to establish longer term milestones, linked to clinical service plan development, to drive sustained planned care improvement (Exhibit 2).
Risk management	
R2	The Health Board should review and update the productivity, improvement and transformation programme risk register to ensure risks are up to date have a clear owner and includes sufficient detail on actions required to mitigate the risks (Exhibit 3).
Monitoring impact of additional funding	
R3	The Health Board should strengthen its reporting on the impact of the additional Welsh Government planned care funding (Paragraph 23).
Efficiency and productivity	
R4	Our work has identified there are opportunities for further efficiency and productivity improvements (Exhibit 6). The Health Board should: 4.1 Address the causes of short notice surgical cancellations to improve use of theatre resources. As part of this, set a clear reduction target for short notice surgical cancellations. 4.2 Improve theatre utilisation rates, with the aim of achieving the GIRFT recommended level of 85%. 4.3 Increase day surgery rates to the GIRFT recommended level of 85%. 4.4 Increase job planning compliance to the 85% target. Use job planning as a means to drive improved productivity and to help shape and transform efficient services.

Recommendations

Treat in turn

- R5 The Health Board needs to strengthen its actions to achieve its treat in turn rate target of 80% within the next 12 months **(Exhibit 6)**.
-

Managing clinical risks associated with long waits

- R6 The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks associated with long waits:
- 6.1 Building on the harm review arrangements in ophthalmology services, develop and implement a consistent methodology across all specialties to assess the risk of, or actual harm, to patients caused by long waits **(Exhibit 7)**.
 - 6.2 Report the risks and actual incidence of harm resulting from delays in access to treatment to the Quality, Safety and Experience Committee **(Exhibit 7)**.

Detailed report

Action that the Health Board is taking to tackle the planned care challenge

- 10 We considered whether the Health Board is effectively planning and delivering planned care improvement, is appropriately utilising and monitoring the impact of Welsh Government funding and is supporting patients who are at most risk of harm as a result of a delay.
- 11 We found that **the Health Board is understandably focussing its efforts and additional funding on addressing the consequence of the Princess of Wales critical incident to help reduce long planned care waits. However, it also needs to maintain the pace of planning to put planned care services on a more sustainable footing in the longer-term as well as strengthening reporting on patient harm associated with long planned care waits.**

Planned care improvement plans and the programme to deliver them

- 12 It is important that the Health Board has a clear plan for tackling the waiting list backlog and delivering sustainable planned care improvement. We considered whether the Health Board has:
 - clear, realistic and costed improvement plans for planned care that align with the national recovery plan ambitions and Ministerial priorities; and
 - appropriate programme management arrangements to support planned care improvement, supported by clear accountabilities and clinical leadership and reporting to committees and the Board.

Planned care improvement plans

- 13 We found that **the Health Board has good plans to support short-term planned care waiting list recovery. However, it needs to ensure it sets out how it sustainably meets growing service demand through its clinical services plan.**
- 14 The findings that underpin this conclusion are summarised in **Exhibit 2.**

Exhibit 2: the Health Board's approach to planned care improvement planning

Audit question	Yes / No / Partially	Comments
Has the Health Board developed a clear plan to support planned care recovery?	Yes	The Health Board's Integrated Medium-Term Plan (IMTP) 2025-28 includes a high-level plan for improvement of its planned care services. This provides reasonably clear actions for the next 12 months and wider 'intent' for the next three years. This is supported by the productivity, improvement and transformation programme which established an annual programme of work aimed to increase both outpatient and elective surgical capacity.
Is the approach for delivering planned care improvement costed and affordable?	No	The IMTP provides a high-level financial plan for the organisation and sets out the overall Health Board financial position. However, there is no costed planned care plan or route-map to financially sustainable planned care services.
Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities?	Yes	The IMTP priorities are sufficiently aligned to the ministerial priorities and the national <u>'transforming and modernising planned care and reducing NHS waiting lists'</u> recovery plan.
Has the Health Board set out realistic yet challenging targets and milestones for planned care?	Partially	The IMTP describes short-term aspirations for planned care, with many targets and milestones linked to the national planned care recovery plan and the Ministerial priorities. The productivity, improvement and transformation programme sets out a clear programme of annual baselines and targets. However longer-term planned care objectives and milestones relating to programmes of change to deliver sustainable services are too high-level (Recommendation 1).
Are the Health Board's planned care priorities informed by analysis and	Partially	The Health Board has undertaken demand and capacity analysis in some areas and is continuing this work across planned care in 2025-26 to inform service plan developments. To help it plan

Audit question	Yes / No / Partially	Comments
modelling of capacity and demand?		for sustainable services in the longer term and required workforce capacity planning, this would need to forecast and anticipate longer-term sub-specialty and condition-level demand growth. Regional projects are also supported by demand and capacity assessments.
Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future?	Partially	The Health Board's IMTP sets out high-level actions that focus on service modernisation and transformation. However, there is little detail on the future shape of services. This will be the focus of the Health Board's clinical services plan currently in development.
Are plans for planned care improvements aligned to other key corporate plans such as the IMTP and plans for workforce, digital and estates?	Partially	The IMTP refers to high-level enablers, including workforce, estates and digital services. This includes service developments at Llantrisant Health Park. However there needs to be a greater focus on how workforce, estates and digital services need to be shaped and invested in, to support planned care improvement and transformation.
Do the Health Board's planned care priorities align with those in other health boards and identify regional solutions to planned care recovery?	Yes	The Health Board has aligned its plans with its partners to create regional capacity in some areas. Regional partnerships between Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards are making some progress. Aneurin Bevan is responsible for hosting the regional ophthalmology (cataracts) programme. Cardiff and Vale and Cwm Taf Morgannwg University health boards are starting to introduce regional orthopaedic arthroplasty and diagnostic services in the Llantrisant Health Park. There is a bi-monthly regional oversight board with regional delivery board taking place monthly. Regional working is considered further in paragraph 31 this report.

Source: Audit Wales fieldwork

Planned care programme delivery and oversight

- 15

We found that the Health Board has reasonably effective planned care programme leadership arrangements. However, it needs to strengthen how it manages programme delivery risks and seek to recover the pace of the programme following the critical incident at Princess of Wales hospital.
- 16

The findings that have led us to this conclusion are summarised in Exhibit 3.

Exhibit 3: the Health Board’s approach to the programme management of planned care improvement

Audit question	Yes / No / Partially	Comments
Does the Health Board have a clear and appropriately resourced improvement programme to support planned care recovery?	Yes	The Health Board launched its productivity, improvement and transformation programme in 2024. This is focussing on effective waiting list management, modernising outpatient and pre-operative services, maximising theatre capacity, getting it right first time (GIRFT) recommendations and diagnostics. The key programme goals were to increase new outpatient capacity by 15% and elective surgical capacity by 25% by April 2025, although we expect that the critical incident in the Princess of Wales will have affected pace of improvement.
Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership?	Yes	The Chief Operating Officer has overarching operational responsibility for planned care and the planned care recovery programme. The productivity, improvement and transformation programme is monitored and scrutinised through the Improving Care Board which is chaired by the Deputy Medical Director. There is clear accountability and strong clinical leadership, with six improvement groups led by a senior responsible officer and a clinical lead. All elective services within the Health Board have also established a clinically led service improvement group, which has a directorate manager and clinical director as its lead.

Audit question	Yes / No / Partially	Comments
Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims?	Partially	The Health Board has a productivity, improvement and transformation programme risk log to capture and manage risks. However, the risk log has not been updated since May 2024 and it needs to clearly set out mitigating actions and owners for each of the risks (Recommendation 2).
Is performance on planned care recovery routinely reported to the appropriate committee/s and to the board?	Yes	The Board and committees effectively oversee planned care performance and improvement. Board and committee performance reports track and monitor planned care targets, including the ministerial priorities and contain good quality data.

Source: Audit Wales fieldwork

Utilisation of additional Welsh Government funding

- 17 We have looked at the Health Board's use of the additional planned care allocation that it has received from the Welsh Government. This section considers:
- the overall amount of additional planned care funding the Health Board has received from Welsh Government over the last three years;
 - how the Health Board spent the money; and
 - the Health Board's arrangements for overseeing how it has spent additional funding.

Use of additional funding

- 18 We found that **between 2022-23 and 2024-25 the Health Board has received a total of £80.8 million in additional Welsh Government planned care funding. Similar to other health bodies in Wales, it is focussing the funding on short-term improvements with limited investments in service transformation to help make planned care services financially sustainable.**
- 19 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £80.8 million between 2022-23 and 2024-25 (**Exhibit 4**)

Exhibit 4: the Welsh Government’s allocation to the Health Board to support planned care improvement

Financial year	Annual allocation (£m)
2022-23	27.5
2023-24	27
2024-25	26.3 ⁴
Total allocated	80.8

Source: Health Board financial self-assessment returns

- 20

We reviewed the use of funding in 2023-24 and 2024-25 in greater detail. We found that the Health Board can fully account for Welsh Government planned care funding it has received. We did note however that during those years, the Health Board allocated £2.1 million of its planned care allocation to Emergency Department nursing. Health Board officers have indicated initial guidance on the use of this funding was quite broad and not specifically ring-fenced to planned care improvement.
- 21

For 2024-25, we found that the Health Board utilised monies appropriately. However, the majority of schemes were short-term and not focused on sustainable service change (**Exhibit 5**). During that year, the Health Board was allocated £26.3 million from Welsh Government, which it supplemented by £3.1 million from additional local investment. In 2024-25, the Health Board spent £13.6 million to increase core short-term planned care capacity, £2.5 million on regional working and £7.5 million on external commissioning. However, of the total allocation only around £2.7 million was used to support transformation and change projects.

⁴ In November 2024, Welsh Government allocated the Health Board a further £4.6 million non-recurrent funding to address the risk to delivery of the 104-week target, subject to several conditions. £2.9 million of funding was also confirmed in November 2024 for the provision of temporary theatres at RGH to support the elective provision in the Health Board’s mitigation plan for the Princess of Wales critical incident.

Exhibit 5: use of the 2024-25 Welsh Government additional financial allocation, Cwm Taf Morgannwg University Health Board

Funded schemes	Annual allocation (£m)
Planned care improvement (including but not limited to, gastroenterology, therapies, endoscopy, CT, MRI, Ear Nose and Throat and dermatology).	13.602
Regional working on cataracts	2.500
External commissioning	7.485
Transformation and change projects	2.665
3Ps programme and harm reviews	1.076
Unscheduled care nursing	2.100
Total allocated	29.428

Source: Health Board self-assessment returns

Monitoring impact of additional funding

- 22

We found that **despite reasonable arrangements to oversee the use of additional Welsh Government planned care financial allocations, we have seen limited evidence of monitoring of impact or value achieved from the spend.**
- 23

We have considered the extent that the Health Board oversees the use of the Welsh Government planned care financial allocations. The Health Board effectively oversees and scrutinises its additional planned care financial allocation. This includes planned care financial reporting to each individual care group meeting, operational delivery committee and the executive management board. The Planning, Performance and Finance Committee and Board receive a high-level picture of planned care spend, and overall waiting list performance which includes performance against ministerial priorities. However, we have not seen any evidence that the Health Board is reporting on the extent that the additional investments delivered the expected impact.
(Recommendation 3).

Operational management of planned care

- 24

Alongside the well-planned use of additional funding, health boards’ ability to secure meaningful and sustainable planned care improvements will be dependent on them optimising their routine operational arrangements for planned care. In this section we consider the actions the Health Board is taking:
 - to maximise its use of existing resources; and
 - to protect and increase its planned care capacity.

Maximising the use of existing resources

- 25

We have examined some opportunities that exist for the Health Board to improve efficiency and productivity, and the actions it is taking to maximise the use of its existing resources. We found that **the Health Board is taking reasonable action to make services more efficient, but there is more to do. It needs to increase theatre utilisation, maximise outpatient capacity and improve job planning.**
- 26

Exhibit 6 identifies efficiency and productivity opportunities that could help maximise the use of existing resources within the Health Board to support planned care improvements.

Exhibit 6: efficiency and productivity opportunities

Opportunity area	Audit findings
Responding to Getting it Right First time (GIRFT) reports	The Health Board is making reasonable progress in addressing its GIRFT recommendations. The Health Board has received reviews on its ophthalmology, trauma and orthopaedics, theatres/elective optimisation, general surgery and urology. Clinically led speciality improvement groups within the productivity, improvement and transformation programme are responsible for reviewing and implementing GIRFT recommendations, with progress monitored by the improving care board.
Arrangements for measuring and managing productivity of services	The Health Board is also focussing on improving productivity of services through its productivity, improvement and transformation programme. This includes initiatives that are focussing on improving health pathways, patient access, outpatient services, diagnostics, elective capacity and theatre utilisation. The Health Board has set delivery milestones, although the Princess of Wales critical incident has impacted timely delivery of these. The Health Board's arrangements also include: • Establishment of a Theatre Improvement Board which monitors key performance metrics through a theatre's performance dashboard. • Establishment of a Diagnostics Improvement Group, which has achieved significant and notable improvements in addressing long diagnostic waits. • Improved demand and capacity planning. Neurology and ENT services in particular have subsequently improved productivity and achieved a sustainable demand and capacity position.

Opportunity area	Audit findings
Reducing non-attendance at outpatient appointments	Exhibit 18, Page 37 shows that the Health Board has been successful in reducing “Did Not Attend” (DNA) rates within its outpatient clinics. The DNA rate has decreased from 8.2% in February 2024 to around 7.2% in February 2025. Over this 12-month period, DNAs have represented around 7.7% of the Health Board’s total outpatient clinic activity. A DNA rate of 7.7% equates to a loss of approximately 43,500 outpatient appointments a year. If the Health Board could further reduce its outpatient DNA rate by a further 20% it could potentially save around £1.3 million (£150 per appointment).
Making use of “virtual” outpatient appointments	Virtual outpatient appointments can have a positive impact in reducing the need for travel and the risk of healthcare acquired infections. For the period April 2024 to February 2025, 13.5% of all the Health Board’s outpatients’ appointments were virtual (Exhibit 19, Page 38). Through its productivity, improvement and transformation programme, the Health Board has • created an Outpatients Improvement Board to drive improvement; and • set a target for the proportion of appointments that are virtual to 15% for new appointment and 25% for follow up appointments.
Reducing the number of cancelled operations	While the Health Board is increasing its focus on reducing cancelled operations, it needs to ensure that the actions it is taking are having sufficient impact. Its Theatres Improvement Board is scrutinising cancellations, including those that occur on the day, with a dashboard used to monitor targets, trends and actions. In the 12-month period between March 2024 to February 2025, there were nearly 2,200 individual surgical procedures cancelled within 24 hours (Exhibit 20, Page 39). Cancellations accounted for 12% of all elective surgical admissions (Recommendation 4.1). The Health Board is struggling to recruit theatre staff and does not have sufficient clinical staff to support the three-site model, adding to these pressures.

Opportunity area	Audit findings
Improving operating theatre utilisation	The Theatres Improvement Board monitors key targets including theatre utilisation, fallow sessions, day surgery rates, cancellations, as well as late starts and early finishes. Its improvement actions include implementation of High-Volume Low Complexity theatre lists and concerted action to protect day case capacity from unscheduled care. Whilst there are clear arrangements for monitoring and managing theatre utilisation, these are at their early stages and have not yet had the desired impact. Progress is also being curtailed due to issues with staff availability in some areas. The GIRFT target for theatre utilisation stands at 85%. Nevertheless, the Health Board's performance dashboard indicated that the average theatre list utilisation during 2024 was 70%, indicating significant room for improvement. (Recommendation 4.2)
Making more use of day case surgery	As can be seen in Exhibit 22 (Page 41), for the period April 2024 to February 2025, 78% of all elective surgery within the Health Board was day case. While this is above the all-Wales average of 74%, GIRFT recommends that on average, 85% of all elective surgery should be day case. (Recommendation 4.3)
Effective consultant job-planning	In October 2024, Health Board job plan compliance was 26% against a target of 85%. An internal audit report in February 2025 evaluated the adequacy of the systems and controls in place for medical job planning and concluded there was limited assurance in this area. The Health Board recognises that it needs to improve, however progress is slow with considerably more work needed. (Recommendation 4.4)
Pooled lists within a Health Board speciality to ensure it treats its patients in turn	The Health Board has introduced pooled waiting lists within some of its regional services, in particular within its cataract service. However, the use of two Welsh Patient Administration Systems⁵ has resulted in significant challenges in pooling waiting lists, as well as managing Treat in Turn rates. The Health Board is tracking and monitoring Treat in Turn targets, with the Outpatients Improvement Board reporting an average of 15% in 2024, against a target of 80%. (Recommendation 5)

⁵ The Health Board has had two patient administration systems since the transfer of Bridgend services in 2019.

Source: Audit Wales fieldwork including analysis of NHS Wales data and Health Board self-assessment and data returns

Protecting and increasing planned care capacity

- 27 We examined the actions the Health Board is taking to protect planned care capacity by separating out elective and emergency activity. We also looked at the actions the Health Board is taking to increase its planned care capacity.
- 28 We found that **the Health Board has taken appropriate measures to protect and supplement its planned care capacity in the short-term to help address the challenges caused by the Princess of Wales critical incident.**
- 29 As of May 2025, the Health Board was still managing the impact of the critical incident, and theatre capacity remained lower than normal. To help mitigate the consequences of reduced capacity and to protect planned care capacity from wider unscheduled care pressures, the Health Board has:
- protected ring-fenced elective orthopaedic capacity at Royal Glamorgan hospital;
 - increased theatre capacity through the procurement of mobile operating theatres units;
 - increased bed capacity through the procurement of modular wards;
 - outsourced capacity to meet demand, with orthopaedics and ophthalmology particularly supported through outsourced provision;
 - insourcing across a range of specialities, with an insourcing company used to facilitate three theatre teams; and
 - utilisation of waiting list initiatives, with over £1.1 million allocated during 2024-25.
- 30 The Health Board recognises that its actions are short-term in nature but are fundamentally necessary. In the longer-term, it intends to create more sustainable core capacity through the development of an elective centre as part of the Llantrisant Health Park developments.
- 31 The Health Board and its partners are starting to make progress with aspects of its regional planned care partnership. The Health Board is working jointly with Aneurin Bevan University Health Board and Cardiff and Vale University Health Board to provide services within south-east Wales, as well as the reconfiguration of specialist services. Each Health Board is leading a formal programme, with Cwm Taf Morgannwg University Health Board hosting diagnostics. The Health Board is currently progressing the development of a business case to develop an endoscopy regional facility.

Managing clinical risk and harm associated with long planned care waits

- 32 Long patient waits increases the risk of preventable irreversible harm. Patients’ health may deteriorate while waiting, they may be waiting in pain and with anxiety and uncertainty not knowing when they will finally receive treatment. They may also not be able to work or support or care for others while they are waiting. We considered whether the Health Board has sound arrangements to:
- identify, manage, and report on clinical risk and harm associated with long waits; and
 - effectively communicating with patients who are on a waiting list and to manage potential inequalities in access to care.
- 33 We found that **the Health Board has implemented the first phase of the Welsh Government’s Promote, Prevent and Prepare policy, but needs to strengthen reporting on actual harm resulting from long planned care waits.**
- 34 The findings which have led us to this conclusion are summarised in **Exhibit 7.**

Exhibit 7: the Health Board’s approach to managing clinical risks and communicating with patients on waiting lists

Audit question	Yes / No / Partially	Comments
Has the Health Board implemented the first phase of the Welsh Government's Promote, Prevent and Prepare for Planned Care policy ⁶ ?	Yes	The Health Board has implemented the first phase of Welsh Government's Promote, Prevent and Prepare policy (3Ps). This policy aims to ensure that support and information is easily accessible for those who are waiting for appointments and interventions in secondary care. The Health Board has developed a dedicated webpage and recruited a Keeping in Touch Team. This team supports patients while they wait for appointments and treatments as part of the Health Board’s waiting well programme. The Health Board has also set up a dedicated patient-initiated phone line. However, there are recruitment challenges maintaining the staffing needed to support this service.

⁶ Promote, Prevent and Prepare for Planned care policy to ensure that support and information is easily accessible to those waiting for appointments and interventions

Audit question	Yes / No / Partially	Comments
Is the Health Board assessing the risk to patients waiting the longest?	Partially	The Health Board uses the DATIX system to record clinical risk resulting from a delay in treatment and these are reported using its incident reporting and management framework. However, there is no consistent methodology throughout specialties to assess risk of harm or instances of recorded harm. (Recommendation 6.1) The Health Board's organisational risk register identifies the failure to meet the demand for patient care at all points of the patient journey as a possible risk, which could result in potential avoidable harm to patients.
Is the Health Board capturing and reporting evidence of harm resulting from waiting list delays and is reporting on it to the Quality and Safety Committee?	Partially	With the exception of ophthalmology and cancer services, there are, in general, insufficient arrangements for routinely reporting actual harms associated with waiting list delays to Board and its committees. (Recommendation 6.2)
Does the Health Board monitor and record how many patients are leaving planned care waiting lists in favour of private treatment?	No	The Health Board has confirmed that it does not monitor and record how many of its patients leave planned care waiting lists in favour of private treatment. It is also unclear how many patients pay for a private outpatient appointment but then return to the Health Board for treatment, and if this occurs, whether they are treated more expediently.

Source: Audit Wales fieldwork

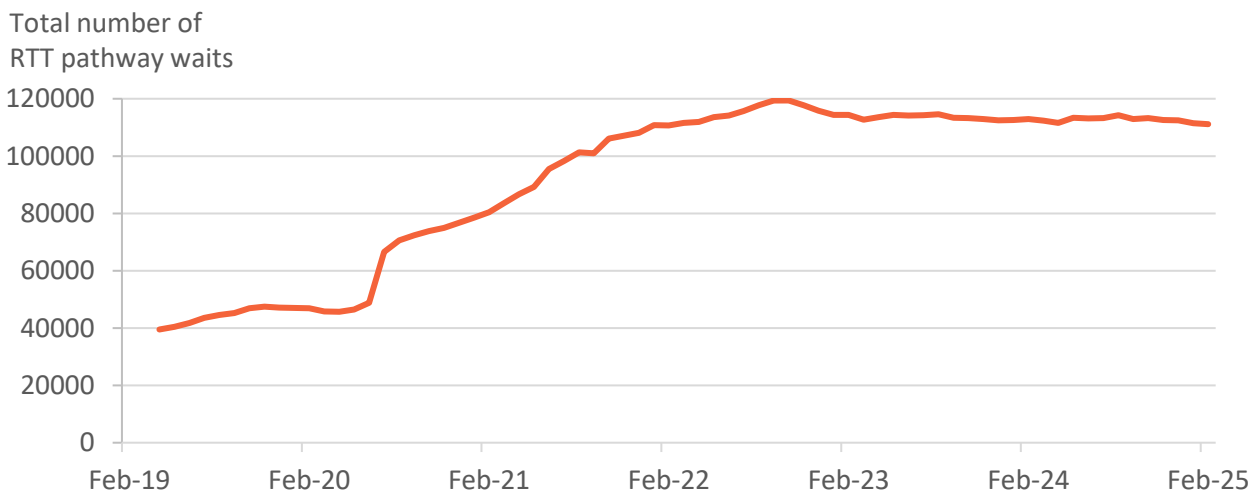
Waiting list performance – Is the action taken resulting in improvement?

- 35 We analysed current ‘Referral to Treatment’⁷ waiting list performance and trends to determine whether the Health Board is:
- reducing the overall levels of waits; and
 - meeting Ministerial priorities and Welsh Government national targets.
- 36 We found that **following deterioration in waiting list performance in 2024, the Health Board is seeing the volume of its longest waits reduce.**

The scale of the waiting list

- 37 Across Wales, the scale and extent of waits substantially increased following the Covid-19 pandemic. We have looked at these changes in terms of the overall size of the waiting list, by Health Board of residence. We found that **following substantial increases in the overall waiting list between April 2020 and October 2022, there are small signs of improvement.**
- 38 **Exhibit 8** shows the overall trend of planned care waits for the Health Board since November 2019. This indicates a 137% increase in the number of waits since 2019 from around 47,000 in 2019 to around 111,000 in February 2025. Overall, the action that the Health Board is taking to reduce the overall numbers of people waiting is marginally reducing overall waiting list size.

Exhibit 8: planned care waiting list size, Cwm Taf Morgannwg University Health Board

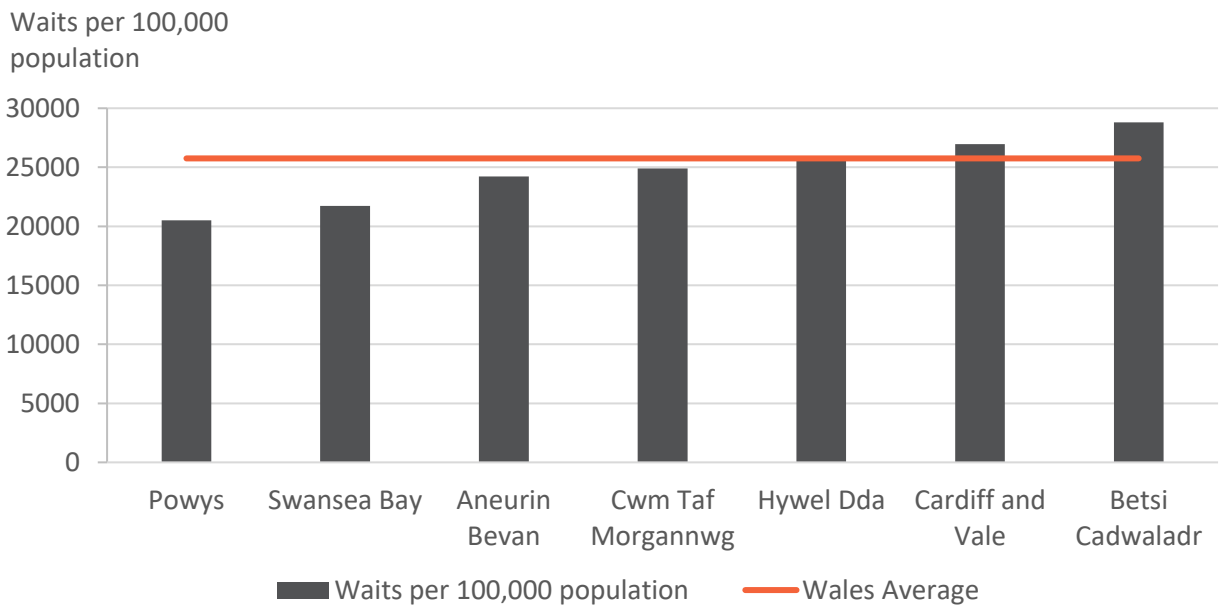


Source: Welsh Government, Stats Wales

⁷ Referral to Treatment is how the NHS records the timeliness of planned care. It starts when a Health Board receives a referral and finishes when it has treated the patient. During that patient pathway, the NHS records distinct stages, including new outpatient appointment, diagnostic, follow up appointment or therapeutic intervention and treatment.

39 **Exhibit 9** provides a comparative picture of the volume of waits across Wales. It shows that proportionately Cwm Taf Morgannwg University Health Board has slightly lower levels of waits than the all-Wales average.

Exhibit 9: Waits per 100,000 population, by health board of residence, February 2025



Source: Welsh Government, Stats Wales. Note: Powys data is for December 2024.

Performance against national targets/priorities

- 40 We looked at the progress that the Health Board is making against the Welsh Government's aims⁸. These are:
- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023⁹**).
 - Eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**).
 - Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
 - Eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

⁸ We have not included the Welsh Government performance on Cancer services as this is outside the scope of this review.

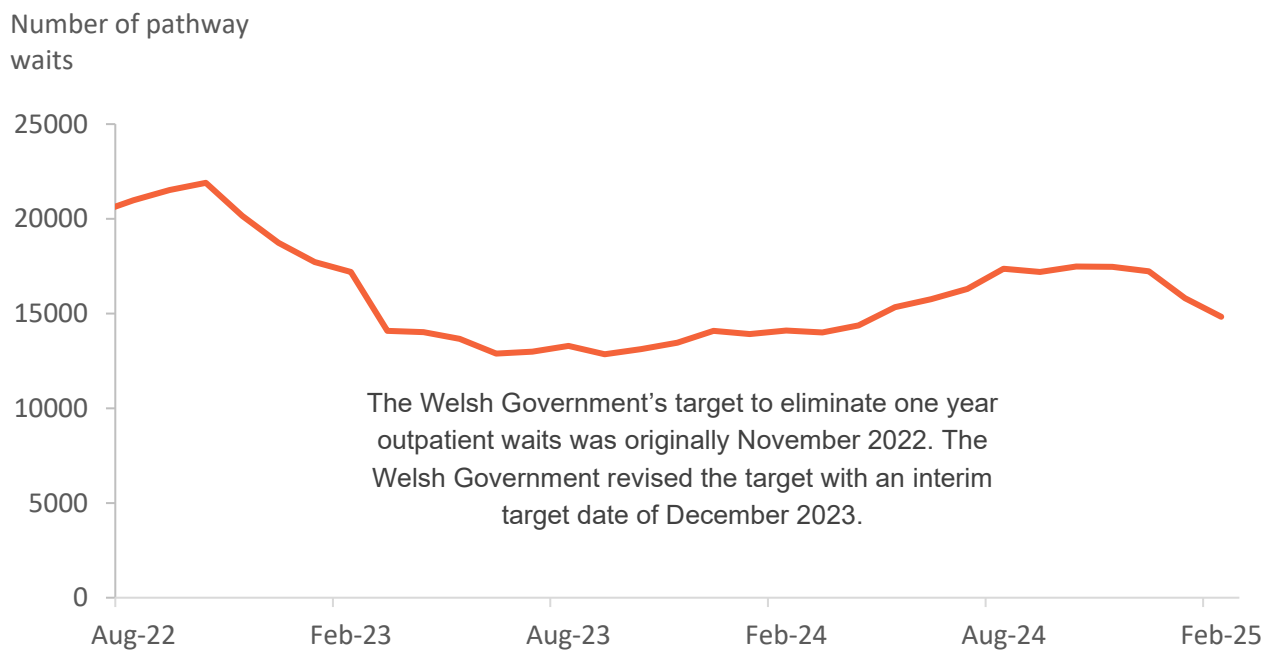
⁹ Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold, above**).

41 We found that while the Health Board did not meet the Welsh Government’s waiting list reduction targets, it is showing some recent signs of improvement in addressing long waits. In addition, from a poor position on diagnostic waits, the Health Board has made significant improvements.

No one waiting longer than a year for their first outpatient appointment

42 Exhibit 10 shows Health Board waiting list performance for first (new) outpatient appointments. The Health Board failed to meet the revised December 2023 Welsh Government target to ensure no one waited more than a year for their new outpatient appointments. While initially improving, the Health Board did not achieve the Welsh Government's target to eliminate outpatient waits that are over a year. It has struggled to maintain the early improvements and only recently made more tangible waiting list reductions.

Exhibit 10: the number of first (new) outpatient appointments waits that are over a year since referral, Cwm Taf Morgannwg University Health Board

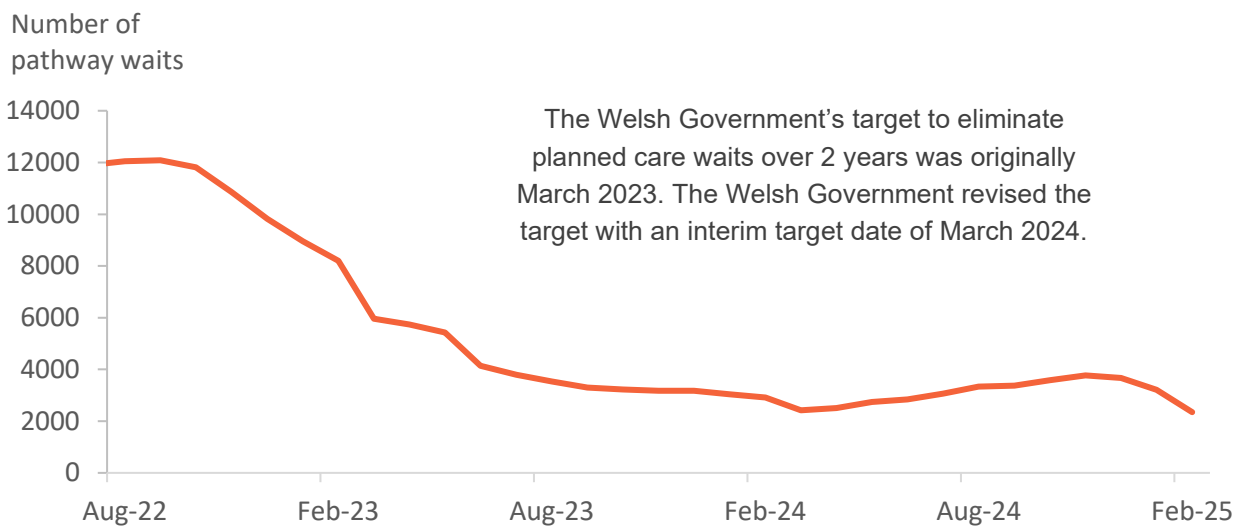


Source: Welsh Government, Stats Wales

Eliminate the number of pathways longer than two years in most specialties by March 2023

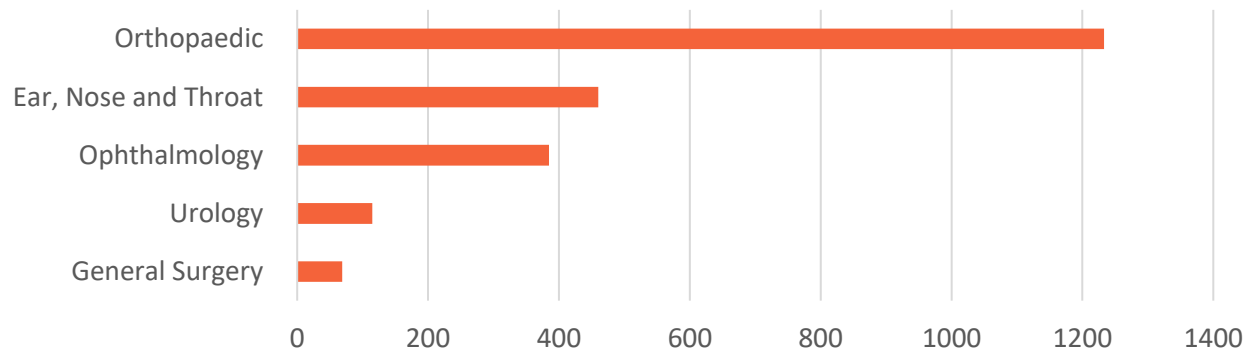
43 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024. Recent performance improvements are now resulting in the lowest level of 2-year waits in the last three years. Of those waits currently over 2 years, **Exhibit 12** shows that the most extreme waits are in a small number of specialties. ENT, orthopaedics and ophthalmology are clear specialties of concern but longer waits in other specialties may also present an elevated risk of harm resulting from treatments delays.

Exhibit 11: the number of planned care waits over 2 years, Cwm Taf Morgannwg University Health Board



Source: Welsh Government, Stats Wales

Exhibit 12: the number of planned care waits over 2 years by specialty as of February 2025, Cwm Taf Morgannwg University Health Board

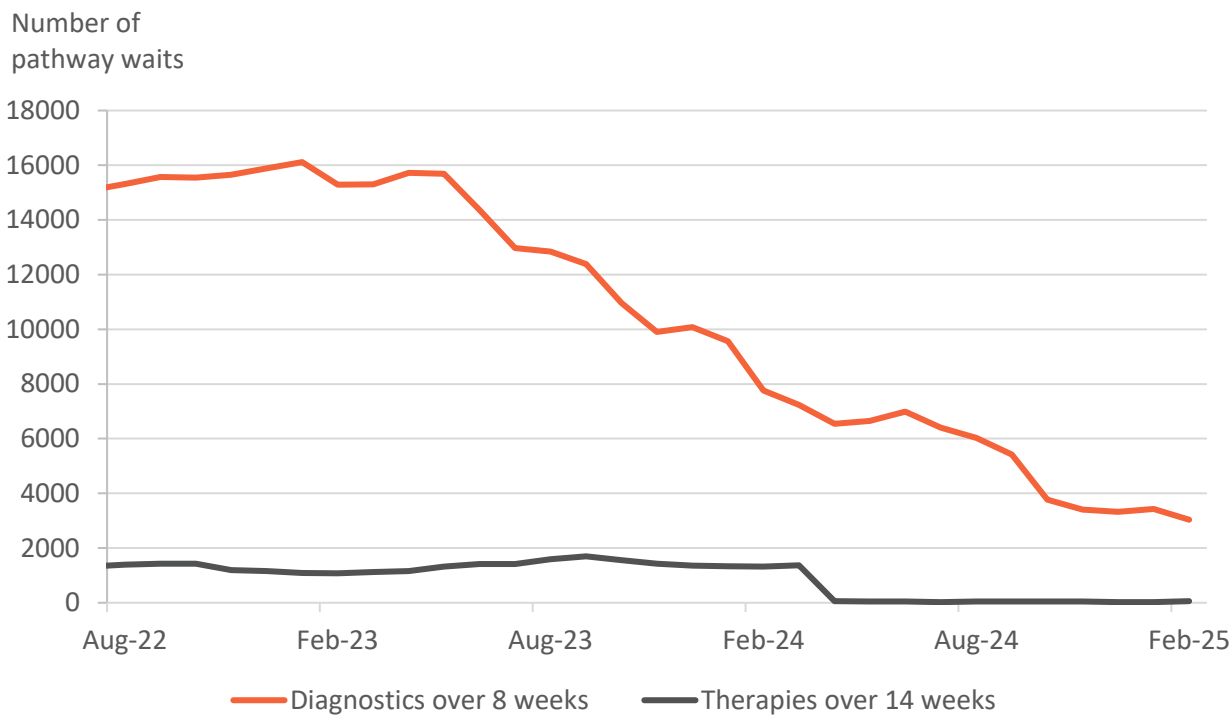


Source: Welsh Government, Stats Wales

Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

44 The Welsh Government sought to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024 (**Exhibit 13**). The Health Board is performing well on its therapies waits. It has also made significant and notable improvement in addressing long diagnostic waits. If the trend continues, the Health Board should eliminate all over 8-week diagnostic waits during 2025. Of its diagnostic services, diagnostic endoscopy and neurophysiology diagnostics are the areas of greatest concern because of the volume and proportion of long waits in those areas.

Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (Diagnostic waits is an 8-week target, therapies waits is a 14-week target), Cwm Taf Morgannwg University Health Board

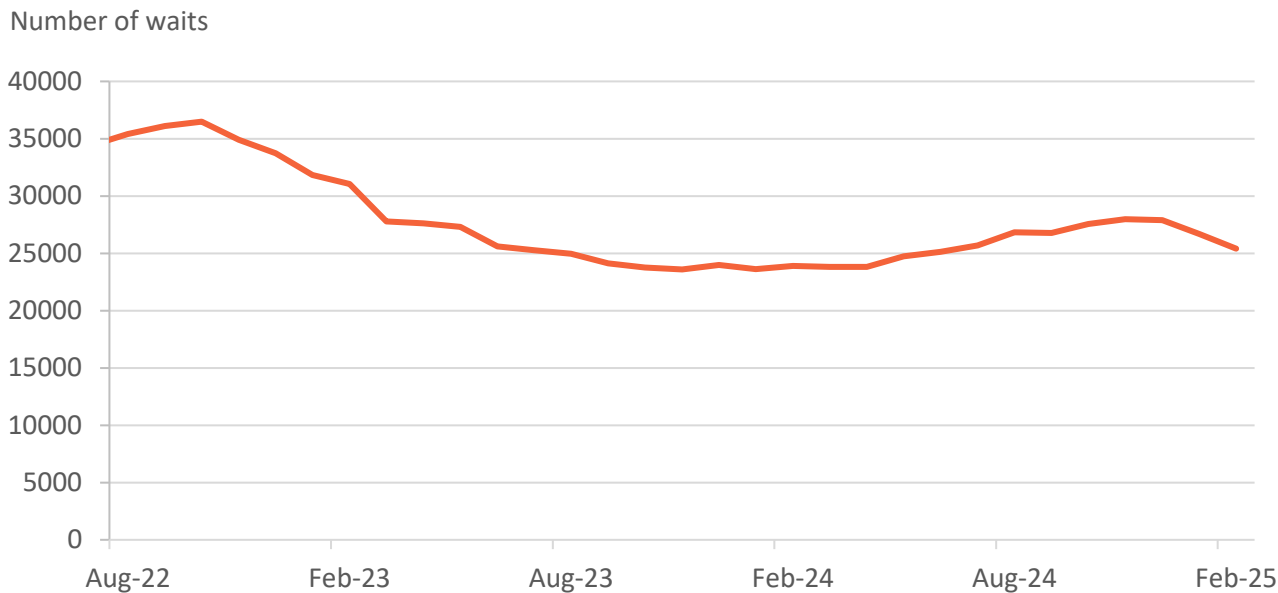


Source: Welsh Government, Stats Wales

Eliminate the number of people waiting longer than one year in most specialties by Spring 2025

45 The Welsh Government’s longer-term ambition was to eliminate waits over 1 year in most specialties by the Spring of 2025. **Exhibit 14** shows a reduction in the numbers of 1-year waits between the November 2022 and 2023, deterioration during 2024 and some recent improvements since December 2024.

Exhibit 14: the number of pathway waits that are over a year, Cwm Taf Morgannwg University Health Board



Source: Welsh Government, Stats Wales

Understanding and overcoming the barriers to improvement

- 46 We have considered the factors that are affecting the Health Board's ability to tackle its waiting list backlog and secure sustainable improvements in planned care, together with actions that it is taking to address them.
- 47 We found that **the Health Board is taking positive steps to identify and address many immediate operational barriers to improvement, but it still has a number of challenging issues to address if it is to secure more sustainable planned care improvements.**
- 48 Our fieldwork has found challenges in the following areas:
- **Demand for planned care services** – The Health Board's referral levels (excluding the atypical pandemic period), show increasing demand (**Exhibit 16, Page 36**). At the same time, our analysis of the levels of medical and surgical admissions indicate that core service activity is lower than 2019 levels (**Exhibit 17, Page 36**). This suggests a possible increasing gap between demand and core funded capacity.
 - **Financial pressures** – While Cwm Taf Morgannwg University Health Board has been able to prepare a financially balanced IMTP, it still experiencing financial pressures. This has resulted in the organisation facing challenging decisions regarding the allocation of funding. In addition, it has been reliant on additional Welsh Government funding, which if not continued to the same extent in future, could mean that it cannot spend to the same extent on planned care service recovery as it has in the past.
 - **The Princess of Wales critical incident** – The Health Board has necessarily taken very short-term measures to address the immediate risks to planned care service continuity as a result of the PoW incident. However, it will need to return to business as usual and rebuild its core service capacity to a level that meets population demand.
 - **Operating two Welsh Patient Administration Systems (WPAS)** – The Health Board has been operating under two WPAS systems which has caused complexities with treat in turn specialities and the movement of patients through pathways. These two systems will be integrated during 2025-26.
 - **Workforce capacity** – The Health Board has identified staffing issues are presenting operational challenges. This includes the recruitment of theatre staff, staffing the current three site model, as well as the recruitment and retention of its Keeping in Touch Team.
- 49 The Health Board has taken action to address some of these barriers. To address issues with productivity the Health Board is focussing on improving health pathways, patient access, outpatient transformation, diagnostic and elective capacity and theatre utilisation. The Health Board needs to continue to embed these arrangements alongside securing the required pace of delivery from wider regional developments. In addition, as the Health Board develops its clinical services plan it needs to ensure that this drives practical transformation programmes to help ensure that services are well placed to meet forecasted growth in demand.

Appendix 1

Audit methods

Exhibit 15 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Exhibit 15: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Programme Initiation Document (PID) – Transformation of Planned and Elective Care – Productivity, Improvement and Transformation • Integrated Medium-Term Plan 2024-2027 • CTMUHB Three Year Plan 2025-2028 • Annual Report & Accounts 2023-2024 • Public Board meeting papers • Planning, Performance & Finance Committee papers • Quality, Safety & Experience Committee papers • Audit & Risk Committee papers • Operational Delivery Committee papers • Service Improvement Group papers • GIRFT reviews • Internal Audit Reports • Highlight Reports • Operational Management Report • Llantrisant Health Park Infrastructure Programme updates • Board Assurance Framework Report • Risk registers
Self-assessment	We issued and then analysed a self-assessment completed by the Health Board.
Interviews	We interviewed the following: • Chief Operating Officer • Operations Service Director for Planned Care

Element of audit methods	Description
	• Medical Director for Planned Care (and Orthopaedic Surgeon) • Assistant Director of Transformation • Assistant Director of Finance for Financial Planning & Reporting • Deputy Director of Finance • Executive Director of Public Health • Head of Clinical Informatics • Head of Planning and Commissioning • Chair of the Quality, Safety & Patient Experience Committee
Observations	We observed the Operational Delivery Committee meeting in January and the Dermatology Service Improvement Group meeting in March 2025.
Data analysis	We analysed key data on: • waiting list performance; • financial spend; and • outpatient and inpatient efficiencies.

Appendix 2

Audit criteria

Main audit question: **Is the Health Board effectively managing its planned care challenges?**

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board's waiting list performance improving?	What is the scale of the challenge? Is the Health Board meeting Welsh Government targets/ambitions?	The Health Board has: - made progress reducing the overall number of referral to treatment waits for planned care services; and - met Ministerial priorities and national targets that were set by the Welsh Government.
Does the Health Board have a clear plan and a programme of action to support planned care waiting list recovery?	Does the Health Board have a clear, realistic, and funded plan in place for planned care recovery? Is there a clear programme structure to deliver planned care improvement?	The Health Board has: - clear, realistic and funded plan in place for planned care recovery in the short and longer term; and - a programme structure that appropriately supports the delivery of the plan.

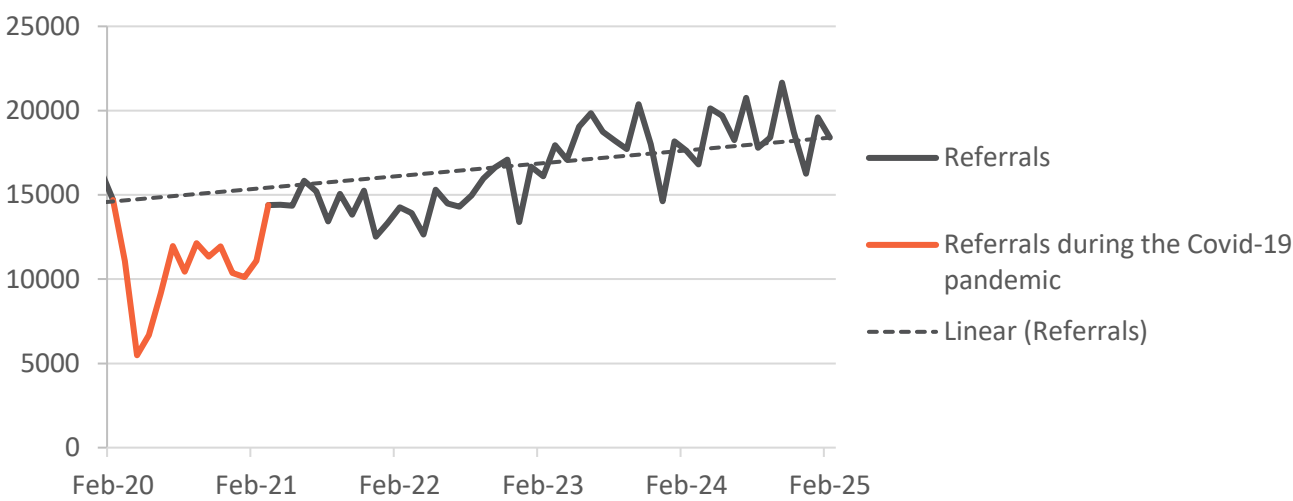
Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board maximising the impact of its funding to address the planned care backlog?	Is it clear what additional monies have been received by the Health Board? Is it clear what the additional waiting list monies has been spent on? Did the Health Board aim to use all the money on planned care improvement? Can the Health Board clearly demonstrate that the money has resulted in performance improvement, enabled service efficiency and/or new ways of working? Is the Health Board's overall financial position affecting its ability to deliver sustainable planned care recovery?	• There is sufficient evidence that the Health Board spent the money as intended by the Welsh Government (i.e. addressing waits and transforming services). • The Health Board can clearly demonstrate that the spend has resulted in improvement. • The Health Board's overall financial position is not affecting its ability to support planned care recovery.
Does the Health Board have effective operational management arrangements to drive improvement and	Is the Health Board improving its operational management of planned care services? How does the Health Board capture information on clinical risk relating to long planned care waiting lists?	The Health Board is: • improving the operational management of planned care services; and • capturing information and managing clinical risks and harm related to long planned care waiting lists.

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
management of clinical risks?	How does the Health Board capture information on clinical risk relating to long planned care waiting lists? Is the Health Board sufficiently managing clinical risks resulting from delays to treatment? Is the Health Board proactively ensuring clear routes of communication when patients are concerned that they are deteriorating?	The Health Board: • has sound arrangements to identify, capturing, and report on clinical risk and harm associated with long waits; • is proactively managing clinical risks resulting from delays to treatment and effectively communicating with patients.
Does the Health Board sufficiently understand barriers to improvement and what needs to be done to address them?	Does the Health Board understand the barriers it has experienced to improvement in planned care performance? (Capacity, funding, recruitment & retention, estates/use of facilities, commissioning external healthcare?) What mechanisms and interventions have been put in place by the Health Board to address these barriers? Is the Health Board learning and sharing good practice where things have gone well?	The Health Board has: • identified its risk and barriers and acted on these to address long planned care waiting lists in the short-term and sustainable service models in the longer term. • good arrangements for seeking good practice and sharing and applying learning to improve planned care services.

Appendix 3

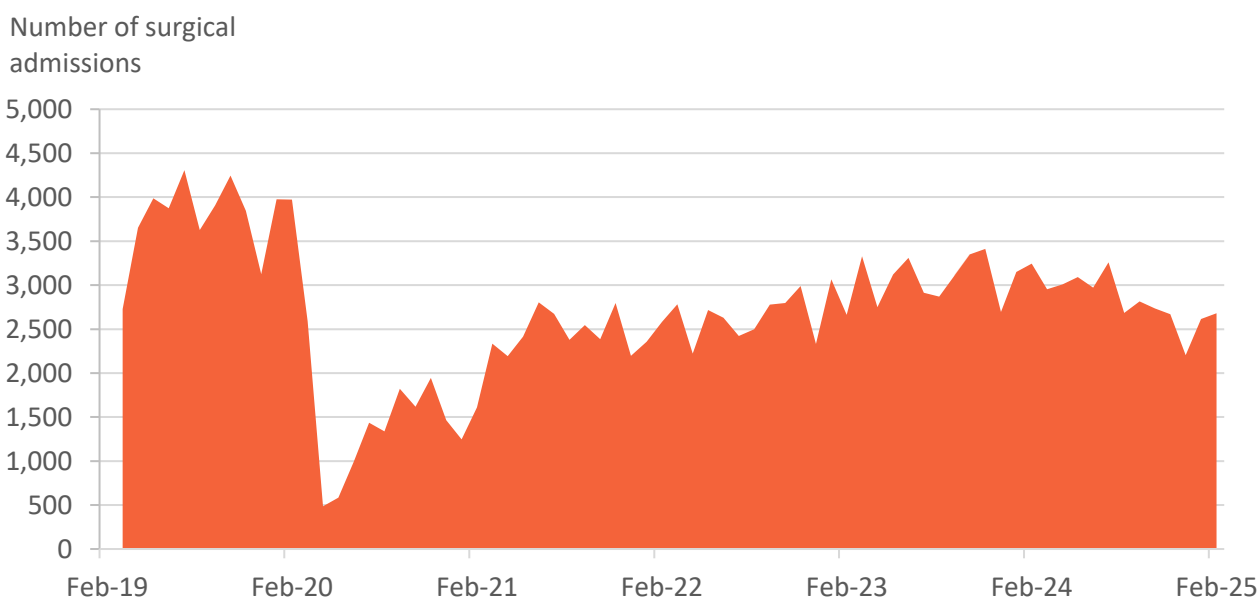
Additional data analysis on planned care

Exhibit 16: trend of monthly referrals to Cwm Taf Morgannwg University Health Board, by Health Board of residence



Source: Welsh Government, Stats Wales

Exhibit 17: monthly elective medical and surgical admission levels and outpatient activity levels, Cwm Taf Morgannwg University Health Board



Source: [Digital Health and Care Wales secondary care dashboard](#)

Outpatient services

50 Outpatient appointments where a patient ‘did not attend’ is inefficient. **Exhibit 18** shows a positive improvement in performance. Nevertheless, the Health Board’s ‘Did Not Attends’ for the last 12 months is around 7.7% of total outpatient clinic activity. This equates to around 43,500 lost patient appointments in the most recent 12-month period to February 2025. It represents a lost opportunity cost of around £6.5 million (£150 per appointment¹⁰). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save around £1.3 million.

Exhibit 18: the number and percentage of outpatient ‘Did Not Attends’, Cwm Taf Morgannwg University Health Board

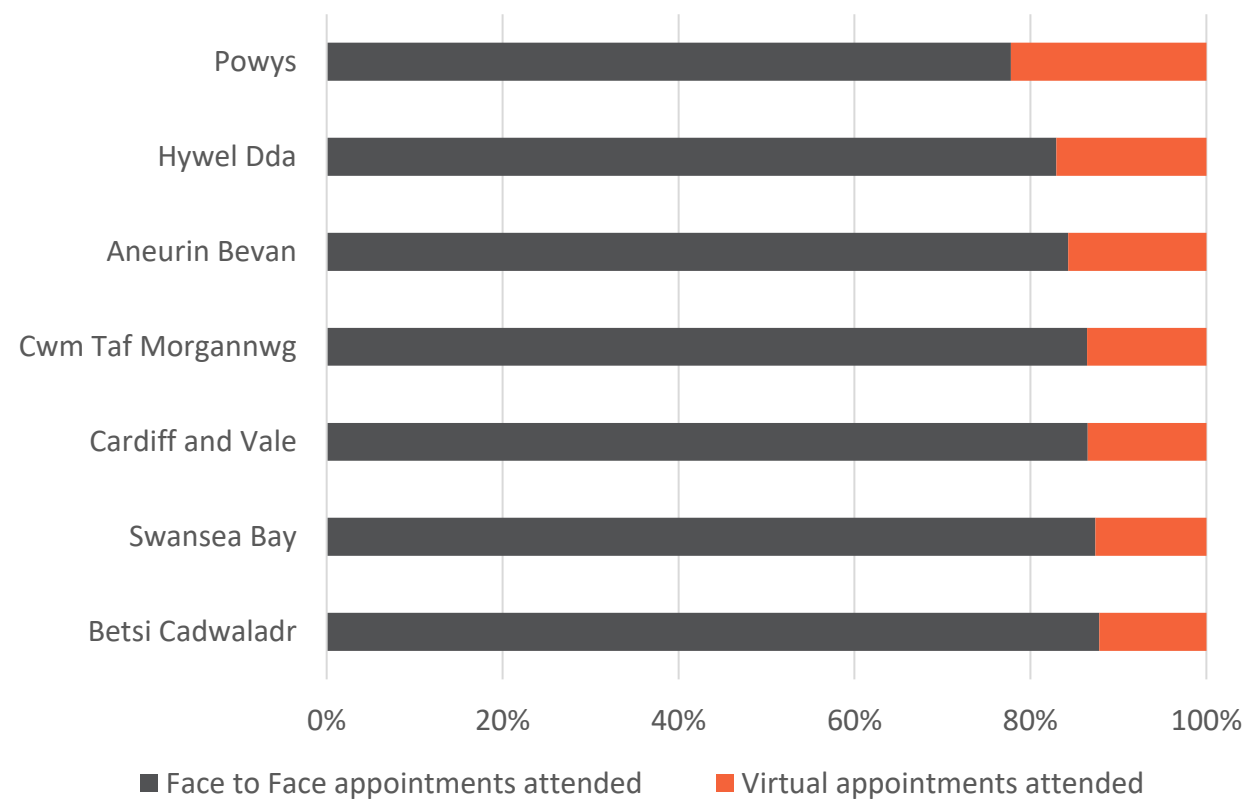


Source: [Digital Health and Care Wales secondary care dashboard and datasets](#)

¹⁰ We have adjusted the [2018 NHS England cost of an outpatient appointment](#) (£120) by [Bank of England CPI](#) rates to estimate current average outpatient costs in 2024.

52 NHS bodies can use virtual outpatient appointments for some but not all patients. **Exhibit 19** shows that the ‘virtual’ consultation approach is not well-adopted in most health boards.

Exhibit 19: proportion of outpatient attendances that are virtual appointments from April 2024 to February 2025

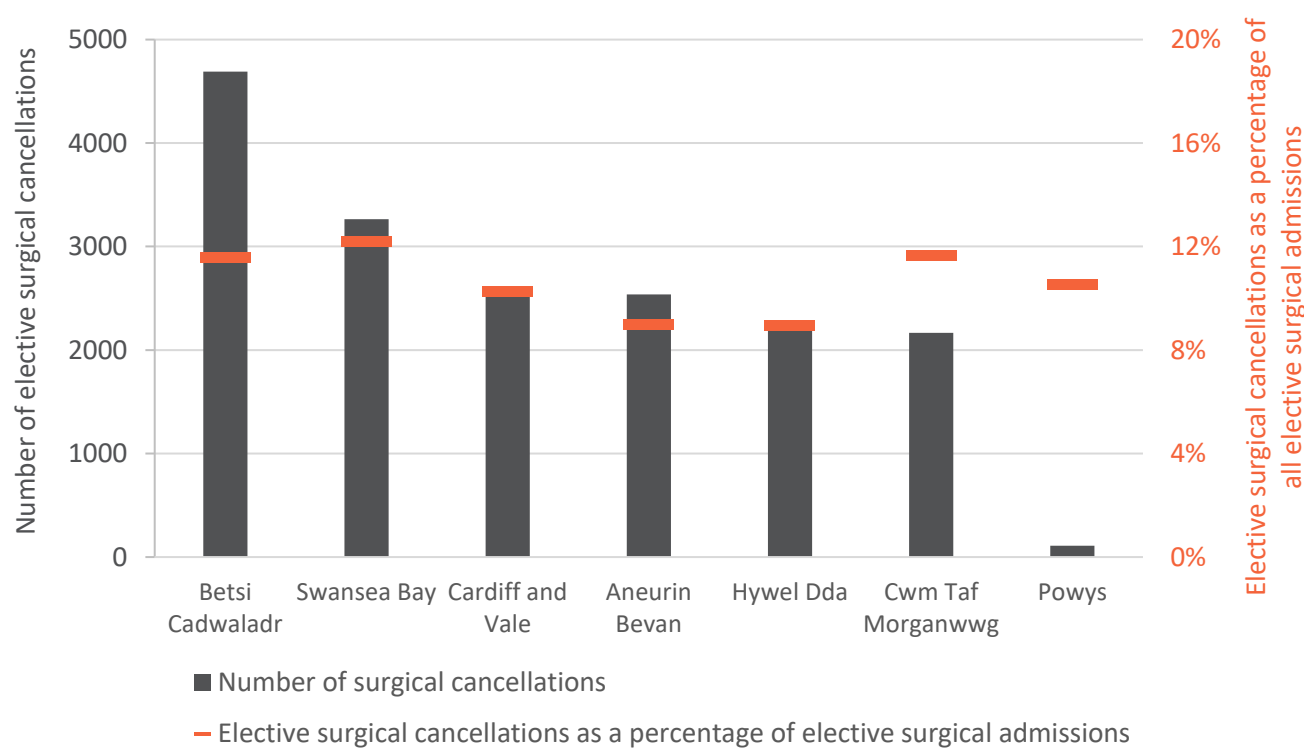


Source: [Digital Health and Care Wales secondary care dashboard and datasets](#)

Surgical cancellations

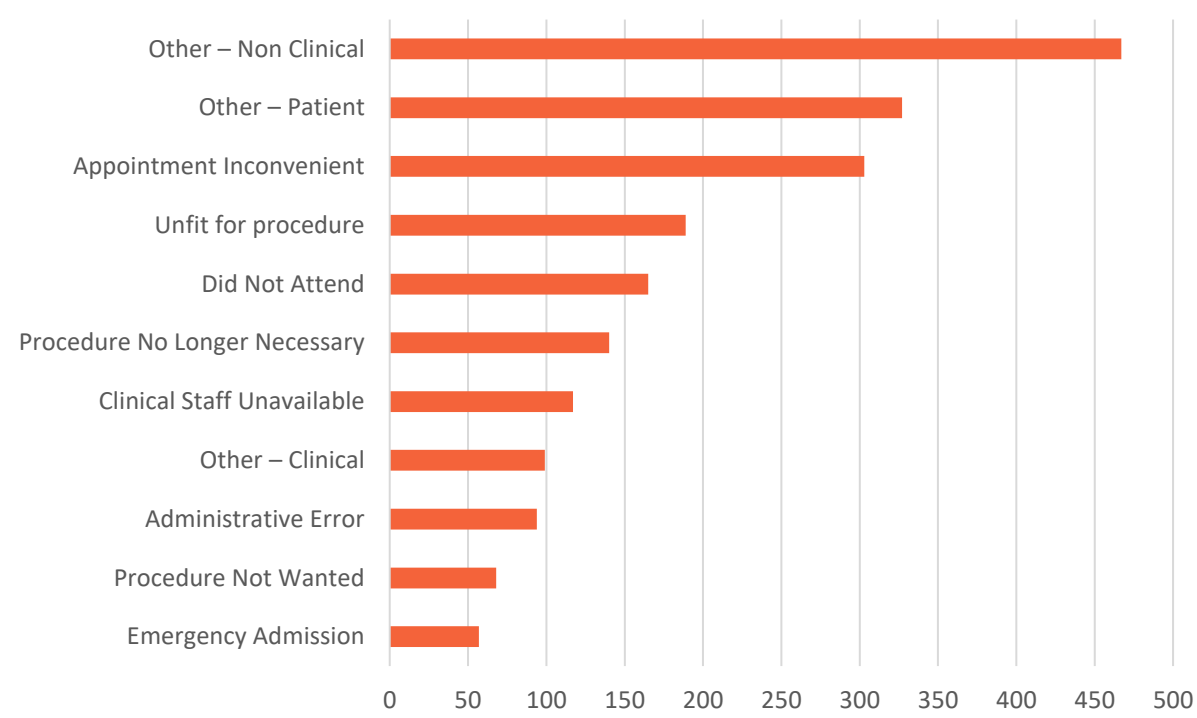
53 Short notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board almost reached 2,200 for the latest 12 month published data (March 2024 to February 2025) (**Exhibit 20**). **Exhibit 21** identifies the cancellation reasons. The Health Board’s use of the recording category ‘other’ does not help it address the underlying causes of the cancellations.

Exhibit 20: the number of short notice (within 24 hours) surgical cancellations alongside cancellations as a percentage of all elective surgical admissions, March 2024 to February 2025



Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Exhibit 21: number of short notice (within 24 hours) surgical cancellations for the latest 12-month reporting period (March 2024 to February 2025), by reason, Cwm Taf Morgannwg University Health Board

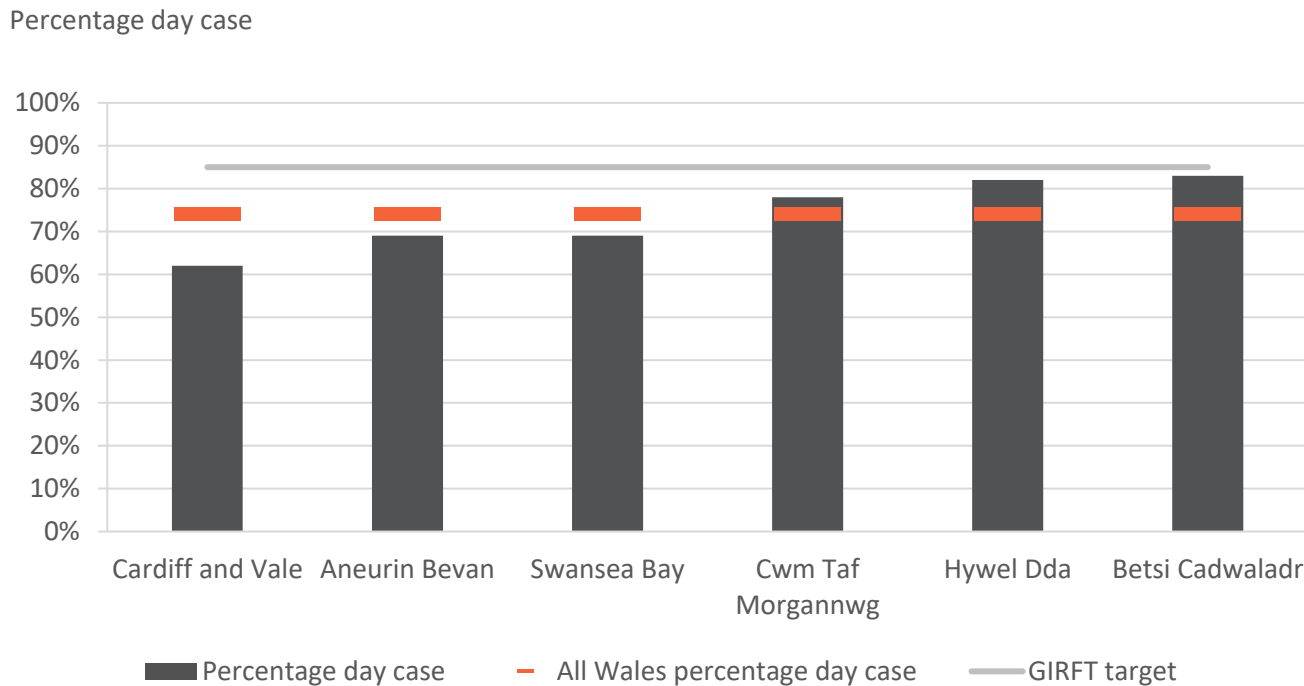


Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Day case surgery

54 Day case surgery offers the potential for improved efficiency, lower costs, lower carbon footprint per patient¹¹ and a better patient experience when compared with inpatient services. Getting It Right First Time recommends that on average 85% of all elective¹² surgery should be day case¹³. Our analysis in **Exhibit 22** indicates that 78% of the Health Board’s elective surgery is day case.

Exhibit 22: proportion of elective surgery undertaken by Health Boards as day case for the period April 2024 to February 2025



Source: [Digital Health and Care Wales secondary care dashboard and datasets](#)

¹¹ [Paper outlines GIRFT’s ‘unique position’ in supporting the NHS drive for net zero carbon emissions - Getting It Right First Time - GIRFT](#)

¹² Elective surgery is the type of surgery associated with a planned care patient pathway.

¹³ [Getting it Right First Time - Elective Recovery High Volume Low Complexity guidance for health systems](#)



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

Audit of Accounts Report Addendum – Cwm Taf Morgannwg University Health Board

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Introduction

This report is an addendum to our Audit of Accounts Report that we presented to you on 25 June 2025. The report sets out the recommendations arising from our audit of the 2024-25 accounts and an update on the progress you have made against previous years' recommendations.

We should like to take this opportunity to once again thank all your staff who helped us throughout the audit.

Recommendations from this year's audit

Exhibits 1 to 5 set out our recommendations arising from this year's audit.

Exhibit 1: matter arising 1

Finding

Some of the assets recorded in the asset register had been disposed and therefore did not exist as at 31 March 2025

We tested the existence of a sample of assets that had a £nil net book value (NBV) as at 31 March 2025. We found a high error rate within the sample where assets did not exist. Some of the existence errors related to an asset that had been replaced and therefore disposed, but had not been removed from the fixed asset register.

We undertook extended testing and analysis and concluded that there was no risk of material misstatement in respect of the 2024-25 year of account. For 2025-26 there remains the risk that many of the Health Board's older and fully depreciated assets have been disposed, but not identified as such and not removed from the register.

Recommendation

The Health Board should:

- undertake a documented assessment of the existence and use of its assets with a £nil net book value;
- introduce a documented annual rolling programme of physical verification and assessment of assets with a £nil net book value, including replaced assets; and
- introduce a periodic review of categories of asset lives, to gain assurance that they remain appropriate.

Accepted in full by management

Yes.

Management response

The £nil net book value assets will be physically verified in line with the relevant FCP which states assets all will be verified in a 3-year rolling period. Asset lives will be reviewed in conjunction with Clinical Engineering to ensure they remain appropriate.

Implementation date

March 2026.

Exhibit 2: matter arising 2

Some of the related party disclosures were unnecessary and were therefore removed from the accounts

Finding

Last year we reported that WHSSC officers had not reviewed the 2023-24 declarations of interest (Dols), to assess whether each declared interest represented control and / or significant influence (such judgements being critical to the preparation of the disclosures). The lack of review by officers led to inappropriate related party disclosures being made, for positions/interest where there was no control and/or significant influence. As a result, twelve disclosures were removed from the 2023-24 accounts, all relating to (the then) WHSSC; and we raised a recommendation for improvement, which WHSSC management accepted.

However, this year we found a similar level of over disclosure by both the (new) NHS Wales Joint Commissioning Committee (NHSWJCC) and the Health Board.

While officers had reviewed the Dols, they had determined to disclose ten related party disclosures for which there was no control and/or significant influence. The ten disclosures were therefore removed from the 2024-25 accounts: five of them relating to the NHSWJCC; and five relating to the Health Board.

We would like to stress that if members and senior officers have any doubt about whether an interest or position held should be declared, it is important to disclose it so that finance officers can then assess the declaration against the accounting requirements and take the appropriate action.

Recommendation

The Health Board and NHSWJCC should ensure that finance the appropriate officers evaluate members and senior officers' Dols in accordance with the requirements of the Welsh Government's Manual for Accounts and the relevant international accounting standard (IAS24 – Related Party Disclosures).

Accepted in full by management

Yes.

Management response

The Director of Corporate Governance / Board Secretary for CTMUHB and the Committee Secretary for the NHS Wales Joint Commissioning Committee will undertake to review related party disclosures in accordance with the requirements set out in the Welsh Government's Manual for Accounts and IAS 24 – Related Party Disclosures.

Implementation date

31 May 2026.

Exhibit 3: matter arising 3

The balance on the revaluation reserve in the financial statements did not agree to the underlying records

Finding

The balance on the revaluation reserve in the financial statements did not agree to the underlying accounting records for two reasons.

Firstly, we identified that a new requirement of the Welsh Government's Manual for Accounts had not been reflected in the Health Board's underlying accounting records. It related to the requirement to record a transfer between the general fund and the revaluation reserve, where previous impairments posted to the income and expenditure account had been reversed.

Secondly, we identified an historical accounting difference of £1.322 million that relates to a past change in the Health Board's underlying accounting system.

Recommendation

The Health Board should ensure that any new requirements of the 2025-26 Manual for Accounts are implemented.

Also, the Health Board should reconcile the balance on its revaluation reserve in the financial statements to the underlying accounting records.

Accepted in full by management

Yes.

Management response

CTMUHB will ensure that any new requirements are met, and reconciliation is completed.

Implementation date

31 May 2026.

Exhibit 4: matter arising 4

We experienced long delays in completing our IT audit in respect of the Wellsky and Retinue systems

Finding

As report to you in June, throughout the audit we had excellent engagement and support from Health Board and NHSWJCC officers, which enabled us to complete the audit by the deadline in place. We did however experience significant delays with the audit of the Health Board's Wellsky and Retinue IT systems. The delays arose due to significant problems with getting access to the relevant IT officers: being the Health Board's IT officers and system administrators for the Wellsky system; and the external contractor's officers for Retinue.

Recommendation

For our 2025-26 financial audit, once we have confirmed with the Health Board the IT systems that we will be reviewing, the relevant Executive Director(s) should provide us with the key contact for each system; and confirm that each contact is available and expecting us to contact them.

Accepted in full by management

Yes

Management response

CTMUHB's Chief Pharmacist is the Health Board lead for Wellsky and has been made aware of the ongoing requirement for engagement with Audit Wales Colleagues as required.

In general, should Audit Wales colleagues encounter any challenges with digital systems used within CTMUHB, then the Director of Digital can be contacted who will oversee and direct any issues to the appropriate lead within CTMUHB.

Implementation date

Leads have been confirmed as above, and it is therefore considered that this action is complete.

Exhibit 5: matter arising 5

The password parameter controls for the Prolease system are weak

Finding

The Prolease supplier MRI state that the password policy for systems without multi-factor authentication should be set to enforce minimum password lengths of 12 characters. We found that the Health Board has not adopted this principle for the Prolease system, with the minimum password length being set to eight characters.

Recommendation

The Health Board should implement password controls for the Prolease system that require a user to create a password that is a minimum 12 characters.

Accepted in full by management

No.

Management response:

This is an all-Wales system and the health board do not have control of system. Public Health Wales now share quarterly reports to confirm who has accessed the system and show access is not being compromised.

Implementation date

N/A.

Recommendations from previous years' audits

Exhibit 6 summarises our audit recommendations from last year, and other recommendations that are still open from our 2021-22 and 2022-23 audits. We comment on the progress that the Health Board has made with them.

Exhibit 6: the Health Board’s progress with past recommendations

Audit year	Recommendation	Progress
2023-24	Salary Sacrifice Deductions 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.	The Health Board has maintained technical compliance with accounting standards.
2023-24	Greenbury Pension Disclosures The Health Board should ensure that all its pension calculations reflect the Greenbury guidance (which provides templated calculation examples).	The Health Board has addressed this recommendation.

2023-24	Operating Leases 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.	There were no issues during the 2024-25 audit, so we are content that the Health Board has addressed this recommendation.

2023-24	Related Party Disclosures (WHSSC) The Joint Commissioning Committee should put in place a robust process to ensure that: • all the necessary declarations of Interests (Dols) from its senior officers and members are received soon after the financial year-end; • the Dols 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.	The Health Board and the NHS Wales Joint Commissioning Committee have made good progress in this area but there continues to be room for improvement regarding the second bullet point, as set out in Exhibit 3.

2023-24	ProLease System 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.	Regular user access reviews now occur. User access reports are run monthly and shared with the NHS bodies quarterly to check, before removing user access rights as necessary. An initial report has been run, to check access by MRI users, and it is now planned to carry out these checks regularly. Therefore, at the time of audit, this process is not yet fully embedded. Audit Wales will confirm checks have occurred at a regular basis as part of the 2025-26 audit.

	Network User Access 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.	The Health Board has not fully implemented the recommendation, as intended. The Health Board has now removed the duplicate accounts that existed in 2023-24 but still needs to ensure that privileged access accounts are regularly reviewed.
2023-24	RAM Asset Register The Health Board should migrate its RAM financial server system to up-to-date and fully supported infrastructure.	The Health Board has not implemented the recommendation, as intended.

2022-23	Primary Care 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.	We did not encounter any issues in this area during this year’s audit and therefore we are content that the Health Board has addressed the recommendation.

2022-23	Retinue System The Health Board should put arrangements in place to regularly review all the access rights to the Retinue system, to ensure that they are accurate and remain appropriate. Also, the Health Board should obtain formal confirmation from Retinue that it has reviewed its Disaster Recovery Plan and is satisfied that it remains robust. As part of this process the Health Board should also obtain a summary of all changes to the Plan. This confirmation should be obtained at least annually	The Health Board has not implemented the recommendation, as intended.

2022-23	Wellsky System The Health Board should regularly check the Wellsky 'Active Users' report to ensure that all live users are set up with the correct access rights, and that any leavers' access has been removed by Digital Health and Care Wales (i.e. where requested by the Health Board). Also, the Health Board should document its review of the Wellsky 'Inactive Users' report to determine whether any inactive user accounts need to be closed or suspended.	The Health Board has not implemented the recommendation, as intended.
2022-23	Health Roster System The Health Board should document its review of the Healthroster super-user report	The Health Board has not implemented the recommendation, as intended.

2020-21	RAM Asset Register The Health Board should perform a restore of the RAM system from backups to confirm that the process works as expected and thereby provide assurance that the system could be recovered in the event of system loss or failure. The Health Board should carry out such testing regularly	The Health Board has not implemented the recommendation, as intended. In addition to the regular testing, the Health Board should ensure that its Disaster Recovery plans are formally documented and approved.

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Rydym yn croesawu gohebiaeth a
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Agenda Item

6.1.3

Unapproved / Minutes of the Audit & Risk Committee

Date and Time of Meeting	Thursday 22 May 2025 at 10:00 am
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member (Chair)
	Carolyn Donoghue	Independent Member (Vice Chair – Interim)
In Attendance	Dilys Jouvenat	Independent Member
	Sally May	Executive Director of Finance & Procurement
	Gethin Hughes	Chief Operating Officer (in-part)
	Dom Hurford	Medical Director
	Stuart Morris	Director of Digital (in-part)
	Paul Dalton	NWSSP – Internal Audit & Assurance
	Emma Samways	NWSSP – Internal Audit & Assurance
	Murray Guard	NWSSP – Internal Audit & Assurance (in-part)
	Huw Richards	NWSSP – Internal Audit & Assurance
	Martyn Lewis	NWSSP – Internal Audit & Assurance
	Nathan Couch	Audit Wales
	Mark Jones	Audit Wales
	Dave Thomas	Audit Wales
	Owen James	Head of Corporate Finance
	Matthew Evans	Local Counter Fraud Specialist
	Amanda Legge	PPV Manager
	Sue Tillman	PPV Manager
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Kathrine Davies	Corporate Governance Manager/Meeting Secretariat
	Claire Brown	Head of Quality Assurance & Compliance
	Kelly Eddington	Quality, Assurance & Compliance Officer

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions



	P. Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed. P. Roseblade 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: • Kath Palmer – Vice Chair/Independent Member • Helen Lentle – Independent Member • Gethin Hughes – Chief Operating Officer
1.3	Declarations of Interest
	No declarations were identified.
2.	CONSENT AGENDA BUSINESS
2.1	The Chair reminded Members that the agenda had been reformatted to include consent agenda items at the end of the agenda. She asked if there were any items from the consent agenda (Item 8) that the Committee Members wished to bring forward to the main agenda for discussion. There were none. P. Roseblade referred to the Clinical Audit Report and suggested that as it was a core responsibility of the Audit, Risk & Assurance Committee that this item should be moved to the main agenda for future meetings. D. Hurford confirmed that he would ensure that the lead for Clinical Audit, M. Townsend and the Assistant Medical Director would attend to provide some direct insights in the discussion.
Action:	To move the Clinical Audit Report onto the main agenda for future meetings and ensure attendance from the Clinical Audit Lead and Assistant Medical Director to aid discussion.
3.	MAIN AGENDA
3.1	Audit & Risk Committee Action Log G. Watts presented the Action Log and provided an update on the following: Key matters: • A number of items were proposed for closure and therefore would not go through those individually. Attention was drawn to the following 'open' actions:



	- Referral to the Quality, Safety & Experience Committee regarding clinical negligence – the response from this would be received at the August 2025 meeting. - Medical Job Planning – additional work was due to come back to the Committee at the August 2025 meeting. - Paediatric dentistry – discussions were ongoing regarding the management of this risk and a commitment to provide further updates to future meetings. C. Donoghue advised that a substantial discussion was held in relation to paediatric dentistry at the Quality, Safety and Experience Committee and suggested that it might be helpful to provide a cross-report to the Audit, Risk & Assurance Committee rather than going through the discussion again.
Resolution	The Committee DISCUSSED and NOTED the Action Log.
Action	To provide a cross-report on paediatric dentistry from the Quality, Safety & Experience Committee.
3.2	Matters Arising not contained within the Action Log
Resolution	There were no matters raised.
4.	COMMITTEE GOVERNANCE ARRANGEMENTS
4.1	Declarations of Interest and Gifts, Hospitality & Sponsorship Report
	G. Watts presented the report. G. Watts advised that the report is brought to the Committee on an annual basis to provide reassurance in accordance with the organisations policy on standards of behaviour and highlighted the following key matters: - Process involved 550 members of staff across various parts of the organisation to gather the necessary information. The process was very resource intensive and was led by the Assistant Director of Governance & Risk. - The report includes high level details of the declarations and was supported by two appendices, Declarations of Interest and Gifts and Hospitality. - The register of interests for staff who are part of the CTM Board is published in the public domain. - The year-end disclosures in terms of related parties are reviewed in detail by colleagues from Audit Wales as part of their year-end audit work.
Resolution	The report was NOTED .
Action	No action identified.
4.2	Annual Review: Risk Management Framework
	G. Watts presented the report. G. Watts provided an overview of the annual review of the risk management framework, highlighting the following points:



	• The review is conducted on an annual basis and brought to the Committee in advance of formal approval being sought by the Board. • Members had a detailed discussion on the board assurance framework and risk appetite during the Board Development Session which had taken place in the previous week. • The Assistant Director of Governance & Risk is the lead for the Risk Management Framework ensuring it is thorough and comprehensive. • The paper includes the risk management strategy, risk domain scoring matrix, Board Assurance Framework, Risk Management Policy and Risk Management Procedure. P. Roseblade queried whether Members had had an opportunity to read the report as it was not contained within the original batch of papers on Admin Control. G. Watts advised that an updated meeting book of the papers was sent out the day before the meeting and the reason for the delay was due to the proximity of the Board Development meeting the previous week to the ARAC meeting which gave limited time for the document to be updated and circulated following the Board Development session.
Resolution	The Committee: • APPROVED the Risk Management Strategy (Appendix 1), which includes: ○ the Risk Appetite Statement and agree that it is implemented for the next 12 months with assurance that it is set to ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve. ○ the Risk Domain & Scoring Matrix and its continued application and the risk escalation threshold. ○ that the Board Assurance Framework remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board as discussed in detail at the Board Development Session on the 15th May 2025. • APPROVED the Risk Management Policy (Appendix 2). • APPROVED the Risk Management Procedure (Appendix 3).
Action:	No Action was identified.
4.3	Organisational Risk Register G. Watts presented the Report and highlighted key updates to members. • Changes from the previous version of the risk register were contained within Section 3 of the report. • Two new risks were added: one related to the cellular pathology service (score of 16) and another concerning overweight and obesity in children and adults. • Some digital and data risks have decreased during this period.



	- The risk related to finance for 2024-25 has been closed, but a new risk for the 2025-26 financial year has been added. - The paper also outlined some emerging risks. C. Donoghue raised a specific question in relation to risk 5761, cross Health Board data sharing and raised the following concerns relating to lack of clarity as the description of the risk indicates no change to the risk score but does not clearly explain the solution and in terms of mitigations the comments "<i>HCW is working on it</i>" does not provide sufficient assurance. C. Donoghue requested further detail on this outside of the meeting.
Resolution	The Committee NOTED the report.
Action	To provide further assurance on clarity and mitigations of risk 5761 outside of the meeting.
5.	FINANCIAL GOVERNANCE ACTIVITY
5.1	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 January to 31 March 2025, as required by the Standing Financial Instructions. P. Roseblade referred to the changes in contributions to the Welsh Risk Pool and queried whether it was claims that were driving that change. S. May, in response, confirmed that the change was based on claims and a three year average, however, she advised that there was concern in relation to the inconsistency in the percentage share across Wales. D. Jouvenat referred to the penalties for late submitted evidence and queried whether anything could be done to prevent these from being late. S. May advised that the issue sits with the Director of Nursing & Midwifery for the Patient Care & Safety Team and suggested that the Committee could request an update from them or refer the matter to the Quality, Safety & Experience Committee for further information. S. May advised that the Director for People would be raising the question about the effectiveness of penalties in improving performance at the Shared Services Committee being held today. P. Roseblade agreed with S. May suggestion and emphasised the importance of ensuring that the organisation benefitted from the learning associated with the penalties and proposed that an update on the matter be brought back to the next meeting of the Committee.
Resolution	The Committee NOTED the losses and special payments made for the period 1 January 2025 – 31 March 2025
Action	To receive an update on penalties for late submitted evidence at the next meeting of the Committee.
5.2	Procurements and Scheme of Delegation Report



	S. May presented the report and highlighted the position on procurement matters for the period 1st December 2024– 31 January 2025. S. May advised that the Purchase to Pay (PSPP) figures show that the Health Board had met its 95% target for paying non NHS invoices within 30 days. However, disappointment had been expressed by Welsh Government regarding the performance on NHS invoices and particularly in relation to the number of payments. S. May advised that there had been a marginal improvement from the previous year with the Health Board paying 87.1% (number) or 97.1% (value) of NHS invoices.
Resolution	• NOTED the position on procurement matters for the period 01.02.25 to 31.03.2025; • NOTED the update regarding Purchase to Pay and achievement of PSPP target up to Month 12 of 2024/25;
Action	No Action was identified.
5.3	Post Payment Verification Annual Report 1st April 2024 – 31st March 2025 A Legge and S. Tillman presented the report and highlighted the high number of revisits and the impact of staff absences.
Resolution	The Committee NOTED the report.
Action	No Action was identified.
6.	COUNTER FRAUD ACTIVITY
6.1	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 highlighted the resource position and drew attention to the referral of a case to disciplinary considerations and professional body.
Resolution	The report was NOTED .
Action	No Action was identified.
6.2	Counter Fraud Annual Report 2024-25 M. Evans presented the report that summarised the Counter Fraud Annual Report, highlighting the integration with the Health Board and the focus on risk as a key performance indicator.
Resolution	The report was NOTED .
Action	No Action was identified.
6.3	Counter Fraud Functional Standard Return 2024-25



	Matthew Evans to present the report that provided detail on the tasks and actions undertaken with the four strategic counter fraud work areas.
Resolution	The NHS Counter Fraud Standards self-assessment was REVIEWED prior to submission to NHSCFA and the report was NOTED
Action	No Action was identified.
6.4	Counter Fraud Draft Work Plan M. Evans presented the report, emphasising the focus on the risk and awareness work.
Resolution	The report was NOTED .
Action:	No Action was identified.
6.5	National Fraud Initiatives Progress and Outcomes M. Evans presented the report that highlighted the progress and outcomes of the National Fraud Initiative including the approach to high-risk matches and the assurance of system operations.
Resolution	The report was NOTED .
Action	No Action was identified.
7.	AUDIT REVIEWS AND ASSURANCE TRACKER
7.1	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 advised that the report was a snapshot of the data from April 2025 with a number of significant internal audit report completed since that period. A session had been held at the end of April 2025 with Independent Members to further discuss their requirements and expectations of the audit tracking process., Other developments in this area include an ongoing internal audit review of the audit tracking process, at the time of the committee meeting and the development of an audit handbook to enhance understanding and implementation of audit recommendations. G. Watts acknowledged the significant work undertaken by the Assistant Director of Governance & Risk and the Quality, Assurance and Compliance team and expressed his thanks.
Resolution:	The Committee NOTED the Report and AGREED the assurances provided.
Action:	No Action was identified.
7.2	Internal Audit Progress Report P. Dalton presented the progress report that provided the Audit & Risk Committee with the current position of the work undertaken by Internal Audit.



	P. Dalton highlighted the significant progress made with regard to the 2024-25 audit plan and advised that 84% of the planned audits were now either in draft or final stages which showed a substantial shift from the last meeting of the Committee. P. Dalton referred to the detail of the individual reviews that were contained in tables 3,4 and 5 of the report.
Resolution	The report was NOTED
Action	No Action was identified.
7.3	NWSSP Internal Audit Services – Annual Audit Plan 2025-26 P. Dalton presented the report. P. Dalton advised that the internal audit annual plan for 2025-26 was risk-based and had been developed through a combination of reviewing organisational risks, attending Board and Committee meetings, considering wider NHS activities, and consulting with management and the Executive Team. P. Dalton highlighted the importance of flexibility in the plan in order to accommodate changes in risks or priorities throughout the year. P. Dalton drew attention to the detailed proposed plan in Appendix A, Key Performance Indicators in Appendix B and the Mandate and Charter document in Appendix C which outlines the relationship with the organisation and approach to disagreements. P. Roseblade thanked P. Dalton for his report which was thorough and risk based and noted the number of limited assurances received as evidence of its effectiveness. P. Roseblade raised a specific query in relation to Medical Annual Leave and Rostering in terms of the Executive Lead and suggested that it should include the Medical Director alongside the Chief Operating Officer. P. Dalton advised that he would check this for accuracy outside of the meeting. C. Donoghue commented that the lack of questions in relation to this report was not due to lack of interest but rather because the report was clear and well structured, and that the explanations of the risk based approach and flexibility of the plan was helpful. C. Donoghue also acknowledged the difficulty in trying to balance independence and objectivity of internal audit whilst working for the organisation.
Resolution:	The report was NOTED
Action	To review the Executive Lead for the Medical Annual Leave and Rostering.
7.4	NWSSP Internal Audit Review Reports (Limited Assurance Reports)
7.4.1	IA Review – Estates Condition – Final



	H. Richards and Murray Guard presented the report which has been given a 'Limited' Assurance rating. H. Richards advised that estates condition audits were conducted across all NHS organisations in Wales to evaluate the scale of challenges and risks. The limited assurance rating given to the Health Board was consistent with other organisations across Wales. M. Guard highlighted the significant backlog maintenance required and the limited resources available to address these issues. M. Guard advised that the audit had identified areas needing improvement such as developing standard operating procedures, engaging with NHS Wales forums and providing regular updates on the Capital Plan and estates infrastructure risks. S. May expressed her concern in relation to the limited assurance rating and advised that the scope of the audit should focus on the ability to access and target available funds effectively, rather than the overall availability of Capital money. P. Roseblade and C. Donoghue also echoed their concerns about the limited assurance rating being based on factors outside the Health Board's control such as insufficient funding. M. Guard clarified that the follow-up audit would focus on the agreed actions within the Health Board's control rather than the overall funding issues. P. Roseblade queried whether the limited assurance would impact on the internal audit opinion and the audit tracker. P. Dalton advised that in terms of the internal audit opinion this had been picked up in last year's (2023-24) internal audit process and would not impact the 2024-25 opinion. P. Dalton confirmed that the follow up audit would focus on the agreed actions within the Health Board's control rather than the overall funding issues.
Resolution:	The Committee NOTED the report.
Action:	No action was identified.
7.4.2	IA Review – Capital Systems – Final M. Guard presented the report which has been given a 'Limited' Assurance rating. S. May advised that one of the issues experienced was a lack of capacity or willingness to support estates from procurement colleagues at NHS Wales Shared Services and that she had been in discussions with the Director of Procurement within Shared Services and had now agreed on a way forward to ensure proper support for the estates team.

	S. May advised that the new procurement regulations would change some of the landscape and it was important to get the right professional input into procurement in accordance with the Standing Financial Instructions. P. Roseblade expressed that she was surprised on the limited assurance rating, and despite the roof issues at the Princess of Wales Hospital previous reports such as the Prince Charles Hospital development had received reasonable or substantial assurances.
Resolution:	The Committee NOTED the report.
Action	No Action was identified.
7.4.3	IA Review – Gastro Intestinal Pathways – Progress Update E. Samways presented the report that had received a 'Limited' Assurance rating.
Resolution:	The Report was NOTED .
Action:	No action was identified.
7.4.4	IA Report – Digital Benefits Realisation M. Lewis presented the report that had received a 'Limited' Assurance rating. M. Lewis advised that the audit assessed the processes in place to ensure benefits from digital investments are fully realized. The audit was given a 'limited' assurance rating due to inconsistencies in the benefits management framework, identification, and tracking of benefits. M. Lewis advised that key issues included the lack of a comprehensive framework, inconsistent identification and baselining of benefits, and the need for better stakeholder engagement and coordinated reporting. S. Morris acknowledged the historical lack of a structured approach to benefits realisation in digital projects and advised that the Health Board was now using the EPME Programme to develop a more disciplined and standard approach. S. Morris advised that he was confident that the gaps identified within the audit would be addressed with the new framework along with the appointment of a Business Change lead and Business Analysts.
Resolution	The Report was NOTED
Action:	No action was identified.
7.5	Audit Wales - Audit & Risk Committee Update M. Jones and N. Couch presented the report. M. Jones provided an update on the financial audit side of the Audit Wales report and advised that the annual accounts for 2024-25 had been submitted in accordance with the Welsh Government deadline. M. Jones advised that the Charity accounts would be picked up in the autumn.



	N. Couch provided an update on the performance audit work and highlighted the following key points: • The digital transformation review is underway, with the Health Board having agreed to the project brief. The self-assessment will be issued imminently, and the report is expected to be presented in November 2025. • Drafting of the Unscheduled Care reports is in progress, with an intention to present them in August 2025. • Drafting of the Planned Care and Eye Care reports is also in progress, with a presentation planned for August 2025. • Scoping of the 2025 Structured Assessment is underway, with fieldwork to be completed during the Summer and early Autumn. The report is expected to be presented in November 2025. • Scoping of the Deep Dive on Estates is underway, with fieldwork anticipated to commence in the autumn. • The thematic reviews of Cancer Services and the local review of Follow-up Outpatients are at the scoping stage, with fieldwork to commence later in the year. • Exhibits three and four in the update provide links to other relevant examinations and studies published by the Auditor General and additional P. Roseblade queried whether the Estates deep dive would differ from the Internal Audit report or would they be relying on that report. D. Thomas advised that they would ensure that the deep dive would not overlap with anything that internal audit had previously undertaken. He added that it was an all Wales piece of work that would also be tailored locally, liaising with internal audit colleagues.
Resolution:	The Report was NOTED .
Action:	No Action was identified.
7.6	Audit Wales National Reports
7.6.1	Audit Wales Report – Audit Wales Report - Cancer Services in Wales G. Watts and D. Thomas presented the report. G. Watts advised that the report is part of the national studies undertaken by the Audit General for Wales and highlighted the importance of considering National reports that impact upon the Health Board. D. Thomas highlighted the key findings: • Cancer outcomes in Wales are improving, but the 62-day target for treatment following suspicion of cancer is not being met by any Health Board since 2020. • There are increasing waits between diagnosis and treatment, and challenges with late diagnosis for certain cancers. • Survival rates in Wales are improving, but mortality rates do not compare well to other parts of the UK and other countries.



	- Screening programmes have mixed results, with Bowel Screening being successful but Breast and Cervical Screening not meeting uptake standards. - There are significant gaps in National leadership arrangements, including unclear status and ownership of the All Wales Cancer Improvement Plan and slow decision making on important areas like Lung Cancer Screening and Digital Pathology programmes. - The report calls for a broader approach to performance management and a clearer commitment to prevention. - Welsh Government has largely accepted the recommendations and is taking action, including the development of a new National Cancer Leadership Board. However, the time scale for implementing the recommendations is challenging and ambitious. P. Roseblade expressed concern about the ambitious timescales for implementing the recommendations contained within the report and questioned how realistic it was considering the challenges referred to. D. Thomas acknowledged the point that the timescale was challenging and ambitious and advised that one milestone had already been missed and emphasised the importance of addressing the issues properly rather than rushing through them and whilst the recommendations are ambitious they need to be realistic to ensure they are dealt with effectively. C. Donoghue expressed concern about the report's findings and particularly the focus on public health and prevention. C. Donoghue referred to the leadership of the cancer agenda and queried whether it had fallen through the gaps. D. Thomas advised that there was a lack of clarity in terms of leaderships roles and responsibilities, however, the new National Cancer Leadership Board aims to address this issue.
Resolution	The report was NOTED .
Action:	No Action was identified.
7.7	Audit Wales 2025 Audit Plan D. Thomas and M. Jones presented the report. M. Jones provided an overview of the financial audit aspects of the 2025 Plan highlighted key risks, areas of focus, the audit team and the fee structure. The Plan also includes a new auditing standard on the auditing of groups and a new auditing standard for the financial year 2024-25. D. Thomas referred to the performance audit side of the plan which included the core Structured Assessment, Deep Dives, Thematic Review into Cancer Services in Wales which had been presented to the Committee at this meeting.
Resolution	The report was NOTED .
Action:	No action was identified.
8.	CONSENT AGENDA
8.1	FOR APPROVAL



8.1.1	Unconfirmed Minutes of the meeting held on 13 February 2025 were APPROVED.
8.1.2	Unconfirmed Minutes of the In Committee meeting held on 13 February 2025 were APPROVED.
8.1.3	Standards of Good Governance and Probity was APPROVED.
8.2	FOR NOTING
8.2.1	Committee Annual Cycle of Business 2025 was NOTED.
8.2.2	Committee Forward Work Plan was NOTED.
8.2.3	Cwm Taf Morgannwg University Health Board (CTMUHB) National Clinical Audit Programme Quarter 3 Update 2024-25 was NOTED.
8.2.4	Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan 2025-26 was NOTED.
8.2.5	Standing Orders – Variation or Breach Report was NOTED.
8.2.6	NWSSP Internal Audit Review Reports (Reasonable and Substantial Assurance Reports) The following reports were NOTED . 8.2.6a – Duty of Candour 8.2.6b – Cancer Tracking Process 8.2.6c – ED Performance – Follow Up 8.2.6d – Service User Experience 8.2.6e – New Care Group Model 8.2.6f – PCH Delivery of Key Project Objectives 8.2.6g – Arrangements for Financial Savings - Follow Up 8.2.6h – New PDR Process 8.2.6i – Electronic White Boards
9.	CLOSE OF BUSINESS
9.1	Any Other Urgent Business There was no urgent business to report.
9.2	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.
9.3	Committee Highlight Report
Resolution:	The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.
10.	CLOSE OF MEETING

Agenda Item
**Unapproved Minutes of the Audit, Risk & Assurance (CLOSED)
In Committee Meeting**

Date and Time of Meeting	Thursday 22 May 2025 at 14:00 pm
Venue	Virtual via MS Teams

Members Present	Patsy Roseblade	Independent Member (Committee Chair)
	Helen Lentle	Independent Member
	Dilys Jouvenat	Independent Member
	Carolyn Donoghue	Interim Health Board Vice Chair
Present		
	Sally May	Executive Director of Finance
	Dom Hurford	Executive Medical Director
	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
	Gareth Watts	Director of Corporate Governance / Board Secretary
	Jaqueline Maunder	JCC Committee Secretary and Associate Director Corporate Services
	Stacey Taylor	JCC Director of Finance & Information
	Tracy Norris	Academy Manager, National Imaging Academy Wales
	Owen James	Head of Corporate Finance
	Kathrine Davies	Corporate Governance Manager
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 Kath Palmer – Independent Member/Health Board Vice Chair
1.3	Declarations of Interest

	There were none to declare.
2.	Draft Annual Report 2024-25
2.1	CTMUHB – Draft Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2024-2025 (Including JCC and NIAW Annual Governance Statements / Compliance Statements and the Draft Head of Internal Audit Opinion as appendices. G. Watts presented the Health Boards’ Draft Annual Report and Annual Accounts for the financial reporting period 2023-2024. The report included the Joint Commissioning Committee (JCC) and the National Imaging Academy Wales (NIAW) Annual Governance Statements. G. Watts emphasised that the report was in compliance with the prescribed format by the Treasury and Welsh Government and highlighted the importance of the Accountability Section that included Corporate Governance, Remuneration of Staff, Financial Accountability and Audit Report. G. Watts thanked C. Hamblyn and E. Walters for their work in pulling this together and everyone who has contributed to the report. G. Watts advised that initial feedback from Welsh Government was positive with only minor comments and that the report was well structured and easy to follow. G. Watts added that the report was still in draft form so there will still sections highlighted in yellow that were in respect of timing aspects and would be updated. The final report would be received at the Extra Ordinary Meeting of the Committee on the 25th June 2025, following which they would be presented to the Board on the 26th June 2025 for endorsement.
Resolution:	The Committee: • ENDORSED the current draft of the Annual Report for 2024-2025 - Appendix 1. • NOTED the Governance Statements received from the Health Board’s Hosted Organisations (Appendices 2-3).
Action:	None identified.
2.2	Head of Internal Audit Opinion – Verbal Update Paul Dalton provided a verbal update. P. Dalton advised that some pieces of work were still in the fieldwork phase but indicated that the overall opinion was likely to be ‘Reasonable Assurance’. Members noted that the final version of the report would be presented to the Extra Ordinary Meeting of the Committee on the 25th June 2025 for endorsement and subsequent approval at the Board Meeting. on the 26th June 2025.



Resolution	The verbal update was NOTED .
Action	None identified.
2.3	CTMUHB Draft Accounts 2024-2025 - **Draft Subject to Final Audit Review** S. May presented the draft accounts and updated to the Audit & Risk Committee on the Draft Financial Statements for the financial year ended 31st March 2025. S May highlighted the key risks within the financial year and advised that the financial targets that were required to remain within the revenue resource target had been met with a balanced plan submitted to Welsh Government with feedback awaited.
Resolution	The Committee is being asked to: • NOTE the Draft Annual Accounts for 2024-25, subject to any issues that may arise from the ongoing external audit process. • NOTE the key critical judgements and estimates that have been used in the accounting period 2024-25 • NOTE the Health Board has not met the financial target of breaking even over a rolling 3-year period.
Resolution:	The report was NOTED .
Action:	None identified.
2.4	CTMUHB Audit Enquiries Letter G. Watts presented the report which had been jointly produced by Corporate Governance with Finance and Counter Fraud colleagues and had been shared with Audit Wales. The report also included the JCC Audit Enquiries Letter as an Appendix. G. Watts advised that this was a standard procedure and a requirement of the Auditor General for Wales. M. Jones confirmed that Audit Wales were currently on track in terms of timing and were engaging with both CTM and the JCC financial teams. There were some minor audit issues and questions that will be reported in due course but no significant issues had been raised.
Resolution	The Committee NOTED the Health Boards response to the Audit Enquiries Letters included at Appendices 1-2.
Action	None identified
3.	GOVERNANCE
3.1	Organisational Risk Register - Business Sensitive Risks G. Watts presented the risk register.

	G. Watts that 2 of the 3 risks identified related to digital risks, namely Ransomware and National Network Potential Outages. The third risk was in relation to CCTV in the Princess of Wales Hospital and Prince Charles Hospital with a significant amount of work due to the be completed by the 15th May 2025, the update of which would be feedback to the Committee once received. G. Watts added that in relation to the digital risks, capital funding had been received in the latter stages of the 2024-25 financial year.
Resolution	The Organisational Risk Register was NOTED .
Action	None identified
4.	ANY OTHER BUSINESS
	There was no urgent business to report on this occasion.
5.	DATE AND TIME OF NEXT MEETING:
	The next Committee meeting is scheduled for the 25 th June 2025 to receive the Annual Accounts

**Minutes of the Extra Ordinary Meeting of Cwm Taf Morgannwg
University Audit, Risk & Assurance Committee held on Wednesday 25
June 2025, via Microsoft Teams**

Members Present:

Dilys Jouvenat	Independent Member (Third Sector) – Committee Vice Chair and Chair of the Committee on this occasion.
Jonathan Morgan	Health Board Chair
Kath Palmer	Independent Member
Carolyn Donoghue	Independent Member
Helen Lentle	Independent Member
Rachel Rowlands	Independent Member
Hayley Proctor	Independent Member

In Attendance:

Gareth Watts	Director of Corporate Governance / Board Secretary
Sally May	Director of Finance & Procurement
Owen James	Head of Corporate Finance
Adele Lewis	Senior Finance Manager - Financial Accounting
Cally Hamblyn	Assistant Director of Governance & Risk (Meeting Secretariat)
Jacqueline Maunder	Committee Secretary and Associate Director of Corporate Services, NHS Wales Joint Commissioning Committee
Stacey Taylor	Director of Finance and Value/Deputy Chief Commissioner,, Joint Commissioning Committee
Nia Roberts	Lay Member JCC
Mark Jones	Audit Manager – Audit Wales
Steve Stark	Financial Audit Lead - Audit Wales
Emma Samways	Deputy Head of Internal Audit
Paul Dalton	Head of Internal Audit

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

D. Jouvenat **welcomed** everyone to the meeting including colleagues from the Joint Commissioning Committee, Internal Audit and Audit Wales.

1.2 Apologies for Absence

Apologies for absence had been received from:

- Paul Mears, Chief Executive
- Greg Padmore-Dix, Director of Nursing & Midwifery/Deputy Chief Executive
- Patsy Roseblade, Independent Member (Finance / Audit)
- Owen James, Head of Corporate Finance

1.3 Declarations of Interest

No Declarations of Interest were noted prior to or during the meeting.

2. Annual Report and Accounts 2024-2025

2.1 CTMUHB Annual Report & Accounts / Hosted Organisations Accountability Report and/or Governance Compliance Statements

2.1.1 CTMUHB Annual Report and Accounts 2024-2025 – Unified Report

G Watts presented and outlined the stages of development for the Annual Report & Accounts for 2024-2025 and advised Members that the report was for endorsement by the Audit, Risk & Assurance Committee for approval by the Board when it meets on the 26 June 2025.

G Watts recognised the efforts involved in the development of the Annual Report and thanked all colleagues involved.

G Watts noted that the Annual General Meeting will be held in July 2025, where the formal presentation of the Annual Report will be undertaken.

G. Watts advised that there had been an omission in the 'Foreword' section of the Annual Report, specifically relating to the failure to recognise thanks to L. Thomas, former Independent Member who resigned from the Board during the year. This had occurred due to timing differences and the fact that the replacements for L. Thomas had not started until the 2025-26 financial year. The omission was identified by Kath Palmer during her review, and an email was sent out to outline the change, which would be reflected in the papers when the Annual Report is formally approved at the Extraordinary Board meeting on 26 June 2025.

G. Watts extended his thanks to various team members and colleagues for their significant contributions to the Annual Report and Accounts, emphasising the collaborative effort involved in the process.

S. May emphasised the significant effort involved in preparing the Accounts and thanked the Finance team, JCC and audit colleagues for their support throughout the process.

S. May advised that the accounts had been prepared, reviewed, and audited and that Audit Wales would present their ISA 260 report later on in the agenda.

S. May flagged that Audit Wales intended to issue an unqualified true and fair opinion for 2024-25 and a qualified regulatory opinion. The qualification of the regulatory opinion related to the three-year break-even duty for the revenue resource limit and despite breaking even in 2024-25 and 2023-24, the deficit incurred in 2022-23 still impacted the revenue resource limit requirement and meant that the overspend in 2022-23 was deemed irregular expenditure.

D. Jouvenat recognised the efforts involved in the development of the Annual Report and the robust financial management throughout the year which has led to a successful unqualified opinion on the accounts. She expressed sincere thanks to all parties involved.

In concluding the item, the Committee agreed the following:

- **ENDORSE APPROVAL** of the CTMUHB Annual Report & Accounts for 2024-2025

Resolution

2.1.2 **NHS Wales JCC Accountability Report 2024-2025**

J. Maunder presented the report providing assurance on the work of the JCC and the governance arrangements within the organisation. J. Maunder advised that only minor changes had been made since the report was last reviewed by the Audit, Risk & Assurance Committee and thanked all colleagues for their assistance and advice in developing the report.

Resolution The report was **Noted**.

2.1.3 **NHS Wales JCC Audited Accounts 2024-2025**

S. Taylor presented the report thanking S. May and her team and Audit Wales colleagues for their efforts in getting the accounts to a place of consolidation.

Resolution The report was **Noted**.

2.1.4 **National Imaging Academy – Annual Governance Compliance Statement for 2024-2025**

G. Watts presented the report.

In addition, G. Watts advised of the strong relationship and interface between CTM and the NIAW proving assurance of the regular interface between CTM and NIAW and also in respect of reviewing and updating the hosting agreement.

Resolution The report was **Noted**.

2.2 **NHS Wales Shared Services Partnership (NWSSP) Internal Audit Services**

2.2.1 **Head of Internal Audit Opinion and Annual Report 2024-2025**

P Dalton advised that the Head of Internal Audit Opinion and Annual Report for 2024-2025 summarises the results of the internal audit work performed during the year and providing a 'Reasonable Assurance' to the Health Board.

P. Dalton referred to section 2.4 and section 2.6 in the report which summaries the scope of opinion and limitations of the audit opinion.

P. Dalton thanked the CTM Governance Team for their help and assistance over the last year.

Resolution The report was **Noted**.

2.3 Audit Wales

2.3.1 Audit of the Financial Statements (ISA 260) Report (including the Letter of Representation and Audit Opinion)

M Jones presented the report and raised a few key points:

- The audit report within the Annual Report and Accounts included many references to the JCC, which was a new addition compared to previous years.
- The Audit Report mentioned an "except for" regularity opinion, indicating that everything else was fine except for the financial duty issue explained by S. May earlier.
- The Health Board achieved its second financial duty under the NHS Wales Finance Act 2013, being the only health board in Wales to do so for the period 2024-2025 to 2026-2027.
- There were very few corrected misstatements and no uncorrected misstatements, which was a positive outcome for an organisation of this size.
- The Letter of Representation this year was signed by the Chair, the Chief Executive and Accountable Officer for the Health Board, and H. George as the JCC Accountable Officer.

M. Jones concluded by thanking all colleagues at the JCC and the Health Board for their co-operation and engagement, which enabled the audit to be completed on time.

K. Palmer expressed her thanks to everyone involved in managing the budgets across CTM and the Hosted Bodies and referred to a significant issue that had been mentioned by Audit Wales in relation to IT Officer availability and queried whether this had now been addressed.

M. Jones, in response, advised that the issue of IT officer availability was related to two specific instances where the audit team had difficulty obtaining the necessary information on time. He added that the audit team would elaborate on the issue of IT officer availability in their Addendum Report, which they would be bringing to the Committee in August this year and that the situation might have improved, however, the audit team would only be able to confirm this during the next year's audit.

Resolution The report was **Noted**.
The letter of Representation was Endorsed for Approval.

3. Any Other Business

3.1 No further items were identified.

4. Date and Time of the Next Meeting

4.1 The next meeting of the Committee is scheduled **at 10.30am on 14 August 2025.**

5. Close of meeting.



Agenda Item

8.1.4a

Audit, Risk & Assurance Committee

**AUDIT, RISK & ASSURANCE COMMITTEE
ANNUAL REPORT 2024-25**

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
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	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Chair/Executive Lead	01/08/2025	Approved

Acronyms / Glossary of Terms	
ARAC	Audit, Risk & Assurance Committee
CTMUHB	Cwm Taf Morgannwg University Health Board

1. Situation /Background

- 1.1 The purpose of this report is to highlight the activities and performance of the Audit, Risk & Assurance Committee (ARAC) during 2024-2025.
- 1.2 The Chair of the ARAC is required to present an annual report outlining Committee business throughout the financial year to provide the Board with assurances on the monitoring and scrutiny undertaken in relation to those issues set out under the Terms of Reference (TOR) for this Committee.
- 1.3 The Committee’s draft Annual Report for 2024-2025 is presented at **Appendix 1** for endorsing.
- 1.4 The revised Terms of Reference for the ARC Committee were last approved by the Board in September 2024 and are available on the Health Boards website via the following link: [Standing Orders - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](#).
- 1.5 An annual self-assessment questionnaire is also required to be undertaken and this will be completed by members outside of the meeting, the results of which will be reviewed at the August 2025 meeting

2. Specific Matters for Consideration

- 2.1 The Committee is asked to approve the Audit, Risk & Assurance Committee Annual Report for 2024-2025.

3. Key Risks / Matters for Escalation

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	If more than one applies please list below:



150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Not Applicable If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

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

5. Recommendation

- 5.1 The Committee are asked to **ENDORSE FOR BOARD APPROVAL** the Audit, Risk & Assurance Committee Annual Report for 2024-25.

Appendix 1

Audit, Risk & Assurance Committee

Committee Annual Report 2024-2025

AUDIT, RISK & ASSURANCE COMMITTEE ANNUAL REPORT 2024-2025

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2024-2025.

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

In January 2025 due to a Re-structure of the Committees of the Board, the Committee changed its name from Audit & Risk Committee to Audit, Risk & Assurance Committee and there was also a re-fresh of the membership.

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

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

2. INTRODUCTION

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

The Terms of Reference for the Committee were reviewed and were formally approved by the Board in March 2025. As part of the wider review being undertaken in relation to the Effective Management of Board Business the terms of reference will be reviewed by the Committee in November 2025.

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

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

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

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

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

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

3.2 MEMBERSHIP

The membership of the Audit, Risk & Assurance Committee comprises of four Independent members, enabling the Committee to provide appropriate

scrutiny and assurance to
of the management decision-making processes.

the Board independently

A summary of the Independent membership during 2024-2025 is outlined in table 1 below:

Table 1 – Composition & Membership of the Audit & Risk Committee April 2024-March 2025

Name	Period
Members	
Patsy Roseblade Committee Chair/Independent Member	April 2024 – March 2025
Kath Palmer UHB Vice Chair/Independent Member	April 2024 – March 2025
Ian Wells Committee Vice Chair/Independent Member	April 2024 – March 2025
Geraint Hopkins - Independent Member	April 2024 – December 2024
Dilys Jouvenat – Independent Member	January 2025 – March 2025
Helen Lentle – Independent Member	January 2025 – March 2025

3.3 ATTENDEES

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

3.4 ATTENDANCE AT AUDIT, RISK & ASSURANCE COMMITTEE 2024-2025

During the year, the Committee met on seven occasions.
*One Extra Ordinary meeting was held during this period which was devoted to the Approval of the Annual Accounts and Annual Report (10 July 2025). All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2024-2025

In Attendance	18 April 2024	20 June 2024	10 Jul 2023*	15 Aug 2023	17 Oct 2025	17 Dec 2024	13 Feb 2025	Total
Patsy Roseblade Committee Chair/Independent Member	✓	✓	✓	✓	✓	✓	✓	7/7
Ian Wells – Independent Member/Committee Vice Chair	✓	✓	✓	✓	✓	✓	✓	6/7
Kath Palmer Health Board Vice Chair/Independent Member	X	✓	✓	✓	✓	✓	✓	6/7
Geraint Hopkins – Independent Member (Until December 2024)	✓	✓	✓	X	X	X		3/7
Dilys Jouvenat – Independent Member (From January 2025)							✓	1/1
Helen Lentle – Independent Member (From January 2025)							✓	1/1

4. AUDIT RISK & ASSURANCE COMMITTEE BUSINESS

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

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

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

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

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

1. Preliminary Matters

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



2. Consent Agenda Approval/Noting

for

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

- Unconfirmed Minutes;
- Action Log;
- Committee Annual Cycle of Business;
- Forward Work Programme;
- Amendment to the Standards of Behaviour Framework Policy – Declarations of Interest Form;
- Declarations of Interest & Gifts and Hospitality Report;
- Clinical Audit Annual Plan and Clinical Audit Annual Report 2024-2025;
- Audit Wales – Annual Audit Enquiries Letter Response;
- Audit, Risk & Assurance Committee Annual Report 2023-24;
- Audit, Risk & Assurance Committee Terms of Reference;
- Audit, Risk & Assurance Committee Effectiveness Self-Assessment;
- Annual Report Timetable 2024-2025
- Ratification of Chairs Urgent Action – Charitable Fund Financial Control Procedure (FPC) and Update of the Scheme of Delegation

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

3. Main Agenda

4. Sustaining Our Future

The following reports were received for discussion:

- Local Counter Fraud Report;
- Counter Fraud Annual Report;
- National Fraud Initiative Progress and Outcomes;
- Counter Fraud Annual Self Review;
- Counter Fraud Draft Work Plan;
- Procurement and Scheme of Delegation Report;
- Post Payment Verification Mid-Year Update
- Post Payment Verification Annual Report and End of Year Update;
- Draft Annual Report and Draft Annual Accounts 2023-2024
- Losses and Special Payments Report;
- Outcome of the Committee Referral to People & Culture Committee – Recruitment Process Risk Assurance
- Financial Control Procedure – Medical Variable Pay – Summary of Authorised Breaches;
- Audit Wales Audit of the Financial Statements (ISA 260) (Including the Letter of Representation and Audit Opinion);
- Breaches to the Standing Orders;
- Progress update on Grant Thornton Recommendations;
- CTMUHB ISO14001 Certification Progress Report;

5. Improving Care

The following reports were received for discussion:

- Audit Recommendations Tracker;
- Joint Advisory Group (JAG) Update;
- Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24
- National Clinical Audit Plan;
- Organisational Risk Register;
- Annual Review Risk Management Framework;
- Consultant Job Planning – Six Monthly Progress Reports;
- Medical Rostering Progress Report;
- Organisational Risk Register.

Also received under this section were reports from:

• Internal Audit

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

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

• External Audit

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

4.2. MAIN AREAS OF AUDIT, RISK & ASSURANCE COMMITTEE ACTIVITY – PART 2 HOSTED BODIES

During 2024/2025 the bodies hosted by the Health Board are the NHS Wales Joint Commissioning Committee (JCC) and the National Imaging Academy for Wales (NIAW).

On the 1st April 2024, the NHS Wales Joint Commissioning Committee (JCC) was established in response to the findings of an independent review

commissioned by Welsh Government into the national commissioning arrangements undertaken by the Emergency Ambulance Services Committee (EASC), the Welsh Health Specialised Services Committee (WHSSC) and the National Collaborative Commissioning Unit (NCCU). From April 01 2024, the JCC replaced EASC and WHSSC and NCCU and has assumed responsibility for the services previously commissioned by these Committees.

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

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

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

The Director of Corporate Governance/Board Secretary for CTMUHB and the CTMUHB Executive Director of Finance also attends both parts of the meetings.

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

4.3. WORK/ACTION LOG

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

5. INTERNAL AUDIT - OVERALL SUMMARY

In overall terms for the year 2024/2025, the Head of Internal Audit opinion provided **Reasonable Assurance** to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the relevant assurance domains. The full opinion report was presented to the Audit, Risk & Assurance Committee in June 2025 and is available on the link [here](#)

A breakdown of the Internal Audit reviews presented to the Audit & Risk Committee and the Board in 2024-2025 is linked in Appendix 1.

6. EXTERNAL AUDIT

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

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

- Audit Wales Audit & Risk Committee Update (at each meeting);
- Audit Wales Annual Report
- Audit Wales Forward Work Programme 2023-2026;
- Audit Wales Audit of Accounts Report Addendum;
- Audit Wales Detailed Audit Plan 2024;
- Audit Wales 2025 Outline Plan;
- Audit Wales – Structured Assessment;
- Audit Wales – MIU follow Up
- Audit Wales – Joint Review Follow Up – Quality Governance
- Audit Wales – Primary Care Follow Up Review;
- Audit Wales – Review of Cost Savings Arrangements – Final Management Response;
- Audit Wales – Workforce Planning Audit.

A breakdown of the Audit Wales reviews presented to the Audit & Risk Committee and the Board in 2024-2025 is linked in Appendix 1.

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

6.2 Approval of the Annual Accounts

A meeting of the Audit, Risk & Assurance Committee was convened on 10 July 2024 to scrutinise the 2023-2024 Annual Accounts prior to approval by the Health Board including the letter of representation to Auditors and the Annual Governance Statement. The 2023-2024 Annual Accounts were scrutinised and approved by the Board on 11 July 2024. The meeting also scrutinised the Accounts and Statements for 2023-2024 from the Health Board's hosted bodies as appropriate. The 2024-2025 sign off accounts will be reported in the 2025-2026 Annual Committee Report.

7. PRIVATE MEETING WITH AUDITORS

In line with recognised good practice a private meeting between Audit, Risk & Assurance Committee members, Internal Audit, External Audit and the Local Counter Fraud Specialist can be held as and when required. This provides an opportunity for free and frank discussion. The Audit & Risk Committee Chair also meets privately with Internal Audit and External Audit on occasions. This process will continue for 2025-2026.

8. LINKS WITH OTHER COMMITTEES

8.1 Other Sub Committees

The Audit, Risk & Assurance Committee has close links with the Quality, Safety & Experience Committee and other Committees of the Board. Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication.

During 2024-2025, a Committee Referral process continued to be adopted for all Committees where the following three questions were posed by the Committee Chair for each referral request:

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

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

9. LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Services is undertaken to help reduce and maintain the incidence of crime within CTMUHB to an absolute minimum. Work is undertaken in accordance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures with adoption of Government Functional Standards:

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

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

The Counter Fraud Team received 29 new referrals for investigation in 2024/25 with 14 investigations carried over from 2024/25. 29 investigations were closed in 2024/25 which resulted in the application of 1 civil sanction. This investigation work led to the recovery of £17,794 of Health Board funds and an overall identified fraud figure of £22,780.

A review of compliance with Government Functional Standards: Counter Fraud NHS Requirements is undertaken annually. The Health Board was required to self-assess on a RAG rated basis against these Standards across 12 requirement areas. The Health Board achieved an overall Green rating following review with Green ratings for all 12 requirement areas for the first time since the introduction of these Standards.

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

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

A fraud risk approach has matured since the introduction of the Government Functional Standards and is fully integrated with the Health Board's Risk Management Framework. This allows for a risk based approach to counter fraud activity within the Health Board with future plans to utilise this work as a strategic key performance indicator going forward.

10. ASSURANCE TO THE BOARD

The Audit, Risk & Assurance Committee provides an essential element of the overall governance framework for the organisation and has operated within its

Terms of Reference and in accordance with the guidance contained in the NHS Wales Audit Committee Handbook.

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

10.2 Governance Statement - For the period 2024-2025 the Health Board produced its Governance Statement, which explains the processes and procedures in place to enable the Health Board to carry out its functions effectively. The Statement was produced following a review of CTMUHB's governance arrangements undertaken by the Board with the support of and the Board Secretary/Director of Corporate Governance. The Statement brings together all disclosures relating to governance, risk and control for the organisation. The Governance Statement is captured in the CTMUHB's Annual Report which is available via this [link](#)

10.3 Tracking of Audit Recommendations

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

10.4 Audit Committee Effectiveness Survey - A Committee Effectiveness Survey was undertaken in 2023-2024 to obtain feedback from Committee members on potential areas for development.

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

11. CONCLUSION AND FORWARD LOOK

The Audit, Risk & Assurance Committee in discharging its scrutiny and assurance role on behalf of the Board considers that on the basis of the risk based work completed by the Committee during 2024-2025, that there are effective measures in place **and that there are no outstanding issues that the Audit, Risk & Assurance Risk Committee wishes to bring to the attention of the Board.**

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

This Annual Report will be supplemented by the annual self-assessment process, which will be undertaken via Microsoft Office Forms, which reviews the individual and collective function of the Committee against the NHS Audit

Committee Handbook best practice guidance and helps to inform the work of the Committee going forward.

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2025-2026 in respect of:

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

Appendix 1 – Audit Reviews Undertaken in 2024-2025

The Internal Audit reviews undertaken in 2024-2025 are captured in the 'Head of Internal Audit Opinion & Annual Report 2024-2025' as received at the Extra-Ordinary Audit, Risk & Assurance Committee which met on the 25 June 2025, available via this link:

[25 June 2025 – Extra Ordinary - Cwm Taf Morgannwg University Health Board](#)

An update on the Audit Wales reviews undertaken in 2024-2025 are captured in the 'Audit Wales Audit Update' received at the Audit, Risk & Assurance Committee which met on the 22 May 2025, available via this link:

[22 May 2025 - Cwm Taf Morgannwg University Health Board](#)



Agenda Item

8.1.3a

Audit Risk & Assurance Committee

Committee Annual Cycle of Business 2025

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
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 Noting

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

Acronyms / Glossary of Terms	



1. Situation /Background

- 1.1 The Audit Risk & 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 **NOTE** 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

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 (as required)		R			R			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
Audit Reviews & Assurance Activity																
15. Clinical Audit Annual Plan	Executive Director of Nursing / Deputy CEO	Annually					R								R	X
16. Clinical Audit Annual Report	Executive Director of Nursing / Deputy CEO	Annually					R								R	X
17. Audit Recommendation Tracker (AW, IA and HIW)	Director of Corporate Governance / Board Secretary	All regular meetings		R			R			R			R		X	R
18. NWSSP Internal Audit Services – Progress Report	Head of Internal Audit	All regular meetings		R			R			R			R		X	R
19. NWSSP Internal Audit Services – Annual Audit Plan	Head of Internal Audit	Annually					R								X	R
20. NWSSP Internal Audit Review Reports	Head of Internal Audit	All Regular Meetings		R			R			R			R		X	R
21. NWSSP Internal Audit Services – Head of Internal Audit Opinion	Head of Internal Audit	Annually					R								X	R
22. Audit Wales Progress Update	Audit Wales - Performance Audit Lead	All Regular Meetings		R			R			R			R		X	R
23. Audit Wales – Audit Review Reports	Audit Wales - Performance Audit Lead	All Regular where applicable		R			R			R			R		X	R
24. Audit Wales Annual Audit Report	Audit Wales - Performance Audit Lead	Annually					R								X	R
25. Audit Wales Structured Assessment Report	Audit Wales - Performance Audit Lead	Annually											R		X	R
26. 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
27. 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																
28. 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	
29. Losses and Special Payments Report	Executive Director of Finance	All Regular Meetings													X	
30. Procurement & Scheme of Delegation Report	Executive Director of Finance	All Regular Meetings													X	
31. Post Payment Verification Mid-Year and Annual Report	Executive Director of Finance	Twice a Year											Mid-Year		X	
Counter Fraud Activity																
32. Local Counter Fraud Report	Local Counter Fraud Specialist	All Regular Meetings													X	
33. Counter Fraud Annual Report	Local Counter Fraud Specialist	Annually													X	
34. Counter Fraud Annual Self-Assessment	Local Counter Fraud Specialist	Annually													X	
35. Counter Fraud Draft Work Plan	Local Counter Fraud Specialist	Annually													X	
36. National Fraud Initiatives Progress and Outcomes	Local Counter Fraud Specialist	Twice Per Annum													X	
CTMUHB Hosted Bodies Audit & Risk Committee																
37. Joint Commissioning Committee Audit Recommendations Tracker	Director of Corporate Governance (JCC)	All Regular Meetings													X	

CTMUHB Hosted Bodies Audit & Risk Committee																
38. Joint Commissioning Committee Corporate Risk Assurance Framework	Director of Corporate Governance (JCC)	All Regular Meetings		R			R			R			R		X	R
39. National Imaging Academy Risk Register	Director of the National Imaging Academy	All Regular Meetings		R			R			R			R		X	R
40. 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
41. 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
July 2025	Welsh Government	Welsh Government	Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards	Model Standing Orders, Reservation and Delegation of Powers for LHBs Schedule 2.1: Standing Financial Instructions Revised Chapter 11 May 2025	Gareth Watts, Director of Governance/Board Secretary	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	This item is on the Agenda for the August 2025 meeting.
July 2025	Audit Wales	Audit Wales	Audit Wales Review – Tackling the Planned Care Challenges	Audit Wales Review Report	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	This item is on the Agenda for the August 2025 meeting.
December 2024	Audit & Risk Committee	Internal Audit	IA Review – end of Life Care Management – Final	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	This item is on the Agenda for the August 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	14 August 2025	This item is on the Agenda for the August 2025 meeting.
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Audit Recommendations Tracker Review	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	This item is on the Agenda for the August 2025 meeting.
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Decarbonisation Follow Up	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	This item is on the Agenda for the August 2025 meeting.
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Financial Systems	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	This item is on the Agenda for the August 2025 meeting.
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Access to Diagnostics Criteria	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	14 August 2025	This item is on the Agenda for the August 2025 meeting.
February 2025	Audit, Risk & Assurance Committee	Committee	IA – Medical Job Planning – to bring further detail on the Job Planning Work	Internal Audit Progress Report	Medical Director	Dom Hurford, Medical Director	14 August 2025	This item is on the Agenda for the (CLOSED) In Committee - August 2025 meeting.

May 2025	Audit, Risk & Assurance Committee	Committee	Penalties for Late submitted Evidence Update	Action arising out of discussion on Losses & Special Payments Report	Deputy Director	Richard Hughes, Deputy Director of Nursing & Midwifery	14 August 2025	This item is on the Agenda for the August 2025 meeting.
February 2025	Audit, Risk & Assurance Committee	Committee	Outcome of Committee Referral to Quality, Safety & Experience Committee	Committee raised concern in relation to increased medical negligence costs and requested that the Quality, Safety & Experience Committee review	Head of Corporate Finance	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	A verbal update was provided to Quality Safety & Experience Committee at its meeting on the 22 July 25 where it was noted that a written update would be presented to the September Quality, Safety & Experience Committee. This item has now been deferred to the November ARAC meeting to await the outcome.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Discharge Planning	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	This item is on the Agenda for the November 2025 meeting.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Operational response critical incident	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	This item is on the Agenda for the November 2025 meeting.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Stroke	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	This item is on the Agenda for the November 2025 meeting.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Estates assurance Asbestos Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	This item is on the Agenda for the November 2025 meeting.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Continuing Healthcare	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	This item is on the Agenda for the November 2025 meeting.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Savings	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	This item is on the Agenda for the November 2025 meeting.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Clinical Coding	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of	13 November 2025	This item is on the Agenda for the

						Governance/Board Secretary		November 2025 meeting.
August 2025	Audit & Risk Committee	Internal Audit	IA Review – Medical Sickness Records	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	13 November 2025	This item is on the Agenda for the November 2025 meeting.

COMPLETED ITEMS:

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	22 May 2025	Received at the May 2025 meeting. Closed.
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	22 May 2025	Received at the May 2025 meeting. Closed.
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	22 May 2025	Received at the May 2025 meeting. Closed.
February 2025	Email	Assistant Director of Governance & Risk	Audit Wales Report – Cancer Services in Wales	Requested to add to agenda for Committee to note.	Audit Wales	Gareth Watts, Director of Governance/Board Secretary	22 May 2025	Received at the May 2025 meeting. Closed.
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	22 May 2025	Received at the May 2025 meeting. Closed.
December 2024	Audit & Risk Committee	Internal Audit	IA Review – Capital Systems	Deferred from last meeting	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	22 May 2025	Received at the May 2025 meeting. Closed.
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	22 May 2025	Received at the May 2025 meeting. Closed.
December 2024	Audit & Risk Committee	Committee	Local Counter Fraud Report – Update on Long Standing Case with regards to the Dispensing Practice	Local Counter Fraud Report	Local Counter Fraud Officer	Sally May, Executive Director of Finance & Procurement	22 May 2025	Received at the May 2025 meeting via the Local Counter Fraud Report. Closed
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	Received at the February 25 Meeting - Closed

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	Received at the February 25 Meeting - Closed
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	Received at the February 25 Meeting - Closed
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	Received at the February 25 Meeting - Closed
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	Received at the February 25 Meeting - Closed
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	Received at the February 25 Meeting - Closed
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	Received at the February 25 Meeting - Closed
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	Received at the February 25 Meeting - Closed
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	Received at the February 25 Meeting - Closed
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 – Recruitment Process Risk Assurance Report	Action arising from the October 2024 Audit & Risk Committee	Assistant Director of People Policy and Compliance/Local Counter Fraud Officer	Executive Director for People	17 December 2024	Received at the December 2024 meeting - Closed
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



Agenda Item

8.2.3

Audit, Risk & Assurance Committee

Corporate Governance Notified Breaches of Standing Orders

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
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

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	
CTMUHB	Cwm Taf Morgannwg University Health Board
WG	Welsh Government



1. Situation /Background

- 1.1 Following approval of the new model of Standing Orders issued by WG and approved by CTM Board on the 27th March 2025, there is now a requirement to publish Board and Committee papers 7 calendar days in advance of public Board and Board Committee meetings.

2. Specific Matters for Consideration

- 2.1 In response to the requirement to publish papers 7 calendar days in advance of the public meeting, the following breaches are reported:
- The papers for the Extra Ordinary Operational Delivery Committee meeting that took place on 19 May 2025 were only published three calendar days in advance of the meeting.

3. Key Risks / Matters for Escalation

- 3.1 There are instances outlined in section 2 where the publication has been shorter than 7 days and it is acknowledged that this may not provide Board Members with sufficient time to review. This will remain a watching brief by the Corporate Governance Team.

4. Assessment

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



Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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

5. Recommendation

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



Agenda Item

8.2.4

Audit, Risk & Assurance Committee

Committee Annual Self Effectiveness Survey Outcome
2024-25 & Improvement Plan

Dyddiad y Cyfarfod / Date of Meeting	14/08/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Committee members / attendees	07/05/2025	Responses returned as outlined in section 1 of the report
Committee Chair	August 2025	Approved

Acronyms / Glossary of Terms	
Nil	

1. PURPOSE

- 1.1 The Chair of the Audit, Risk & Assurance Committee is required to present an annual report to the Board outlining the Committee's business through the financial year to provide an assurance. As part of this process, The Committee are required to undertake an annual self-assessment questionnaire.
- 1.2 Members of the Committee are asked to discuss and review the feedback set out in this report which relate to its activities and performance during 2024-25.
- 1.3 Members should note that 6 responses were received out of a total of 11 which equated to 54%.

2. SUMMARY REPORT

Positive Assurance	• Committee Effectiveness: There was a clear consensus that Members/Attendees were aware that: • There were approved Terms of Reference in place defining the role of the Committee. • 100% of respondents were aware that the Terms of Reference were reviewed annually. • 100% of respondents were aware that a Committee Highlight Report is produced following each meeting that is submitted to the next Health Board meeting. This is the mechanism that the Committee Chair uses to provide information on activity, areas or assurance and/or areas of escalation • A Committee Annual Report was produced and reported to the Board to provide assurance that the Committee considers activity consistent with its remit. • 100% of respondents were aware that the Committee's self-evaluation process is in place and effective. • A Committee Annual Cycle of Business was presented at each meeting. • Committee Business • Members of the Committee felt that they met with sufficient frequency to deal with planned matters in an effective manner. • Members of the Committee felt that where possible, Committee meetings were scheduled prior to important decisions. • Members felt that Committee had formally considered how it integrated with other Committees reviewing risk, recognising that the Audit, Risk & Assurance Committee received the risk register in its entirety, whilst other Committees received their assigned risks only • There was clear consensus that the Committee's meeting papers were complete and received with enough lead time for members to give them due consideration and that minutes were received as soon as possible



following meetings, although on one occasion they were delayed due to clarification requirement.

- 100% of respondents felt that the Committee's role in the approval of the Annual Accounts was clearly defined.
- 100% of respondents felt that the appropriate internal or external support and resources were available to the Committee and it had sufficient membership and authority to perform its role effectively.

Performance

- In terms of the overall assessment of the performance of the Audit, Risk & Assurance Committee, feedback reflected that performance was very thorough and that the Committee was effective and discharged its responsibility well.
- 100% of respondents agreed that the Committee was briefed on its assurance responsibilities with regard to internal control and risk management, particularly with regard to the Statement of Internal Control, the Assurance Framework, Standards for better Health and the Head of Internal Audit's opinion.

Internal Audit

- 100% of respondents felt that there was appropriate consideration of Internal Audit's plan, resources and ability and that the Internal Audit Plan was reviewed at the beginning of each financial year.
- 100% of respondents thought that there was appropriate consideration of Internal Audit Reports, Management Responses and improvement actions.
- With regard to any scope restrictions placed on internal audit, feedback reflected that Internal Audit plans are fully discussed, agreed and monitored.
- 80% of respondents felt that in terms of the Committee reviewing the effectiveness of Internal Audit and the adequacy of staffing and resources, that effectiveness was considered but not adequacy of staffing.

External Audit

- 100% of respondents agreed that the Committee received and monitored actions taken in respect of prior year External Audit plans.
- 100% of respondents agreed that the Committee reviewed the External Auditor's Annual audit letter and assessed the performance of External Audit.

Areas of Note

1. Committee Effectiveness

- The Terms of Reference were reviewed and approved by the Board at the March 2025 meeting as part of the annual review.
- The Committee **received** and approved its Annual Report for 2023-24 at its August 2024 meeting and was submitted to the Board in September 2024.

	- The Committee Cycle of Business has been implemented to further complement the Forward Work Programme and was approved by the Committee at their February 2025 meeting. 2. Committee Business - The Audit, Risk & Assurance Committee utilises a Consent Agenda system for routine business consideration. Members are aware that should they consider that any item on consent requires further assurance and scrutiny then it will be moved to the main agenda for discussion. - As with all Board Committees, the Committee, where sufficiently urgent can consider any item 'Out of Committee' via 'Chairs Urgent Action'. - Highlight reports are produced following each meeting so that the Board is kept informed of the nature of the issues considered and any decisions reached. These reports are available as part of the 'public' Board papers to demonstrate the Health Board's commitment to openness and transparency. Feedback reflected that the Highlight reports were succinct and to the point.
Areas Requiring Further Consideration	Not applicable.
Action Plan	Not applicable.
Appendices	Independent Member Scrutiny Toolkit available upon request.

3. RECOMMENDATION

3.1 The Committee is asked to **NOTE** the report.