

Agenda

09:00 - 09:05 **1. PRELIMINARY MATTERS**
5 min

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

09:05 - 09:10 **2. CONSENT AGENDA BUSINESS**
5 min

Discussion 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

09:10 - 09:15 **3. MAIN AGENDA**
5 min

3.1. Action Log

Discussion Patsy Roseblade, Committee Chair

 3.1 Action Log ARAC 3 Feb 26.pdf (18 pages)

3.2. Matters Arising Not Captured on the Action Log

Discussion Patsy Roseblade, Committee Chair

09:15 - 09:45 **4. RISK MANAGEMENT**
30 min

4.1. Organisational Risk Register

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

 4.1a Org RR Jan 26 - ARAC.pdf (7 pages)

 4.1b App 1 - Org RR Jan 26 - ARAC.pdf (8 pages)

4.2. Response to the updated HM Treasury Audit & Risk Assurance Committee Handbook

Decision Gareth Watts, Director of Corporate Governance

 4.2 National Audit Handbook ARAC 3 February 2026.pdf (6 pages)

 4.2a Appendix 1 - GIAA_ARAC_tool_-_August_25.pdf (16 pages)

 4.2b App 2 -CTM ARAC Self Assessment Checklist.pdf (5 pages)

09:45 - 10:05
20 min

5. FINANCIAL MANAGEMENT AND REPORTING

5.1. Losses and Special Payments Report

Discussion Sally May, Executive Director of Finance

The Appendices to this report are contained within the supporting documents folder on Admin Control

 5.1 Losses Special Payments Report ARAC 3 Feb 26.pdf (10 pages)

5.2. Procurement & Scheme of Delegation Report

Sally May, Executive Director of Finance

-  5.2 Procurement and SoD Report ARAC 3 Feb 26.pdf (9 pages)
-  5.2a App 1-FP17 Patient Property Income Allowance.pdf (26 pages)
-  5.2b App 2 - FP24 Overseas Patients.pdf (11 pages)
-  5.2c App 3 - Medical Variable Pay FCP.pdf (13 pages)
-  5.2d App 4 - Changes to FCP's.pdf (1 pages)
-  5.2e App Medical Bank and Agency SOP 140126.pdf (22 pages)

10:05 - 10:15
10 min

6. COUNTER FRAUD ACTIVITY

6.1. Local Counter Fraud Report

Discussion Matthew Evans, Local Counter Fraud Manager

-  6.1 Local Counter Fraud Update Report.pdf (4 pages)
-  6.1a Local Counter Fraud Update Report FEB 26.pdf (3 pages)
-  6.1b Appendix 1 Counter Fraud Benchmark Report.pdf (6 pages)

10:15 - 11:40
85 min

7. GOVERNANCE AND CONTROL ENVIRONMENT

7.1. Audit Recommendations Tracker

Discussion Gareth Watts, Director of Corporate Governance/Board Secretary

-  7.1a Audit Tracker cover report - ARAC 3 Feb 26.pdf (7 pages)
-  7.1b Appendix 1 - OVERDUE AMaT Audit Recs Tracker_ARAC 03.02.2026.pdf (6 pages)

7.2. NWSSP Internal Audit Services Progress Report

Discussion Paul Dalton, Head of Internal Audit

-  7.2 IA Progress Report ARAC 3 Feb 2026.pdf (10 pages)

7.2.1. IA Review - Clinical Coding

Discussion Paul Dalton, Internal Audit

-  7.2.1 Clinical Coding ARAC 3 Feb 2026.pdf (6 pages)

7.2.2. IA Review - Asbestos Management Audit - Final

Discussion Internal Audit

-  7.2.2 Estates Asbestos ARAC 3 Feb 26.pdf (11 pages)

7.2.3. IA Review - Response to Critical Incident - Final

Discussion Internal Audit

-  7.2.3 Response to Critical Incident ARAC 3 Feb 26.pdf (12 pages)

7.2.4. IA Review - Stroke Services - Final

Discussion *Internal Audit*

 7.2.4 Stroke Services ARAC 3 Feb 2026.pdf (10 pages)

7.2.5. IA Review - Discharge Planning - Final

Discussion *Internal Audit*

 7.2.5 Discharge Planning ARAC 3 Feb 2026.pdf (16 pages)

7.3. Audit Wales Progress Update

Discussion *Nathan Couch, Audit Wales*

 7.3 AW Update ARAC 3 February 2026.pdf (12 pages)

7.3.1. Audit Wales Report - Eye Care Services

Discussion *Audit Wales*

 7.3.1 AW Report Eye Care Services Final.pdf (30 pages)

7.3.2. Audit Wales Report - Urgent and Emergency Care: Arrangements for Managing Demand

Discussion *Audit Wales*

 7.3.2 AW Report Managing UEC Demand Final.pdf (36 pages)

 7.3.2a Mmt RespUEC Managing Demand ARAC 3 Feb 26.pdf (8 pages)

7.4. Clinical Audit Annual Forward Plan & Monitoring

Discussion *Dom Hurford, Medical Director/Mark Townsend, Head of Clinical Audit and Quality Informatics*

 7.4a Clin Audit Annual Plan ARAC 3 Feb 26.pdf (5 pages)

 7.4 Clinical Audit Annual Forward Plan.pdf (10 pages)

 7.4b App 1 Nat Clinical Audit Annual Plan.pdf (11 pages)

7.5. JAG Accreditation Update

Discussion *Gethin Hughes, Chief Operating Officer*

Deferred from November 2025

 7.5 JAG Accreditation ARAC 3 Feb 2026.pdf (6 pages)

11:40 - 11:45
5 min

8. CONSENT AGENDA

8.1. ITEMS FOR APPROVAL

8.1.1. Unconfirmed Minutes of the Meeting held on 13 November 2025

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

 8.1.1 Unconfirmed Minutes ARAC 13.11.25 v2.pdf (11 pages)

8.1.2. Unconfirmed Minutes of the In Committee Meeting held on 13 November 2025

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

 8.1.2 Unconfirmed IC Minutes 13.11.25 ARAC 3 Feb 2.pdf (2 pages)

8.2. ITEMS FOR NOTING

8.2.1. Committee Forward Work Plan

Information

Gareth Watts, Director of Corporate Governance/Board Secretary

 8.2.1 Forward Work Plan ARAC 3 February 2026.pdf (5 pages)

8.2.2. Annual Report Timetable 2025/2026

Information

Gareth Watts, Director of Corporate Governance

 8.2.2a Annual Timetable 2025 2026 ARAC 3 February 2026.pdf (4 pages)

 8.2.2b Annual Report Timetable - Draft V4 23.01.26.pdf (1 pages)

11:45 - 11:50

5 min

9. CLOSE OF BUSINESS

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 today?

Discussion

Patsy Roseblade, Committee Chair

11:50 - 11:55

5 min

10. PRIVATE IN COMMITTEE SESSION

1. Organisational Risk Register - Business Sensitive Risks
2. Financial Control Procedure - Medical Variable Pay - Summary of Authorised Breaches
3. Local Counter Fraud Report - Cases Report
4. Counter Fraud Services in NHS Wales Operational Performance Report 2025/2026 Quarter 1

11:55 - 12:00

5 min

11. DATE AND TIME OF NEXT MEETING

19th May 2026 at 12:30 pm

Audit Risk & Assurance Committee - Action Log (as at 20.01.26)									
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 - 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	nov-25	Propose to Close	Outcome report received by the Committee at the November 2025 meeting.
Audit Risk & Assurance Committee - November 2025	2.1 & 8.2.1	2	Outcome of the Committee Referral to Quality, Safety & Experience Committee	To review the statement in the report regarding increased thresholds for redress cases to £50k outside of the meeting.	Head of Corporate Finance	Director of Finance	feb-26	Open	An update will be provided at the meeting
Audit Risk & Assurance Committee - November 2025	2,1	2	Consent Agenda Business	Governance Team to liaise with the Chief Operating Officer regarding a date to receive the JAG accreditation update.	Corporate Governance Manager	Director of Corporate Governance/ Board Secretary	feb-26	Propose to close	On Agenda for February 26 meeting
Audit Risk & Assurance Committee - November 2025	3,1	3	Action Log		Corporate Governance Manager	Director of Corporate Governance/ Board Secretary	feb-26	Propose to Close	Report has been formatted as requested.
Audit Risk & Assurance Committee - November 2025	4,1	3	Organisational Risk Register	To provide an update on 6372 - Cost escalation risk – Microsoft Enterprise Agreement renewal.	Director of Corporate Governance/ Board Secretary	Director of Digital	feb-26	Open	Update to risk reported in December - Negotiations with Microsoft continue. They are proposing three differing profile types. Profile 1 covers Frontline worker, those that share a device on wards etc. Profile 2 is for Advanced Clinical Users that want to use dedicated devices with additional functionality. Profile 3 Is for Information workers that need full M365 functionality. There is also an offer of CoPilot licensing and Power Platform licensing. The detail is still being worked through. The initial costs look high with a potential for CTM costs to go up between £1-1.5m per year. Negotiations are looking to reduce that big step up in costs.
Audit Risk & Assurance Committee - November 2025	4,1	3	Organisational Risk Register	Discussions to be held offline on the usefulness of the heat map, narrative context and trend analysis improvements.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	feb-26	Open	Discussions held with Assistant Director of Governance & Risk about some of these options. Other operational demands have taken precedence in recent months but once we have someone in place to cover risk will restart the discussions and consider the options.

Audit Risk & Assurance Committee - November 2025	4,3	4	Data Lapses Report	To provide an update on whether the master patient index incident had led to data breaches outside of the meeting	Director of Digital	Director of Digital	feb-26	Propose to Close	There have been no reported issues as a result of the master patient index incident.
Audit Risk & Assurance Committee - November 2025	4,4	5	Declarations of Interests and Gifts, Hospitality and Sponsorship Report	To amend the detail listed in relation to P. Daniels.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	feb-26	Propose to Close	Detail has been amended
Audit Risk & Assurance Committee - November 2025	5,3	6	Post Payment Verification Mid-Year Report	To reformat the report for future meetings.	Corporate Governance Manager	Director of Finance	feb-26	Propose to Close	Report has been formatted as requested.
Audit Risk & Assurance Committee - November 2025	7,1	7	Audit Recommendations Tracker	To check with the team on the numbers listed on the pie chart includes the 39 recommendations proposed for closure.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	feb-26	Open	Clarified that the number of recommendations noted as proposed for closure means those recommendations approved for closure by Execs but which have not yet gone to ARAC - if no further questions at ARAC those recommendations then move into the closed columns.
Audit Risk & Assurance Committee - 14 August 2025	6,1	7	Local Counter Fraud Report	Local Counter Fraud Team explore the possibility of mandating Counter Fraud Training requirements for the Health Board to improve learning in this area and advised the team to contact G Watts for advice and signposting.	Local Counter Fraud Specialist	Local Counter Fraud Specialist	nov-25	Open	In progress pending discussions

Audit Risk & Assurance Committee - 14 August 2025	7.3.4	10	IA Review – Decarbonisation – Follow Up	Executive Director of Strategy & Transformation and Executive Director of Finance to meet Head of Internal Audit to review recommendations 4.1 and 4.2.	Executive Director of Strategy & Transformation Executive Director of Finance Head of Internal Audit	Executive Director of Strategy & Transformation Executive Director of Finance	nov-25	Closed
				Head of Internal Audit to set out the approach to follow up reviews within the next Internal Audit Progress Report update to the November meeting.	Head of Internal Audit	Head of Internal Audit	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	7,5	12	Audit Wales Review – Tackling the Planned Care Challenges	A focus for the Strategic Development Committee is how the Health Board compares service transformation with short term improvements and that sustainable transformation should be the focus.	Chair of the Strategic Development Committee Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	nov-25	Closed
								Closed
Audit Risk & Assurance Committee - 14 August 2025	7.3.1	9	IA Review - End of Life Care Management	Revisit the audit review and recommendations with relevant Executive Leads and if there were any changes needed to the recommendations and management responses these would return to the Committee following engagement and agreement with Internal Audit Colleagues. Explore the risk around training identified within the audit review and report back to the next Strategic Development Committee.	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	nov-25	Closed

Audit Risk & Assurance Committee - 14 August 2025	5,2	5	Procurements and Scheme of Delegation Report	Future updates to FCPs to include a detailed appendix to the report which outlines the amendments made to the documents.	Head of Corporate Finance	Executive Director of Finance	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	5,1	4	Losses and Special Payments Report	To provide an update as to whether there has been an increase in Clinical Negligence claims following the introduction of the Duty of Candour.	Deputy Executive Director of Nursing	Executive Director of Nursing	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	4,2	3	Interim Amendments to the Model Standing Financial Instructions (SFIs) Chapter 11 for Local Health Boards	Future updates to the Standing Orders and Standing Financial Instructions to provide a summary paragraph so any amendments are specified and clearly visible to the reader.	Corporate Governance Team	Director of Corporate Governance/ Board Secretary	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	4,1	3	Organisational Risk Register	The September iteration of the Organisational Risk Register to capture an update on the "Lack of Resuscitaire in Princess of Wales Hospital Emergency Department" (Datix Risk ID 6152).	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	nov-25	Closed

	4,2	3	Interim Amendments to the Model Standing Financial Instructions (SFIs) Chapter 11 for Local Health Boards	Future updates to the Standing Orders and Standing Financial Instructions to provide a summary paragraph so any amendments are specified and clearly visible to the reader.	Corporate Governance Team	Director of Corporate Governance/ Board Secretary	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 2025	4,1	3	Organisational Risk Register	The September iteration of the Organisational Risk Register to capture an update on the "Lack of Resuscitaire in Princess of Wales Hospital Emergency Department" (Datix Risk ID 6152).	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	nov-25	Closed

Audit Risk & Assurance Committee - 14 August 2025	4,1	3	Organisational Risk Register	The September iteration of the Organisational Risk Register to capture an update on the "Lack of Resuscitaire in Princess of Wales Hospital Emergency Department" (Datix Risk ID 6152).	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	nov-25	Closed
Audit Risk & Assurance Committee - 14 August 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	45870	Closed
Audit Risk & Assurance Committee - 14 August 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	45870	Closed
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	45870	Closed
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	45870	Closed

Audit, Risk & Assurance Committee - May 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	45870	Closed
Audit, Risk & Assurance Committee - May 2025	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	45689	Closed
Audit Risk & Assurance Committee - February 2025	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	45689	Closed
Audit & Risk Committee December 2024	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	45778	Closed

Audit & Risk Committee December 2024	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	45778	Closed
Audit Risk & Assurance Committee - February 2025	5.4.2	46002	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	45778	Closed
Audit Risk & Assurance Committee - February 2025	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	45689	Closed
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	45778	Closed
Audit & Risk Committee December 2024	4,1	3	Local Counter Fraud Report	To bring an update to a future meeting of the Committee on the long standing case with regard to the dispensing practice	Local Counter Fraud Officer	Executive Director of Finance & Procurement	45778	Closed

Audit Risk & Assurance Committee - February 2025	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	45627	Closed
Audit Risk & Assurance Committee - February 2025	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	45689	Closed
Audit & Risk Closed In Committee October 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	45689	Closed
Audit & Risk Committee December 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	45627	Closed

Audit & Risk Committee December 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	45627	Closed
Audit & Risk Committee October 2024								
Audit & Risk Committee October 2024								

Following discussion outside of the Committee with Internal Audit Colleagues and the Executive Director of Strategy & Transformation and the Executive Director of Finance the management response action has been reframed to the satisfaction of all concerned and amended report received. The new wording is captured in the Audit Tracker Report received at this meeting.
An explanatory paragraph has been added to the Internal Audit Progress report for the November meeting of the Committee.
A meeting has been arranged between the SDC Chair and the Executive Director of Strategy & Transformation for the 17 November 2025

Audit outcomes reviewed and confirmed as achievable with colleagues

A number of FCPs will be presented at the November 2025 ARAC meeting, attached to that is going to be an appendix outlining the amendments to each FCP.
Data has been reviewed and a response sent via email on 06.11.25
This has been noted for future updates. The report was also updated ahead of submission to the Board in September to address the feedback received at the Committee.
This risk will now not be escalated to the Organisational Risk Register as the risk score has been significantly reduced as the Resuscitaire equipment for the Emergency Department has been received and was being put together by the Electro-Biomedical Engineering (EBME) department. The interim arrangements regarding the Resuscitaire from maternity scheduled to cease at the end of September allowing for training on the new Resuscitaire equipment.

This has been noted for future updates. The report was also updated ahead of submission to the Board in September to address the feedback received at the Committee.

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Report was shared via email to the Committee on the 30.7.25
Update was shared via email to the Committee 23.05.25
Penalties for Late Submitted Evidence Update report scheduled for the August meeting at agenda item 5.3.
Report was reviewed outside of meeting and amended to reflect the Executive Leads as the Medical Director & Executive Director for People

Included as an update in the In Committee session on the 14 August at Agenda item 2.2.
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.
The actions from the last meeting will be built into the improvement programme for the development of the Audit Tracker
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.

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Received at the Health Board Meeting 27.03.25
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.
Report to be brought to May 2025 meeting to include coloured text to highlight last updates.
Primary Care review in progress. Update to be brought to May 2025 meeting as part of the Local Counter Fraud Report

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/
Nothing to flag within papers for this meeting. Noted for future drafting.
Table has an additional column to highlight actions since last report. Happy to review formatting for future meetings if Committee would prefer different style.
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

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	3 February 2026
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	December / January 2026	RISKS REVIEWED
Executive Leadership Group	12 January 2026	MANAGEMENT REVIEW AND SIGN OFF RECEIVED
Quality, Safety & Experience Committee	20 January 2026	ASSIGNED RISKS REVIEWED
Operational Delivery Committee	22 January 2026	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 6 January 2026. Please note that as a result of site pressures with capacity and flow there are some risks within Appendix 1 which do not have a progress update captured. The Chief Operating Officers Business Team are seeking an update, and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the Business Team as required.

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 **861** 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. A dedicated risk session was also

delivered to the Local Public Health Team Away Day on the 4 November 2025. A risk update was also provided to the Unscheduled Care Teams Away Day on the 21 November 2025.

- 2.9 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.
- 2.10 124 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 4.81 out of a maximum score of 5.
- 2.11 100% of the 124 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 120 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 in January 2026, received through evaluation, have been included below:
- *Understanding the score system and Datix was really helpful*
 - *Trainer ran through the relevant documents and processes for logging risks which gave me a better understanding of the escalation processes and how it's logged in the organisation.*
 - *New to Datix so really helpful with risk assessing process*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Primary Care & Community Care Group

- Datix Risk ID 6397 - Shortage of GPs to deliver urgent primary care services for escalation. New risk escalated to the Organisational Risk Register in January 2026. Risk score of 16.

3.2 CHANGES TO RISKS

Risk Score Increased

None identified this period.

Risk Score Decreased

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. Risk score reviewed and whilst recognising that

there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability. Risk likelihood score has been reduced from a 4 to a 3 and the risk de-escalated from the Organisational Risk Register. The risk will continue to be monitored by the Capital and Estates Directorate.

Primary Care & Community – Care Group

- Datix Risk ID 5417 - Paediatric Dentistry - General Anaesthetic (GA) theatre list. As a result of the progress being noted to lists , the care group have reviewed and reduced the score to a 12 (Likelihood reduced to a 3) but will keep under review to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the plans to mitigate risk, as a result of the progress against the plan the Health Board were able to reduce this risk).

Patient, Care & Safety – Care Group

- Datix Risk ID 6228 - Effective and efficient management of requests from the HM Coroner. The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for Executive Leadership Group oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk score now 12.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Finance Function

- *Datix Risk ID 6240 - Failure to achieve the planned break-even position in 2025/26.* Likelihood risk score reduced from a 4 to a 3 in January 2026 as The Health Board is continuing to forecast a break-even position for 25/26. The key risks to the forecast have improved following confirmation of non-recurrent WG funding for the Welsh Risk Pool contributions together with Band 2/3 settlements in 2025/26. The Finance Function have therefore closed this risk as the target score of 12 has been achieved.



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

Consequence	5			3337 6217	4664 5276		
	4			5820	4417 5374 4671 4885 6039 5576 6229 6235 4632 2713 6318 6397	5579 5761 5793 5045 4973 6231 1793 6372 6294 6379 6280 5877	4491 3826 6179 5753 6239 5821 6052
	3						4672 4691 5040 6232
	2						
	1						
CxL	1	2	3	4	5		
	Likelihood						

Emerging Risks Identified for possible future escalation

Identified as part of the risks considered and reviewed for escalation in the January 2026 iteration of the Organisational Risk Register:

- **Pharmacy & Medicines Management** – Datix Risk ID 5890 – risk identified for escalation in relation to the temperature monitoring system which is used within CTMUHB to monitor the temperature for various areas within the Pharmacy departments and has a mechanism to alert to temperature deviations. This autodialler alert system requires action and the risk around this is being considered with a view to escalate to the Organisational Risk Register if necessary.
- **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. The deep dive to understand the risks around this activity is ongoing and yet to be escalated.
- **The Planned Care - Care Group** are continuing to review the risk regarding Laser Safety at Princess of Wales Hospital as there is no designated laser safety advisor on site. As part of the risk review the Operational Management Board has directed the Care Group to engage with the Diagnostics, Therapies, Pharmacy and Sciences Care Group to consider workforce cover across CTM. Once the review is complete further consideration will be given to escalation to the Organisational Risk Register. (Datix Risk ID 6124).

- **The Planned Care and Unscheduled Care - Care Group** are continuing to jointly consider a risk in relation to 'Lack of Capacity for Hydroxychloroquine Screening in Ophthalmology'. Once the co-ordinated review between both Care Groups has been undertaken the risk will be considered for escalation to the Organisational Risk Register as one risk with shared actions across both Care Groups as appropriate. (Current Datix Risk IDs are 5797 and 3596).
- **Primary Care & Community Care Group** are considering the escalation of the following risks:
 - a risk relating to pathway of care delays following a notable increase. This has been highlighted with Welsh Government and Local Authorities and this will be further explored at the Discharge Board, which has representation from Local Authorities.
 - Social Care Capacity within Care Homes / Community is also being reviewed due to increasing concerns.

The Service Director for Primary Care is currently reviewing these risks to reflect current position with a plan to formally escalate to the Operational Management Board in January 26 and then onto the Organisational Risk Register if required.

4. Assessment

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



**Environmental
/Sustainability Impact (5Rs)**

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:

Not required for the
Organisational Risk
Register. Individual risks
may have been subject to
QIA.

Cydraddoldeb a'r Gymraeg

*Ydych chi wedi ymgymryd â
Sgrinio Asesiad o'r Effaith ar
Cydraddoldeb a'r Gymraeg? /*

Equality and Welsh Language

*Have you undertaken an Equality
and Welsh Language Impact
Assessment Screening?*

Yes: ☐

No: ☒

Outcome for Equality
(delete as appropriate):
POSITIVE/NEUTRAL
NEGATIVE
Outcome for Welsh
Language (delete as
appropriate):
POSITIVE/NEUTRAL
NEGATIVE

If no, please include
rationale below:

Not required for the
organisational Risk
Register. Individual risks
may have been subject to
an Impact Assessment.

Cyfreithiol / Legal

Yes (Include further detail below)

See detail captured for each risk

Enw da / Reputational

Yes (Include further detail below)

See detail captured for each risk

Effaith Adnoddau

(Pobl /Ariannol) /

Resource Impact

(People / Financial)

Yes (Include further detail below)

See detail captured for each risk

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	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	6052	Chief Operating Officer	Facilities Directorate	Facilities Director	Sustaining Our Future	Statutory Duty, Regulation, Mandatory Requirements	Patient hydration risks associated with the replacement of aged Beverage Trolley fleet (ultrabarts)	IF: The patient beverage trolley fleet is not maintained/replaced Then: Patients are unable to be fed breakfast and beverages. This is an essential part of the patient care. Resulting in: Patient hydration and nutrition non-compliance. Existing fleet of beverage trolleys in CTM UHB require a replacement programme (as per regen trolleys). The current fleet (apart from the Seven assets) are 10 plus years old and maximum life is 10 years old if maintained. The Ultrabarts are used for patient breakfast and beverages and then on used on average 5 times a day for beverages so are heavy use. The current models at all district general and community sites are not able to be put on maintenance contracts due to age, hence non compliant. Several sites are now running with one per two/three wards and the service level is one per ward. VCC have 1 beverage trolley that is non-repairable.	There is a repair programme in place at each site when equipment is broken. However the beverage trolleys are too old to put on maintenance contracts. Replacement is the only alternative.	Update December 2025 An agreed replacement process has been approved, the risk will remain high until such time the service have sufficient spares from replaced carts to maintain the existing equipment.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	8 (CxL2)	↔	15.01.2025	02.01.2026	30.01.2026
2	5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning DTFS Care Group	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 December 2025: Internal working group now meeting monthly and will produce paper to go for executive discussion. New outpatient capacity has been secured to bring adult over 52 weeks waiting list down to zero by 31/3/26 but there remains an issue with follow up appointments. Options are being considered for this. Work on paediatrics continues around gaps in service. Awaiting communications from Welsh Government regarding service development across Wales.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	4 (CxL1)	↑	08.07.2024	18.12.2025	27.02.2026
3	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. • WIG 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 Directorates. • Regular reporting to the Executive Leadership Group, the Operational Delivery Committee and the Board. The Month 8 Year To Date (YTD) position is a £4.0m deficit and this position presents a risk to both the 1 year forecast and the recurrent forecast. The forecast recurrent position at the end of 25/26 has deteriorated from the planned £1.7m surplus to a £10.2m deficit due to lower than anticipated financial allocations for Pay awards and National Insurance along with under achievement of Savings Targets and operational cost pressures. The recurrent impact of Welsh Risk Pool contributions and the recurrent impact of Band 2/3 Healthcare Support Workers settlement remain a risk to this forecast position pending confirmation of WIG financial settlements for 2026/27. 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	CxL5	12 CxL3	↔	30.06.2025	22.12.2025	31.01.2026	
4	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/acuity/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. 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.	A range of work is currently underway in response to high levels of obesity in CTM including: • Ongoing funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment • Adult Weight Management Service - the scale of this is vastly insufficient to make a difference to population level rates of obesity • Children and Young People's weight management service - current time-limited funding for Pippin, 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 • 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.	Update December 2025 This risk was reviewed by the Local Public Health Team Strategic group on 9th December 2025. Although a positive update was received that the business case to continue the PIPPIN service has been approved via the Integrated Medium Term Plan, as there still remains a significant gap in funding to fully support level 1 and 3 services for children, the risk remains the same. The Healthy Weight roadmap is awaited and will be submitted to Board for approval in early 2026.	Quality, Safety & Experience Committee. Strategic Development Committee.	20	CxL5	9 CxL3	↔	06.05.2025	15.12.2025	31.1.2026
5	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey. IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: The Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: • 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 avoidable harm which will be reported and acted upon accordingly. • A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. • All unreported lists that appear to require reporting have been added to the RTT reported lists. • All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology - it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILU 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 HbAs in order to utilise their estate for operating.	January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Teams are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team. October 2025 - Unscheduled Care A number of actions are being taken by the care group to address the demand and improve patient experiences/outcomes. Launch UNITE (Unscheduled care Improvement, Transformation and Efficiency programme) POW ED Ambulatory Footprint opened Re-set RGH - short term de-escalation and re-alignment of Acute Medicine complete Medical workforce review and Job Planning Significant invest to save in Medical workforce UTC Pilot extended in PCH March 2026 45 min Escalation Action Cards and escalation policy implemented Weekly performance meetings established support by Unscheduled Care Dashboard Phase one GP intake back to POW Additional Ambulatory area in POW identified by the team to support the STAMP reset Targeted recruitment currently underway for additional consultant posts Single Point of Access (SPOA) meeting with Primary & Community Care. Programme established Successful recruitment of medical staff to uplift rates and reduce reliance on agency completed CTM UHB Winter Planning progressed October 2025 - Planned Care The below is a summary of initiatives reflecting the ongoing efforts by the care group to improve capacity and meet the elective demand. Centralisation of Cataract Service: All cataract treatments have been consolidated to the POW Eye unit from 1st September 2025. Two main theatres plus sessions in the surgicube are dedicated to the service. Direct listing of cataracts has commenced. Paediatric Dental Surgery: A recovery plan has been agreed upon between the Community Dental and RGH Theatre Service to increase theatre capacity. Cancer Services: Performance for August was 63.4%, and September 2025 is currently unvalidated but aiming at over 63%. Key actions are required for tertiary referrals, pathology, and optimisation pathways. The backlog has started to reduce against the trajectory, with a focus on Urology, Gastrointestinal, and Gynaecology. Centralisation of Trauma & Orthopaedics: The POW theatres opened on 1st September 2025 with three dedicated arthroplasty theatres. Ward 7 is now a protected elective Orthopaedic Ward with 28 beds. Between 1st September and 22nd October, 239 elective arthroplasty cases were performed at POWH. The average length of stay has reduced to 1.9 days compared to 5 days this time last year. Theatres, Urology and lab starts are improving, especially in the Princess of Wales Hospital (POWH), although they are still below target. Specialty deep dives are being introduced.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	12 CxL3	↔	13.7.2023	06.11.2025	06.12.2025	
6	5276	Director of Digital	Central Corporate - Digital & Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025.	IF: the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. Then: operations delivery of pathology services may be severely impacted. Resulting in: potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provision. 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 October 2025 Call Path deployment pushed back to October 2025 and is now very close to Micro deployment - concerns around short time frames planned for User Acceptance Testing sign off and Cutover Qualification (CQ). Blood Sciences deployment is now delayed until 2026 due to significant issues in the aligning process in Biochemistry. It has been agreed to roll out on a per discipline basis instead of per Health Board. The predicted time lines are: Pre production environment - July 2025 (completed). Production Environment - Beginning of October 2025. Call Path and Andrology - End of October 2025. Microbiology - Beginning November 2025. Blood Transfusion and Blood Sciences - No dates yet agreed, likely in the new year. Update January 2026 LIMS2 Implementation has continued to slip into 2026. The delays with completing Tranche 1 & 2 requirements under the Technical Delivery and Cellular Pathology workstreams for Data Migration, Outstanding Severity 1 & 2 Defects and configuration, impacted on completion of testing to exit UAT. Mortuary has been decoupled for deployment to post winter pressures. CTM Cellular Pathology has been coupled with CAVUHB & ARLUHB health boards for Go Live week 26 Jan. Microbiology is scheduled for an end March/ early April 2026 deployment. Pending completion of outstanding configuration and defects. Deployment dates for Blood Sciences and Blood Transfusion have not been defined by the Programme. The LIMS Programme Board have circulated Delay papers and WLIMS Infrastructure slide packs with all Health Boards (HbAs) CEOs & DuD; To advise HbAs on the Risk associated with LIMS1 End of Life and Out of Support by June 2026. Costs for extending the LIMS1 contract, supporting infrastructure have been detailed as part of the mitigation plan, should LIMS2 not be in place for all disciplines by June 2026.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL4	5 (CxL1)	↔	26.10.2022	07.1.2026	7.2.2026
7	4664 Closed session due to business sensitivities.	Director of Digital	Central Corporate - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			Operational Delivery Committee	20	CS x L4	15 (CxL3)	↔	26.05.2021	7.1.2026	7.2.2026
8	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff / Public Safety Impact on the safety - Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	IF: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour branches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting in: Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of 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 repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. Daily site wide safety meeting to ensure flow and site safety is maintained. There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. Twice weekly meetings with RCHC 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.	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 UHB Development of Urgent & Emergency Care Rapid Improvement Plan (45 minute ambulance handover and 90-day ED performance) • TRUE Rapid Improvement Plan through 4 Goals Programme - SRO - Deputy Exec Med Director and Deputy COO • USC CG Formalise 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 Update December 2025 The Emergency Department (ED) huddle is now live, which provides a live snapshot of each of the ED departments including crowding score is captured. Introductions of RATS at PCH for a number of sessions a week, this will assist in alleviating ED overcrowding due to timely assessments and redirection.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	12 (CxL3)	↔	24.09.2019	7.1.2026	7.2.2026
9																		

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																	
5753	Executive Nurse Director	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 Henthy who are the only LEAs who contribute financially into the SLA Resulting in: Dissatisfaction and fractured relationships within RCT and Henthy LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), impact on Consultant Led clinics, viability 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 EDON, 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. SSAR 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 January 2026 A Care Group meeting with the Chief Operating Officer and Interim Executive Director of Nursing took place in December 2025. Next steps agreed: 1. Service Director to engage with Schools directly 2. Interim Executive Director of Nursing to review current nursing model with the Head of Nursing 3. Additional Executive led meeting to review current engagement outcome and workforce modelling proposal 4. On-going active monitoring during this period of time for escalation to executives.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CxL5	8 (C4xL2)	↔	16.04.2024	5.1.2026	8.2.2026
6372	Director for Digital	Central Corporate - Digital & Data	Assistant Director for Digital Delivery	Sustaining our Future	Financial Risk	Cost escalation risk - Microsoft Enterprise Agreement renewal	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			Operational Delivery Committee	19	CxL4	12 (C4 x L3)	↔	16.10.2025	7.1.2026	7.2.2026
11																	
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) while ensuring optimal performance and quality standards are consistently met IF: changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM THEN: available strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care Resulting In: higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community. Additionally, the performance targets to monitor improvement of the stroke prevention and care service will be adversely affected, leading to significant challenges for the health board to include noncompliance with Quality Improvement Measures (QIMs).	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • Lrk 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 • Clinical evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCT guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update October 2025 Risk reframed to take into account feedback received from the September 2025 Quality, Safety & Experience Committee to capture the performance element of the risk. Medical Workforce Update 1.0 wie consultant returning from maternity leave October 25 1.0 wie consultant appointed, starting January 26 1.0 wie consultant returned from LTS - phased return Speciality Medicine Directorate aiming to appoint 2.0 wie consultant neurologists. Job plan will support 1 clinical session allocated to stroke on call rota. In terms of the risk score remaining at 16 the USC Care Group considers that the following mitigations support this rating. - There has been and will be a senior decision maker for stroke i.e. a consultant who will immediately attend all stroke calls – Monday – Friday with Thrombolysis prioritised. - CNS 6/7, based in ED, covering core hours 9-5 (some days till 1800). - Enhanced monitoring with senior leadership oversight in place, through daily breach huddles with a live improvement plan. This is undertaken using an MDT approach, we have already seen improvement in CT and admission to ASU. - Daily breach and weekly reports of top breach reasons and associated actions captured and tracked. - A robust improvement action plan is in place for the unit which focuses on leadership, workforce, PRC, and fundamentals of care – the actions are 89% complete. - Nursing workforce and leadership now significantly improved; we have 2 x Band 7 ward manager which enables 7/7 cover for the unit. - Medical workforce stabilised with a return from mat leave and start date for new consultant end of November - Internal Audit report recently received indicates a positive outcome with an overall reasonable assurance rating. Whilst the USC Care Group acknowledge there has been limited improvement in the QIMs to date there has been clear improvement in overall quality of care which was the basis of reducing this score from a 20 to a 16. January 2026 Note: Due to the pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee Operational Delivery Committee	16	CxL4	12 (C4 x L3)	↓	11.05.2021	06.11.2025	31.12.2025
12																	
1793	Executive Nurse Director	Central Directorate - Patient Care & Safety - Infection Prevention and Control	Infection Prevention and Control Unit	Improving Care	Safety/Well-being Patients/Staff/Public	Lack of isolation facilities available - negative pressure rooms	If: there are no negative pressure isolation facilities available. Then: there will be no appropriate isolation facilities to manage patients with infections transmitted via the airborne route. Resulting In: an increased risk of infection to other patients/ staff/visitors. There are 2 positive pressure ventilated lobby rooms available at Prince Charles Hospital. Non compliant with national guidance Welsh Government expectation.	High Consequence Infectious Diseases (HCID) plan prioritizes Prince Charles Hospital for HCID cases for use of the positive pressure lobbies, Capital funding approved to build 2 negative pressure rooms in the Health Board.	Update January 2026 Funding solutions have now been secured for two areas within the health board, and the design phase will be initiated with involvement from IPC teams, Capital, and Estates. An Executive briefing is scheduled to commence in February 2026. While some cubicles are available for isolation, the absence of appropriate negative-pressure ventilation continues to present a risk for airborne infection transmission. Capital funding has been agreed to support the development of negative pressure rooms on acute sites, with locations to be determined based on resident pathways and patient flow requirements. During the lead time for these dedicated isolation rooms, current practice of isolating patients in suitable single-patient cubicles in line with IPC isolation policy will remain in place. Risk continues to be monitored by the Ventilation Safety Group and the Infection Prevention and Control Committee.		16	4x4	4 (C4xL1)	↔	16.12.2014	08.1.2026	8.3.2026
13																	
6229	Executive Nurse Director	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Improving Care	Quality, Complaints, Assurance / Patient Outcome	Timely development of management and response 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 CTMHUB'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 Visibility of data using the Datix System. Listening and Learning Framework	Update January 2026 The LFER panels are now fully operational, and we are seeing positive success rates in approvals through the Welsh Risk Pool. While there is scope to reduce the number of panels, the decision is to maintain the current approach until an additional cycle of WRP panels is completed to confirm sustained performance. The Legal Services Recovery Plan remains active, focusing on ensuring sufficient capacity to manage cases effectively, reviewing internal processes and systems for improvement, and identifying areas for further enhancement.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	CxL2 = 8	↔	3.7.2025	08.1.2026	8.3.2026
14																	
6231	Executive Nurse Director	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 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. Available 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 CTMHUB'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.	Update January 2026 Sustained improvement has been observed, although complexity remains within the process. Work is underway to develop a clear structure for the team, which will require recruitment of specialist portfolio holders to strengthen capability. The Operational Control Plan (OCP) is on track for full implementation by the end of the financial year, with mitigations and monitoring in place alongside continued engagement with Welsh Risk Pool and Legal & Risk teams. The LFER panels are now fully operational, delivering positive success rates in approvals through WRP. While there is scope to reduce the number of panels, the current approach will be maintained until an additional cycle of WRP panels confirms sustained performance. The Legal Services Recovery Plan remains active, focusing on ensuring sufficient capacity to manage cases effectively, reviewing internal processes and systems for improvement, and identifying further opportunities for enhancement.	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	16	C4 x L4	CxL2 = 8	↔	3.7.2025	08.1.2026	8.3.2026
15																	
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.	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	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 as to work in real time, this has helped to maintain performance despite the staff shortages Internal - Regular Monitoring through CTMHUB'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 (NWSPP-SES) have collected Estates and Performance Monitoring System data (EPNMS) 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 replaces the highest priority replacement assets. Update January 2026 Risk reviewed and no change to current risk score at this stage. Capital and Estates continue to seek all opportunities for Welsh Government funding. CTM had the highest capital allocation in 2025-26 than any other health board in NHS Wales. However, this still does not mitigate all of the gaps and controls and the resulting impact of this risk. In November 2025 CTMHUB Board approved the Prince Charles Hospital (PCH) Refurbishment Project Finalised Phase 3 Full Business Case for submission to Welsh Government which subject to approval will support some further reduction in backlog on the PCH site.	Operational Delivery Committee Health, Safety & Fire Sub Committee	16	(C4xL4)	9 (C3xL3)	↔	4.7.2025 - Opened on Date	6.1.2026	6.3.2026
16																	
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 mental 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 x3 consultant neurologists within CTM as part of the Neurology Liaison Plan.	Update December 2025 Interview will take place Wednesday (7/1/26) for the consultants post, providing the post can be covered following interview within 3 months we will be in an improved position. CTMHUB will report the neurology waiting list from 1 April. Locum post extended until December 2026. CAVHB have committed to reducing over 52 week stage 1 backlog to 102 patients by the end of March 2026.	Quality, Safety & Experience Committee Operational Delivery Committee	16	CxL4	8 (C4xL2)	↔	09.3.2022	7.1.2026	7.2.2026
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	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	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 December 2025 The status for the SPC in YCC has been temporarily changed and removed as a result of implementation of admission criteria for end of life and complex care. This is an interim measure whilst the engagement process is complete around the long term future of the centre enabling the Care Group to commence a redesign of P&L/C across the CTM wide footprint. This will be under review as the care group continue the process around the long term future of the centre.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 (C&L2)	↔	11.10.2023	7.1.2026	7.2.2026
18	4973	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	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. Substantive jobs which are new posts are being developed and advertised 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 given by Executive Medical Director and the necessary paperwork submitted. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements. Substantive and significant programme of work running alongside this in medical workforce productivity in place International recruitment drive looking to recruit two speciality doctors to inpatient and rehab in August 2025 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 The directorate plans, organises and publishes medical cover through a spreadsheet (updated reference) so everyone knows who is providing medical cover where and when.	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 December 2025 Risk reviewed, no change in the risk rating Due to ongoing respect and resolution related issues medical staffing in RGH has been further pressured in December, to mitigate this further control measures have been implemented. Two Interim Clinical Directors have been appointed. Dr Sally Bolt is also supporting the MHLD Care Group with sessions as Interim Medical Director The Directorate plans and organises publishes medical cover through a spreadsheet so everyone knows who is providing medical cover where and when.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	12 (C&L3)	↔	06.01.2022	19.12.2025	30.01.2026
19	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/VXRail) 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 VXRail 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 December 2025 - The £2.1m was rejected by Welsh Government (WG) in the initial ask for capital. We have reviewed costs and looked to sequence activity this has enabled us to reframe our ask of WG for an initial investment of £1.5m, with a second investment of £0.8. These bids have been submitted to WG and we are awaiting a response. Update January 2026 - WG have awarded us £1.5m in funding. Procurement planning has begun.	Operational Delivery Committee	16	C&L4	8 (C&L2)	↗	09.01.2025	7.1.2026	7.2.2026
20	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 December 2025 The revised "Policy on Policies" is going forward for approval at the Quality, Safety & Experience Committee on the 21 January 2026. Once approved this will be circulated and published on the internal policy page. This will be accompanied by a simplified process flow chart for approval. The new policy library web page is planned to 'go live' by the end of January 2026, however, this is dependent on the capacity within the Corporate Governance, Web Development Team and the Digital & Data Team. The archiving of previous policy versions has been delayed, however, all available documents have been downloaded and are in a searchable format should any requests be received. All Directorates have received the latest update as to the status of their current policy lists. Whilst it is hoped that the new policy and current master library will be live by the end of January it is anticipated that other aspects will be delayed until circa the end of March 2026. The policy programme continues to be monitored via the Executive Management Board.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 (C&L2)	↗	26.10.2021	05.01.2026	05.03.2026
21	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety	Cross Health Board Data Sharing	IF Digital services across Wales are unable to 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. CTM/HB have asked for alternate options for a quicker solution and timescale to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems - this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by CBV 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 ABUHB and DHCW. CTM/HB are asking and raising the concern, however, cannot directly resolve. Update September 2025 - remains as August 2025. It is raised at the relevant forums (All Wales Medical Director Meetings) regularly. No changes to risk score. Update October 2025 - remains as reported previously. The risk continues to be raised at the relevant forums (All Wales Medical Director Meetings) regularly. Update Jan 2026 - remains as reported previously. The risk continues to be raised at the relevant forums (All Wales Medical Director Meetings) regularly.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C&L4	8 (C&L2)	↔	26.04.2024	23.12.2025	23.02.2026
22	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	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 PIPYN continues to be delivered in Merthyr (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 IHTP consideration. Business case proposes a phased approach at levels 1 and 2 and was developed in collaboration with stakeholders Finance-dependant controls: 1) Set up service if funding identified via IHTP process.	Update December 2025 31/12/25 - Risk reviewed. No change in score. Budget confirmed for Health Board role out of L1 PIPYN 3-10 from March 26 onwards. L3 still significant gap and put forward again as part of Integrated Medium Term Plan planning process. (PIPYN aims to support children (aged 3-7 years) and their families make healthy choices in Merthyr Tydfil and Rhondda and Taff Ely)	Quality, Safety & Experience Committee Strategic Development Committee	16	C&L4	8 C&L2	↔	13.10.2023	31.12.2025	23.02.2026
23	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 • DAP updated and signed off by Board March 2024 • Board and Committee cover papers also now include environmental impact against 5Rs. • 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 December 2025 Refreshed governance arrangements to start in January 2026. Refreshed plan delivery on track for March 2026. High level risks relating to adaptation being developed for submission to Welsh Government	Strategic Development Committee	16	C&L4	8 (C&L2)	↔	21.2.2023	18.12.2025	27.02.2026
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Date ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4417	Chief Operating Officer (Linked to Risk IDs 4706 and 4703)	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons; 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. If: the Health Board do not comply with the notice. THEIR: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update December 2025 Actions reviewed and additional action recorded. A meeting will be scheduled to ensure that all relevant disciplines are aware of the programme of work and mitigating actions in place.	Health Safety & Fire Sub Committee	18	C4 x L4	8 C4xL2	↔	30.09.2020	7.1.2026	7.2.2026
4671	Director of Digital	Central Corporate - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service/business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets	Due to business sensitivities the details of this risk are captured in the closed session of the Committee.			Operational Delivery Committee	16	C4 x L4	9 (C3xL3)	↔	03.05.2021	7.1.2026	7.2.2026
6294	Chief Operating Officer	Planned Care - Care Group	Service Director Planned Care	Sustaining our Future	Workforce / Organisational Development / Staffing / Competence	Insufficient Consultant Workforce - Endoscopy / Gastroenterology	If the Consultant posts cannot be filled, then it will impact on Service Delivery and affect our ability to deliver both diagnostics and clinical services to patients. If the Consultants that are currently in post were no longer in post, then this would significantly affect our ability to deliver both diagnostics and clinical services to patients. Furthermore it would impact on ability to support inpatient services at POW. Fragility of the Consultant workforce is contributing to potential gaps within the on call bleed rota, with little redundancy. This could result in a situation in which the on call bleed rota could not be covered. Unsustainable service provision to safely care for inpatients.	In terms of recruitment posts remain out to advert. In post for one of the vacancies however they are due to leave in the near future due to other obligations. There has been no interest from agencies in supporting the vacancies.	Mitigating actions currently limited. Continuing to advertise for posts. Update December 2025 No further mitigation. Rota remain out to advert. Locum has now left post as of early December (this was earlier than expected, with significant disruption to Endoscopy). Extremely fragile staffing position in POW. There has been no interest from agencies.	Quality, Safety & Experience Committee. Operational Delivery Committee	16	C4 x L4	9 (C3xL3)	↔	07.08.2025	7.1.2026	7.2.2026
6713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTIPS	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Backlog of Reporting Radiology Examinations	If there is consistent backlog of Radiology reports THEN there will be a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes. Resulting in impact on patient outcomes, delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service The reporting backlog has been compounded by: Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Dataix incident and concerns procedures in place.	There is a significant backlog of reporting radiology examinations, with just over 10,000 X-rays pending. Current mitigation measures include rostering SPIRs for extra reporting, outsourcing RSK cases, utilising training posts and the returning from parental leave. We are aiming to address the backlog in the more likely clinical urgent cases (chest x rays) by December as a priority. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee. Operational Delivery Committee	16 New risk escalated November 2025	C4 x L4	6 (C2xL3)	↔	08.02.2017	6.11.2025	15.12.2025
6379	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Service Director - DTIPS	Improving Care	Safety & Wellbeing Patients / Staff and Public	CT Scanners at RGH damaged by power outage and manual generator/UPS switch over	If the manual switch over following a power outage is not rectified. THEN the CT scanners/tubes may become damaged Resulting in no CT service on site, causing significant delay in patient outcomes, and significant cost to repair (circa £350k per tube)	Discussion with manufacturer and All Wales procurement Discussion with estates team Estates will ensure CT is switched on first, for generator to kick in Regular weekly meeting with GE and estates to monitor	Action plan required urgently to show regular monitoring. If a separate or modified UPS is required then a statement of need for Capital consideration will be required. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the COO Business Team.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	4 C4xL1	↔	20.10.2025	06.11.2025	31.12.2025
6318	Chief Operating Officer	Mental Health Care Group	Service Director - MHLD	Improving Care	Safety & Wellbeing Patients / Staff and Public	Tier 3 SHED Team Service Delivery	If the level of vacancies continues in the CAVUHB service for high risk eating disorder patients (SHED) Then: The service will be unable to fully deliver assessment and treatment interventions for CTM UHB residents. Resulting in: Patient safety concerns for a number of high risk patients	Controls update December 2025: •The recent appointment of a band 7 practitioner within CTMUHB to help with coordination individual would be starting in this role on 15th December for a fixed term until 31st March 2026. The costs for this post would be recharged to CAVUHB. •The establishment of fortnightly SHED drop in clinic for adult CMHT staff in CTMUHB. MH Team colleague had helpfully been involved in establishing these regular meetings and initial feedback was positive. •CTMUHB adult CMHT services will continue to provide physical health monitoring arrangements for their patients who have been referred to SHED. •The Consultant lead for SHED, had agreed to schedule some training sessions for CTMUHB CMHT staff which was welcomed. Further Measures are under way •To evaluate the SHED service specification (when staffed at typical levels) and agree a supplementary document describing what is currently available. CTMUHB have provided comments to facilitate further discussion. •CAVUHB have commissioned JG Degrees to review the SHED service and provide recommendations for its strategic future. The review requires CTMUHB input and lead identified to facilitate this. •In advance of the review CAVUHB are recruiting to key posts. Details of the recruitment will be shared with MH Team so that CTMUHB can help to promote and to give real time updates on the restoration of assessment and intervention work •A key risk is the reduction in medical cover (2 sessions CAVUHB and 4 sessions CTMUHB) from end Feb 2026. CAVUHB agreed that there were opportunities to use these sessions to create an attractive new consultant role. Colleagues will meet to consider the provision of future cover and any transition plan required.	Escalated at OMB 29.10.25 risk rating increased following dialogue with CMHTS. escalated to service director and director of nursing. The care group will progress with an action plan to mitigate the risk and the Care Group Service Director has requested a meeting with CAVUHB senior Mental Health leadership team to consider a route forward. Update December 2025 Risk reviewed and updated, current control measures have been updated. Update from a meeting held with CAVUHB colleagues 02/12/25 also captured in Dataix. No change to the current risk score at present	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	C3xL2 = 6	↔	29.08.2025	19.12.2025	30.01.2026
6280	Chief Operating Officer Executive Director of Strategy & Transformation Executive Medical Director	Planned Care - Care Group	Service Director - Planned Care	Improving Care	Safety & Wellbeing Patients / Staff and Public	Suspension of the Regional Hepato-Pancreato Biliary service model	If... The commissioning of this service is not prioritised as part of the regional commissioning arrangements. Then... there will be no Regional service for Severe Acute Pancreatitis Resulting in... sub optimal care for this group of acutely unwell patients	Each case currently being discussed on a case by case basis between neighbouring Health Board Medical Directors, however, this will add delays to an already complex and time sensitive treatment pathway.	As this is a service that is regionally commissioned the Health Board will need to have ongoing discussion with the Joint Commissioning Committee as to a way forward. Update December 2025 Risk was noted as a risk at Executive Management Board on the 29.12.26 , as a result a decision was shared by the Chief Operating Officer that the risk will sit with the Executive Director of Strategy & Transformation and Executive Medical Director. As this is a service that is regionally commissioned the Health Board will need to have ongoing discussion with the Joint Commissioning Committee as to a way forward.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	9 C3xL3	↔	06.08.2025	05.01.2026	31.03.2026
5877	Chief Operating Officer	Primary Care and Community Care Group	Service Director - Primary Care	Improving Care	Service / Business interruption	New Worker Contract for Out of Hour GPs	If the new worker contract for out of hours GPs is implemented (ambition is for Dec 2025) it will require the application of Working Time Regulations. THEN there will be a significant impact on shift fill rates. Resulting in the Health Boards ability to fill shifts across the whole roster having a negative impact on both NAST and ED departments.	Recruitment of more GPs who do not also work day time in other roles. Whilst the weekend service will be affected to some degree, weekday evening service will be most adversely affected as any GP working until midnight will not be able to work in practice the next morning.	Additional recruitment of GPs is critical to establish the service. Update December 2025 To mitigate the risk alternative methods for recruitment of GPs has been explored. However this process is not agile and flexible and suitable to the way in which GPs book shifts. Sometimes at very short notice as they work elsewhere. Options still being explored.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	C3xL2 = 6	↔	07.08.2024	7.1.2026	7.2.2026
6397	Chief Operating Officer	Primary Care and Community Care Group	Service Director - Primary Care	Improving Care	Service / Business interruption	Shortage of GPs to deliver urgent primary care services for escalation.	If the decision to have a 'hold' on the recruitment of GPs into GP OOH and Navigation Hub continues of engagement and contractual status of Out of Hours GPs. THEN there will be a continued reduction in shift fill rates. Resulting in shifts remaining unfilled (specifically home visiting shifts) and this will lead to more patients (palliative and end of life) being conveyed into the Emergency departments.	Explore alternative engagement routes such as bank and salaried contracting although there are challenges as these due not offer flexible engagement for GPs who have permanent day time and other employment.	Update December 2025 The following has been applied to mitigate the risks. All GPs on a 'holding list' have been contacted. Adverts have been placed via bank and GPs encouraged to apply through this, but the process is not compatible with rota and does not offer flexibility for shift fill and short notice changes. Shift fill was challenging over the Christmas Period but was covered by senior GPs from the leadership team.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4 x L4	C4xL3 = 12	New Risk Escalated to the Organisational Risk Register in January 2026	31.10.2025	02.01.2026	31.01.2026

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
6232	Executive Nurse Director	Central Directorate - Patient Care & Safety	Deputy Nurse Director	Sustaining our Future	Safety & Wellbeing Patients / Staff and Public	Stability of the Legal Services Function	IF: the Health Board fails to adequately equip the Legal Services Function with the resources and support to fulfil the requirements of the function. Then: there is a risk to staff turnover and retention, wellbeing and morale. Risk to the reputation of the function and the Health Board as an employer of choice. Lack of resilience and capacity to fulfil the obligations under the relevant legislation surrounding the activity of the function. Resulting in: an adverse impact to the wellbeing and morale of staff leading to increased sickness absence and staff turnover. Lack of job satisfaction. Increasing risk of breaching relevant legislation due to lack of sustainable resources and resilience of the existing function. Loss of Trust and Confidence in the Legal Service Function / Reputation.	Review initiated to understand CTMHB's position in terms of the number of inequities underwritten and the response to requests. Current controls: ICP underwrite to consider structures of the function. Benchmarking and learning from other organisations.	Update January 2026 The position is now much more stable, with strong engagement from key stakeholders contributing to improved oversight and progress. However, risks remain associated with the pending closure of the Organisational Change Process (OCP). The Legal Services Recovery Plan continues to be implemented, focusing on ensuring sufficient capacity to manage cases effectively, reviewing internal processes and systems for potential changes, and identifying areas for further improvement.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C3xL5	C3xL2 = 6	↔	1.7.2025	08.1.2026	8.1.2026
6217	Executive Medical Director	Children & Family Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	A number of Nationally reportable incidents have been raised since February 2025 within Obstetrics / Maternity	IF: the safeguards and quality systems and processes are not robust Then: - mothers and babies may not receive the best evidence based care Resulting in: Potential for patients to have poor outcomes and experience within the service.	Rapid reviews have been undertaken on all cases with findings and learning from each. Meetings held with Care Group and executive team to decide on way forward. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan).	Update September 2025 External review commissioned on Nationally Reported Incidents. Action plan put in place by the clinical teams and care group. (details of all actions within that action plan) - the action plan and risk will be further reviewed once external report received. Response received from obstetrician reviewer with further information requested. Update October 2025 The Health Board is still awaiting obstetric review from the external clinician in order to be able to review the risk and continuation of actions. January 2026 Note: Due to site pressures with capacity and flow this risk was not updated at the time of the Organisational Risk Register for January being finalised. The Chief Operating Officers Business Team are seeking an update and this will be reflected in the next iteration of the Organisational Risk Register. Updates prior to this can be sought from the CCO Business Team.	Quality, Safety & Experience Committee.	15	C5xL3	10 (C5xL2)	↔	14.05.2025	6.11.2025	31.12.2025
4672	Director of Digital	Central Corporate - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes. Service /business interruption	Access to a complete, integrated, and coded medical record.	IF: The Health Board is not able to record information accurately and reliably, with complete and up to date information. Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting in: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	Operational controls: Digital element of the strategic programme board monitors scanning times, adherence of contractor to terms and quality of staff in maintaining a record DHCW annual coding quality audit. Coding Improvement and transformation plan established incorporating additional trained coding capacity, coding at source, use of data captured in other systems and e-forms implemented. Natural language programming resource deployed and outputs of programme being validated. Tactical - EPR programme with deployment of snomed-CT ontology server, WCP & E-forms etc. Tactical controls: Digital element of the strategic programme - Culture to digitise the EPR, our communications, how we do business National Architecture Review - encompassing (NCR /CDR & Sharing arrangements) Coding transformation programme Gaps in controls Scanning time of outpatient activity to digitise the record is at 51 days of maximum clinically safe time of 24-48 hours Quality of paper record and its filing is very poor with audits identifying over 70% of paper records are not maintained to acceptable standards Digital solutions not yet using snomed-CT structurally coded data Information and Technical Standards not being followed with national body favouring document rather than data exchange Vast amounts of clinical information stored in disparate spreadsheets not visible to central medical record or available to patients or system leaders (including value based healthcare) Digital transcription programme unsupported & unsupported from march 23	Update December 2025 Work ongoing on strategic roadmap for development of a modular approach to an integrated care record and delivery of core functionality to ensure consistent record of information. This will form part of the Digital & Data IMTP submission for 2026/2027. Key requirement is on integration and data acquisition, which incorporates AI to undertake transform free text to clinically assured structural information. This area of skill mix has been identified as a key enabler to the UHB's modular EPR strategy deployment and to our data and AI strategies, and as such is being factored into the resource allocation made for these developments.	Operational Delivery Committee	15	C3 x L5	9 (C3xL3)	↔	05.06.2021	7.1.2026	7.2.2026
5040	Director of Digital	Central Corporate - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Projects Including systems and processes. Service /business interruption	Digital Healthcare Wales (DHCW) interdependencies	IF: The Health Board can not integrate new applications into its digital architecture in a timely fashion Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEOS) 3. Possible breaches to the GDPR, safeguarding and information governance risks 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted	A Myrdin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome SLAs are in place between DHCW and NHS Wales organisations, however their fulfilment has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months Gaps in controls: WG have agreed some funding for the PAS element, however the DHCW IMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace Cansico) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curate egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.	Update December 2025 As part of the EPMA programme Digital Health Care Wales have provided integrations into the document repository service they host, and limited outbound feeds of test results and administrative data. These have yet to pass testing, despite considerable effort, resulting in the delay of the EPMA programme. Further concerns now noted that the Maternity system may be delayed as the integrations have not been provided and the UHB has not released the resource required.	Operational Delivery Committee	15	C3xL5	9 C3xL3	↔	07.02.2022	7.1.2026	7.2.2026
3337	Chief Operating Officer Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Central Corporate - Digital & Data	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Lack of a Single Electronic Patient Record in Mental Health Services	IF: Mental Health Services do not have a single integrated clinical information system that captures all patients details. Then: Clinical staff may make a decision based on limited patient information available that could cause harm. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought: this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMHB staff who currently use WCCIS via local authority over to CTMHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update December 2025: CTMHB still await the Outcome report that recommends the Supplier and allows us to plan next steps. The team continue to escalate at all relevant meetings. Therefore, our next steps are unchanged:- 1. Awaiting recommendation/outcome report 2. Report will be taken to Programme Board and Executive Board for approval 3. Supplier to be known 4. Procurement process to conclude 5. Start of implementation The first Workshops have been arranged to review the forms used and current processes. These will take place:- 20th January CAMHs and Specialised Services (Ty Llidardd) 22nd January Adults and Older Persons (Glanrhydy)	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	2.1.2026	01.01.2026
4691	Chief Operating Officer Linked to RTE Risk 4803, 4790, 3273 and 3019.	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes. Service /business interruption	New Mental Health Unit	IF: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting in: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April Assistant Director of Strategic Transformation - Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommending a capital business case for a new Mental Health Unit. Annual revisiting of all patient fixture risks and completion of Statement of Needs via capital process for any fixture 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 December 2025 Risk Reviewed, no change in scoring The inpatient review and remodeling programme continues to progress, with Safe Wards interventions and enhanced therapeutic input positively received by staff, patients, and external reviewers. The inpatient renaming of the wards to align with the new model remains paused pending resolution of governance and safety compliance requirements. The programme reports to the MHLD Improving Care Board. November update included in data risk assessment record.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	22.12.2025	01.01.2026
5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	IF: as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. Then: there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. Resulting in: avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	Update December 2025 This risk was reviewed in the Local Public Health Team strategic group meeting on 11.12.25. The uplift in Health Protection funding for 25/26 still does not bring parity to the funding across forms and is insufficient for the Health Protection team. A submission to Welsh Government was made in December 2025 highlighting the remaining funding gap and areas this is impacting. Therefore the risk is to remain unchanged and for review upon confirmation of the funding allocation for 26/27	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	11.12.2025	11.03.2026

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)
6234	Executive Director of Finance (Executive Lead for Estates)	Sustaining Our Future	Environmental / Estate / Infrastructure	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.	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 request. There is also a risk of being unable to support the delivery of capital projects, and departmental virement 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. Falling 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. Update January 2026 Risk score reviewed and whilst recognising that there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability. Ongoing activity continues with the support of the People Directorate to explore routes to further promote and attract candidates to roles advertised particularly around the Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge. On the basis of this review the risk likelihood score has been reduced to a 3 and the risk de-escalated from the Organisational Risk Register. The risk will continue to be monitored by the Capital and Estates Directorate.	Operational Delivery Committee & Health, Safety & Fire Sub Committee	12 C4xL3 (Reduced from a 16)	9 (C3xL3)
5417	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	If... Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. Then... the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. Resulting in... 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped from 48% to 80%. Children can only wait 8 wks from assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update December 2025 Prince Charles Hospital additional theatre lists have commenced and now beginning to see the positive impact on the waiting list. October figures show 443 children waiting for assessment for GA. There are also 516 children waiting for a PMBA assessment which may increase the number of children requiring GA once assessed. Following a delayed start to the RGH lists they are now due to commence the 1st week of January, with all lists in place, this should start addressing the backlog issue, however winter pressures does lead to dental GA lists being cancelled so the decrease in numbers may take time to be seen. As a result of the progress being noted to lists , the care group have reviewed and reduced the score to a 12 but will keep under review to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).	Quality, Safety & Experience Committee Operational Delivery Committee	12 Decreased from a 20	9 (C3xL3)
6228	Executive Director of Nursing	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 2013" 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 inquests, 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 CTMUHB's position in terms of the number of inquests underway and the response to requests. Review and remap internal processes in the management of inquest cases within the organisation. Weekly coronial 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.	Update January 2026 The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12	Quality, Safety & Experience Committee Audit, Risk & Assurance Committee	12 Decreased from a 16	8 (C4xL2)

De-escalation Rationale
Risk score reviewed and whilst recognising that there continues to be a National UK skills shortage the Health Board has had recent success in appointing to two Senior Estate Manager roles, and due to robust succession planning filled other gaps within the team which has provided stability. Ongoing activity continues with the support of the People Directorate to explore routes to further promote and attract candidates to roles advertised particularly around the Band 6 opportunities within the team as it is acknowledged that recruiting to these roles continues to be a challenge. On the basis of this review the risk likelihood score has been reduced to a 3 and the risk de-escalated from the Organisational Risk Register. The risk will continue to be monitored by the Capital and Estates Directorate.
As a result of the progress being noted to lists , the care group have reviewed and reduced the score to a 12 (Likelihood reduced to a 3) but will keep under review in the Care Group to ensure there is no notable impact to the lists to change position. (Action plan submitted to Board September 2025 to outline the HB plans to mitigate risk, as a result of the progress against the plan the HB were able to reduce this risk).
The review of inquest management has been completed, and new processes are now operational with SOPs in place. Weekly meetings with the Senior Coroner's Officer continue to monitor progress, supported by internal briefings for ELG oversight. These improvements have strengthened governance and reduced the likelihood rating to 3. Risk now 12

	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											
	6240	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 directorates. • Regular reporting to the Executive leadership Group, the Operational Delivery Committee and the Board.	Update December 2025 The M8 Year To Date (YTD) position is a £4.0m deficit, which includes a £5.6m shortfall in savings delivery. The Health Board is continuing to forecast a break even position for 25/26. The key risks to the forecast have improved following confirmation of non recurrent WG funding for the Welsh Risk Pool contributions together with Band 2/3 settlements in 2025/26. There remains a requirement to achieve further mitigation actions of £1m in maintaining our breakeven forecast. 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	Risk Closed January 2026	The Health Board is continuing to forecast a break even position for 25/26. The key risks to the forecast have improved following confirmation of non recurrent WG funding for the Welsh Risk Pool contributions together with Band 2/3 settlements in 2025/26. The Finance Function have therefore closed this risk as the target score of 12 has been achieved.
2											



Agenda Item

4.2

Audit, Risk & Assurance Committee

Response to the updated HM Treasury Audit & Risk Assurance Committee Handbook

Dyddiad y Cyfarfod / Date of Meeting	03/02/2026
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>	Cally Hamblyn, Assistant Director of Governance & Risk
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>	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Forum Individuals	Date	Outcome

Acronyms / Glossary of Terms	
ARAC	Audit, Risk & Assurance Committee



1. Situation /Background

- 1.1 In August 2025, the HM Treasury Audit and Risk Assurance Committee handbook, reflecting developing best practice in governance was revised, and as best practice this presented an opportunity to revisit the current business activity for this Committee in the following areas:
- ARAC Terms of Reference
 - ARAC Annual Cycle of Committee Business
 - ARAC Self-Assessment Questionnaire
- 1.2 The revised handbook is available here: [Audit and Risk Assurance Committee Handbook - GOV.UK](#)

2. Specific Matters for Consideration

2.1 ARAC Business Activity

2.1.1 **Accountable Officer Attendance**

Paragraph 3.4 of the handbook suggests that the Accounting Officer (Chief Executive Officer) should routinely attend ARAC meetings. Whilst currently the CEO attends the ARAC for the endorsement of the Annual Report and Accounts the Director of Corporate Governance / Board Secretary has explored this with the CEO and it is felt that our current approach is proportionate to the nature of the Health Board. However, should the Chair of the ARAC feel the need for the Accountable Officer to attend for a particular meeting this will be determined at Agenda Planning meeting and agreed with the CEO.

2.1.2 **Private meeting of Members**

Paragraph 3.4 of the handbook suggests that Independent Members of the ARAC should be provided with the opportunity to meet privately without any non-members present for part of the meeting if they so wish. To address this, it is proposed that in advance of each ARAC meeting the Chair meets with the Corporate Governance to determine if the Independent Members wish to hold a private session of their own.

2.1.3 **Meetings outside the Formal Committee structure**

Paragraph 3.5 of the handbook suggests that it is good practice for the Chair of the ARAC to meet separately with the Accounting Officer (referred to as the Accountable Officer for NHS Wales bodies), the Finance Director, the Head of Internal Audit and the external auditor's senior representative outside of the formal committee structure. This is already in place for the Chair and audit colleagues, with the agreement of the Chair we will now look to put in place meetings with the Accountable Officer and the Director of Finance.

2.1.4 **Structure of the meeting, Terms of Reference and Annual Cycle of Committee Business**

Reflecting on Chapter 5 and Annex D within the Handbook which relates to the role and scope of the Committee, the flow and structure of the ARAC ToR and Cycle of Business will be reformatted in the hope that flow and structure has improved.

Annex E within the Handbook outlines an example of the core work programme based on a quarterly meeting structure. We intend to explore this approach to consider if it works for the health board.

2.1.5 **Raising Concerns (Speaking Up Safely)**

The handbook suggests that the ARAC considers updates and an annual report on raising concerns / speaking up safely (previously known as Whistleblowing). The ARAC is asked to consider if it is content to include this in the remit of the Committee as it is recognised that this currently falls within the business of the Operational Delivery Committee. In seeking assurance on this area of activity the Committee would need to assure themselves that:

- there are appropriate and effective speaking up safely practices in place?
- these provide suitable channels for staff and others to raise their concerns?
- the policies appropriately cover the issues on confidentiality and anonymity?
- that staff are offered appropriate support and provided with suitable and timely feedback?
- that concerns raised are dealt with properly and reported to senior management?

The Independent Member Champion for Speaking Up Safely is a member of the ARAC and the Executive Member Champion attends each meeting.

If content the Terms of Reference will be drafted to reflect the changes and taken to the March 2026 Board meeting for approval.

2.1.6 **Strategic Risk**

Whilst the ARAC routinely receive the Organisational Risk Register, upon review of the Handbook it is proposed that the ARAC also receive the Board Assurance Framework for scrutiny and assurance to ensure it reflects key strategic risks. It is proposed that the BAF is also still received at the Strategic Development Committee.

2.2 Self-Assessment Toolkit

The Committee will be aware that the Corporate Governance Team currently use MS Forms for capturing self-assessment reflections on Committee Effectiveness, within the handbook an alternative format. We have included this information in the appendices. Please note that Appendix 1 is the complete assessment including the analysis aspects which could be used by the Corporate Governance Team. Appendix 2 is a CTMUHB adapted version which is what individuals would receive for completion.

The Committee are asked to consider this with the view to whether they would wish to implement the approach and consider if it is open to Members and attendees or just Members. The recommendation of the Corporate Governance Team is to invite feedback from Members and attendees but perhaps differentiate between the two groups in collecting the information recognising that some questions may not apply to attendees.

2.3 Further Supporting Information

ARAC Members and attendees are encouraged to read the handbook as there are several areas of good practice which will support attendance and roles at the Committee. Members may in particular find Annex F helpful which relates to "Key questions for an Audit & Risk Assurance Committee to Ask".

3. Key Risks / Matters for Escalation

- 3.1 There are no risks identified with the changes proposed in section two as it is anticipated that the proposals will further strengthen the governance and business activity of ARAC.
- 3.2 If the changes are supported by ARAC the Terms of Reference will be submitted to Board for approval and updating of the Standing Orders.

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	A Resilient Wales
	If more than one applies please list below:



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

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required in relation to this item.
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 required in relation to this item.
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:

5.1.1 **Approve** the proposals outlined in sections 2.1.1-2.1.3

5.1.2 **Endorse** the proposed changes to the ARAC Terms of Reference which are the updates which are outlined in 2.15 on Speaking up Safely, for onward approval by the Board and updating of the Standing Orders.

5.1.3 **Approve** the proposed future role of ARAC in relation to:

- Speaking up Safely
- Board Assurance Framework (Strategic Risks)

5.1.4 **Consider and Approve** the approach to the annual Committee Self-Assessment Process and agree the target audience.

6. Next Steps

6.1 As indicated above if the Committee endorse the approval of the updated Terms of Reference these will be submitted to the Board for approval and the Standing Orders updated.

6.2 All other changes will be implemented in readiness for the 2026 calendar year of ARAC meetings.

INTRODUCTION

Welcome to the **GIAA Audit and Risk Assurance Committee Self-Assessment Tool**.

The purpose of the tool is to help you understand the overall effectiveness of your ARAC, based on the result of each response.

The tool allows you to score your ARAC's performance against a set of criteria and highlight the areas which are above the standard, have met the standard or where improvement is needed.

VIEWING OR UPDATING THE RESPONSES

1. Enter responses for each question into the table in the **Responses** sheet. Example responses have been filled in for the first column, **please overwrite these with actual responses**.
2. If there are more than 10 responses, right click on the last column in the 'Responses' table and **Insert**. This will add a new column for the additional respondent.
3. Responses must be entered as a number from 1 to 3 for most questions. However, we have recognised some questions may not be applicable to all organisations and these have a N/A option which can be used.
4. Where a Yes or No answer is required, please answer 3 for Yes and 1 for No.
5. Score definitions are: 1 - Needs to Improve, 2 - Standard Met, 3 - Working Above the Standard. Questions 11, 13, 42c, 51c, 51d, 51g and 86e also have a N/A option.
6. Questions 89 and 90 are free text boxes for your comments.
7. To allow comparison, average scores are shown:
 - at the base of each column in the 'Responses' sheet
 - for each question in the 'Average Scores by Question' sheet
 - for each area in the 'Average Scores by Area' sheet



This form can be completed by each member in turn or each member can complete their own copy, for the results to be collated into one.
Scores of 1,2 or 3 should be selected from the drop-down menu in the relevant Member column or can be entered directly as a number.
Score definitions are: 1 - Needs to improve, 2 - Standard met, 3 - Working above the standard.
Some questions also have a N/A option. Where a Yes or No answer is required, please answer 3 for Yes and 1 for No.

		Comments	Response 1	Response 2	Response 3
Role and Remit					
1	Does the committee have written terms of reference?		1		
2	Are the terms of reference regularly reviewed?		1		
3	Do the terms of reference clearly set out the committee's role and are they consistent with the example terms of reference in this ARAC handbook?		1		
4	Are the terms of reference approved by the committee and the board?		1		
5	Are the terms of reference made publicly available?		1		
6	Has the committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?		1		
7	Do committee members have appropriate authority to require reports on areas of the committee's responsibilities?		1		
8	Does the organisation's annual report and accounts/Governance Statement mention the committee's existence and its broad purpose?		1		
Membership, Induction and Training					
9	Has the membership of the committee been formally agreed by the board and/or accounting officer and a quorum set?		2		
10	Does the committee have at least three members (or the number stated in the agreed terms of reference) who are independent and objective?		2		
11	Are members appointed for a fixed term?		n/a		
12a	Do all members of the committee have a clear understanding of what is expected of them in their role, including: time commitments, the duration of their appointment, training required and how this will be provided?		2		
12b	Do all members of the committee have a clear understanding of what is expected of them in their role, including: an understanding of the organisation – strategy, operating environment and key risks?		2		
12c	Do all members of the committee have a clear understanding of what is expected of them in their role, including: role of the board in managing risk and of the committee in supporting the board to provide review and challenge?		2		
13	Have members received formal appointment letters (setting out their terms of appointment including work required) before their term of office commenced?		n/a		
14	Does the committee have the relevant/required range of skills in governance, risk, control, and financial management and is this reviewed on a regular basis?		2		
15	Does at least one committee member have recent and relevant financial experience?		2		
16	Is the committee empowered to co-opt members and procure specialist advice to support them when needed?		2		
17a	Is the Chair a Non-Executive Board member (NEBM) with relevant experience to chair the committee?		2		
17b	Is at least one other member a NEBM?		2		
17c	Do governance processes ensure the chair of the board is not a member of the committee?		2		
18	Are new committee members provided with an appropriate induction, including training to help them understand the public sector accountability framework, if they have not previously worked within central government?		2		
19a	Does the induction include a programme of engagement with the organisation to help members understand: the organisation, its objectives, business needs, priorities, risk profile and challenges?		2		
19b	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's vision and purpose?		2		
19c	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's corporate governance arrangements?		2		
20	Are regular training and development opportunities (especially for recent developments or emerging risk areas) considered and implemented for committee members?		2		
21	Has each member formally declared their business interests and/or conflicts of interest and have these been appropriately dealt with?		2		
22	Are members sufficiently independent of the other key committees of the board?		2		
23	Has the committee considered the arrangements for assessing the attendance and performance of each member, including the chair?		2		
Meetings					
24	Does the committee meet regularly and at least four times a year?		3		
25	Do the terms of reference set out the frequency?		3		

26	Does the committee calendar meet the organisation's business and governance needs, as well as the requirements of the financial reporting calendar?		3		
27	Are members attending meetings on a regular basis and if not, is appropriate action taken?		3		
28	Does the accounting officer attend all meetings and, if not, are they provided with a record of discussions?		3		
29	Does the director of finance attend all meetings and, if not, are they provided with a record of discussions?		3		
30	Does the committee have the benefit of attendance of appropriate officials at its meetings, including representatives from internal audit, external audit, finance and if relevant, the sponsoring/sponsored body?		3		
31	Does the committee meet privately without any non-members present for all or part of a meeting if considered necessary?		3		
32	Do committee members or the committee chair meet separately with relevant executives as required (especially the accounting officer and any relevant newly appointed executives soon after their appointment)?		3		
33a	Is a verbal or written report summarising the business taken by the committee provided to the board after each meeting?		3		
33b	Does the verbal or written report offer views and advice from the committee on issues that require the board or accounting officer to take action?		3		
Internal Control					
34	Does the committee consider the findings of reviews by internal audit and others, on the effectiveness of the arrangements for governance, risk management and control?		1		
35a	Does the committee: have an understanding of the overall assurances provided within the organisation (by the three lines)?		1		
35b	Does the committee: consider adequacy of these assurances, especially for outsourced services?		1		
36	If the committee does not consider the overall assurance provided to be adequate, does the committee raise these concerns to the executive to commission additional work?		1		
37a	Does the committee consider how meaningful the Governance Statement is?		1		
37b	Does the committee consider if all pertinent issues have been included in the Governance Statement from the work the committee has undertaken during the reporting period?		1		
38	Does the committee satisfy itself that the arrangements for governance, risk management and control have operated effectively throughout the reporting period?		1		
39	Has the committee undertaken deep dives into significant risks to review and challenge management's actions to manage and mitigate the risk?		1		
40	Has the committee considered how it should coordinate with other committees that may have responsibility for risk management and corporate governance?		1		
41	Has the committee satisfied itself that the organisation has adopted appropriate arrangements to counter and deal with fraud, including reporting losses, investigating fraud incidents, and submitting quarterly returns to the Cabinet Office?		1		
42a	Does the committee receive regular reports on anti-fraud policies?		1		
42b	Does the committee receive regular reports on whistleblowing processes?		1		
42c	Does the committee receive regular reports on arrangements for special investigations?		n/a		
42d	Does the committee receive regular reports on relevant fraud and whistleblowing cases and near misses?		1		
43	Has the committee been made aware of the role of risk management in the preparation of the internal audit plan?		1		
44	Does the committee's terms of reference include oversight of the risk management process to ensure risks are managed and new risks will be identified?		1		
45	Does the committee review the corporate risk register to ensure it reflects key strategic risks?		1		
46	Does the committee consider/challenge assurances provided by senior staff on the adequacy and effectiveness of control processes?		1		
47	Does the committee ensure any significant weaknesses found have been appropriately dealt with?		1		
Financial Reporting and Regulatory Matters					
48	Is the committee's role in the consideration of the annual report and accounts clearly defined?		2		
49	Does the committee review the annual report and accounts (including the Governance Statement) and discuss the comprehensiveness, reliability and integrity of assurances in meeting the board and accounting officer's needs?		2		
50	Does the committee gain an understanding of management's procedures for preparing the organisation's annual report and accounts?		2		
51a	Does the committee consider, as appropriate: the suitability of accounting policies and treatments and/or changes in accounting treatment?		2		
51b	Does the committee consider, as appropriate: assurances regarding the financial systems that produce the accounts?		2		
51c	Does the committee consider, as appropriate: major judgements made (and if specialists were used to help with the judgements)?		n/a		
51d	Does the committee consider, as appropriate: large write-offs?		n/a		
51e	Does the committee consider, as appropriate: the reasonableness of accounting estimates?		2		
51f	Does the committee consider, as appropriate: the narrative aspects of reporting?		2		

51g	Does the committee consider, as appropriate: any differences of opinion between the auditor and executives?		n/a		
52	Is a committee meeting scheduled to receive the external auditor's report to those charged with governance including a discussion of proposed adjustments to the accounts and other issues arising from the audit?		2		
53	Does the committee review management's letter of representation?		2		
54	Does the committee have a mechanism to keep it aware of topical legal and regulatory issues?		2		
Internal Audit					
55	Does the Head of Internal Audit attend meetings of the committee?		3		
56	Does the committee approve, annually and in detail, the annual internal audit plan (and fee) including consideration of whether the scope of internal audit work addresses the body's significant risks and does not duplicate assurances provided by other lines?		3		
57	Has the committee approved the internal audit mandate/formal terms of reference/internal audit charter defining internal audit's objectives, responsibilities, authority and reporting lines?		3		
58	Does internal audit have a direct reporting line, if required, to the committee?		3		
59	Has the committee considered the information it wishes to receive from internal audit?		3		
60a	Does the committee receive progress reports from internal audit and review and challenge progress?		3		
60b	Does the committee review the annual report from the Head of Internal Audit?		3		
61	Are outputs from follow-up audits by internal audit monitored by the committee and does the committee consider the adequacy of implementation of recommendations?		3		
62	Does the committee (chair) hold private discussions with the Head of Internal Audit at least once annually?		3		
63	Is there appropriate co-operation between the internal and external auditors?		3		
64a	Does the committee review the adequacy of internal audit staffing and other resources?		3		
64b	Does the committee review internal audit performance measures?		3		
64c	Does the committee review reports on internal audit quality assurance arrangements?		3		
External Audit					
65	Does the external audit representative attend meetings of the committee?		1		
66	Do the external auditors present and discuss their audit plans and strategy with the committee (recognising the statutory duties of external audit)?		1		
67	Does the committee challenge external audit plans if considered not to cover key risks?		1		
68	Does the committee (chair) hold periodic (at least annually) private discussions with the external auditor?		1		
69	Does the committee review the external auditor's annual report to those charged with governance?		1		
70	Does the committee ensure that executives are monitoring action taken to implement external audit recommendations?		1		
71	Are reports (including general value for money reports) on the work of external audit presented to the committee?		1		
72	Does the committee assess the performance of external audit?		1		
73	Does the committee consider the external audit fee and challenge it if considered inappropriate?		1		
Administration					
74	Does the committee have a designated secretariat and is the secretariat sufficient to deal with the committee's business?		2		
75	Is a draft forward workplan for the committee agreed at the start of each financial year to adequately cover all areas of the committee's responsibility?		2		
76	Are agenda papers circulated in advance of meetings to allow adequate preparation by committee members and attendees?		2		
77	Do reports to the committee communicate relevant information at the right frequency, time, and in a format that is effective?		2		
78	Does the committee issue guidelines and/or a proforma concerning the format and content of the papers to be presented?		2		
79	Are minutes prepared and circulated promptly (after review by the chair) to the appropriate people?		2		
80	Is a report on matters arising from committee meetings presented and/or does the chair raise them at the committee's next meeting?		2		
81	Do action points indicate the owner and due date?		2		
82	Does the committee provide an effective annual report on its own activities, which is timed to support the preparation of the Governance Statement?		2		
Role of the Chair of the Committee					
83	Is the chair involved in the appointment of new committee members and the head of internal audit?		3		

84	Does the chair agree the annual core programme of work and agendas for each meeting?		3		
85a	Does the chair ensure meetings run effectively and efficiently?		3		
85b	Does the chair ensure additional meetings are convened as required?		3		
85c	Does the chair ensure the number of meetings held are sufficient to allow the committee to consider all relevant areas?		3		
86a	Does the chair ensure committee has access to appropriate resources and support and committee budget is managed?		3		
86b	Does the chair ensure members work collaboratively?		3		
86c	Does the chair ensure an effectiveness review is undertaken at least annually (or an external review is commissioned if considered relevant)?		3		
86d	Does the chair ensure the self-assessment tool is used at least once in every three years?		3		
86e	Does the chair ensure internal and external audit have free and confidential access if required?		3		
86f	Does the chair ensure governance needs of sponsor/ALB are considered?		n/a		
Overall					
87	Does the committee effectively contribute to the overall control environment of the organisation?		1		
88	Does the committee seek feedback on its performance from the board and accounting officer?		1		
89	Are there any areas where the committee could improve upon its current level of effectiveness?		Type your response here		
90	Do you have any further comments?		Type your response here		
Average Score			1,97	#DIV/0!	#DIV/0!

[illegible]



This sheet contains formulae which read from the Responses sheet, so please do not overtype its contents.

The Average Score column shows the average score per question for all members recorded in the Responses sheet.

Score definitions are: 1 - Needs to Improve, 2 - Standard Met, 3 - Working Above the Standard.

Average score ratings are Improvement Needed - amber, Standard Met - light green, Above Standard - dark green.

Colour Rating Average Score

Improvement Needed	Up to 1.60
Standard Met	1.61 to 2.60
Above Standard	2.61 to 3.00

Questions		Average Score
Role and Remit		
1	Does the committee have written terms of reference?	1,00
2	Are the terms of reference regularly reviewed?	1,00
3	Do the terms of reference clearly set out the committee's role and are they consistent with the example terms of reference in this ARAC handbook?	1,00
4	Are the terms of reference approved by the committee and the board?	1,00
5	Are the terms of reference made publicly available?	1,00
6	Has the committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?	1,00
7	Do committee members have appropriate authority to require reports on areas of the committee's responsibilities?	1,00
8	Does the organisation's annual report and accounts/Governance Statement mention the committee's existence and its broad purpose?	1,00
Membership, Induction and Training		
9	Has the membership of the committee been formally agreed by the board and/or accounting officer and a quorum set?	2,00
10	Does the committee have at least three members (or the number stated in the agreed terms of reference) who are independent and objective?	2,00
11	Are members appointed for a fixed term?	n/a
12a	Do all members of the committee have a clear understanding of what is expected of them in their role, including: time commitments, the duration of their appointment, training required and how this will be provided?	2,00
12b	Do all members of the committee have a clear understanding of what is expected of them in their role, including: an understanding of the organisation – strategy, operating environment and key risks?	2,00
12c	Do all members of the committee have a clear understanding of what is expected of them in their role, including: role of the board in managing risk and of the committee in supporting the board to provide review and challenge?	2,00
13	Have members received formal appointment letters (setting out their terms of appointment including work required) before their term of office commenced?	n/a
14	Does the committee have the relevant/required range of skills in governance, risk, control, and financial management and is this reviewed on a regular basis?	2,00
15	Does at least one committee member have recent and relevant financial experience?	2,00
16	Is the committee empowered to co-opt members and procure specialist advice to support them when needed?	2,00
17a	Is the Chair a Non-Executive Board member (NEBM) with relevant experience to chair the committee?	2,00
17b	Is at least one other member a NEBM?	2,00
17c	Do governance processes ensure the chair of the board is not a member of the committee?	2,00
18	Are new committee members provided with an appropriate induction, including training to help them understand the public sector accountability framework, if they have not previously worked within central government?	2,00
19a	Does the induction include a programme of engagement with the organisation to help members understand: the organisation, its objectives, business needs, priorities, risk profile and challenges?	2,00
19b	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's vision and purpose?	2,00
19c	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's corporate governance arrangements?	2,00

20	Are regular training and development opportunities (especially for recent developments or emerging risk areas) considered and implemented for committee members?	2,00
21	Has each member formally declared their business interests and/or conflicts of interest and have these been appropriately dealt with?	2,00
22	Are members sufficiently independent of the other key committees of the board?	2,00
23	Has the committee considered the arrangements for assessing the attendance and performance of each member, including the chair?	2,00
Meetings		
24	Does the committee meet regularly and at least four times a year?	3,00
25	Do the terms of reference set out the frequency?	3,00
26	Does the committee calendar meet the organisation's business and governance needs, as well as the requirements of the financial reporting calendar?	3,00
27	Are members attending meetings on a regular basis and if not, is appropriate action taken?	3,00
28	Does the accounting officer attend all meetings and, if not, are they provided with a record of discussions?	3,00
29	Does the director of finance attend all meetings and, if not, are they provided with a record of discussions?	3,00
30	Does the committee have the benefit of attendance of appropriate officials at its meetings, including representatives from internal audit, external audit, finance and if relevant, the sponsoring/sponsored body?	3,00
31	Does the committee meet privately without any non-members present for all or part of a meeting if considered necessary?	3,00
32	Do committee members or the committee chair meet separately with relevant executives as required (especially the accounting officer and any relevant newly appointed executives soon after their appointment)?	3,00
33a	Is a verbal or written report summarising the business taken by the committee provided to the board after each meeting?	3,00
33b	Does the verbal or written report offer views and advice from the committee on issues that require the board or accounting officer to take action?	3,00
Internal Control		
34	Does the committee consider the findings of reviews by internal audit and others, on the effectiveness of the arrangements for governance, risk management and control?	1,00
35a	Does the committee: have an understanding of the overall assurances provided within the organisation (by the three lines)?	1,00
35b	Does the committee: consider adequacy of these assurances, especially for outsourced services?	1,00
36	If the committee does not consider the overall assurance provided to be adequate, does the committee raise these concerns to the executive to commission additional work?	1,00
37a	Does the committee consider how meaningful the Governance Statement is?	1,00
37b	Does the committee consider if all pertinent issues have been included in the Governance Statement from the work the committee has undertaken during the reporting period?	1,00
38	Does the committee satisfy itself that the arrangements for governance, risk management and control have operated effectively throughout the reporting period?	1,00
39	Has the committee undertaken deep dives into significant risks to review and challenge management's actions to manage and mitigate the risk?	1,00
40	Has the committee considered how it should coordinate with other committees that may have responsibility for risk management and corporate governance?	1,00
41	Has the committee satisfied itself that the organisation has adopted appropriate arrangements to counter and deal with fraud, including reporting losses, investigating fraud incidents, and submitting quarterly returns to the Cabinet Office?	1,00
42a	Does the committee receive regular reports on anti-fraud policies?	1,00
42b	Does the committee receive regular reports on whistleblowing processes?	1,00
42c	Does the committee receive regular reports on arrangements for special investigations?	n/a
42d	Does the committee receive regular reports on relevant fraud and whistleblowing cases and near misses?	1,00

43	Has the committee been made aware of the role of risk management in the preparation of the internal audit plan?	1,00
44	Does the committee's terms of reference include oversight of the risk management process to ensure risks are managed and new risks will be identified?	1,00
45	Does the committee review the corporate risk register to ensure it reflects key strategic risks?	1,00
46	Does the committee consider/challenge assurances provided by senior staff on the adequacy and effectiveness of control processes?	1,00
47	Does the committee ensure any significant weaknesses found have been appropriately dealt with?	1,00
Financial Reporting and Regulatory Matters		
48	Is the committee's role in the consideration of the annual report and accounts clearly defined?	2,00
49	Does the committee review the annual report and accounts (including the Governance Statement) and discuss the comprehensiveness, reliability and integrity of assurances in meeting the board and accounting officer's needs?	2,00
50	Does the committee gain an understanding of management's procedures for preparing the organisation's annual report and accounts?	2,00
51a	Does the committee consider, as appropriate: the suitability of accounting policies and treatments and/or changes in accounting treatment?	2,00
51b	Does the committee consider, as appropriate: assurances regarding the financial systems that produce the accounts?	2,00
51c	Does the committee consider, as appropriate: major judgements made (and if specialists were used to help with the judgements)?	n/a
51d	Does the committee consider, as appropriate: large write-offs?	n/a
51e	Does the committee consider, as appropriate: the reasonableness of accounting estimates?	2,00
51f	Does the committee consider, as appropriate: the narrative aspects of reporting?	2,00
51g	Does the committee consider, as appropriate: any differences of opinion between the auditor and executives?	n/a
52	Is a committee meeting scheduled to receive the external auditor's report to those charged with governance including a discussion of proposed adjustments to the accounts and other issues arising from the audit?	2,00
53	Does the committee review management's letter of representation?	2,00
54	Does the committee have a mechanism to keep it aware of topical legal and regulatory issues?	2,00
Internal Audit		
55	Does the Head of Internal Audit attend meetings of the committee?	3,00
56	Does the committee approve, annually and in detail, the annual internal audit plan (and fee) including consideration of whether the scope of internal audit work addresses the body's significant risks and does not duplicate assurances provided by other lines?	3,00
57	Has the committee approved the internal audit mandate/formal terms of reference/internal audit charter defining internal audit's objectives, responsibilities, authority and reporting lines?	3,00
58	Does internal audit have a direct reporting line, if required, to the committee?	3,00
59	Has the committee considered the information it wishes to receive from internal audit?	3,00
60a	Does the committee receive progress reports from internal audit and review and challenge progress?	3,00
60b	Does the committee review the annual report from the Head of Internal Audit?	3,00
61	Are outputs from follow-up audits by internal audit monitored by the committee and does the committee consider the adequacy of implementation of recommendations?	3,00
62	Does the committee (chair) hold private discussions with the Head of Internal Audit at least once annually?	3,00
63	Is there appropriate co-operation between the internal and external auditors?	3,00
64a	Does the committee review the adequacy of internal audit staffing and other resources?	3,00
64b	Does the committee review internal audit performance measures?	3,00
64c	Does the committee review reports on internal audit quality assurance arrangements?	3,00

External Audit		
65	Does the external audit representative attend meetings of the committee?	1,00
66	Do the external auditors present and discuss their audit plans and strategy with the committee (recognising the statutory duties of external audit)?	1,00
67	Does the committee challenge external audit plans if considered not to cover key risks?	1,00
68	Does the committee (chair) hold periodic (at least annually) private discussions with the external auditor?	1,00
69	Does the committee review the external auditor's annual report to those charged with governance?	1,00
70	Does the committee ensure that executives are monitoring action taken to implement external audit recommendations?	1,00
71	Are reports (including general value for money reports) on the work of external audit presented to the committee?	1,00
72	Does the committee assess the performance of external audit?	1,00
73	Does the committee consider the external audit fee and challenge it if considered inappropriate?	1,00
Administration		
74	Does the committee have a designated secretariat and is the secretariat sufficient to deal with the committee's business?	2,00
75	Is a draft forward workplan for the committee agreed at the start of each financial year to adequately cover all areas of the committee's responsibility?	2,00
76	Are agenda papers circulated in advance of meetings to allow adequate preparation by committee members and attendees?	2,00
77	Do reports to the committee communicate relevant information at the right frequency, time, and in a format that is effective?	2,00
78	Does the committee issue guidelines and/or a proforma concerning the format and content of the papers to be presented?	2,00
79	Are minutes prepared and circulated promptly (after review by the chair) to the appropriate people?	2,00
80	Is a report on matters arising from committee meetings presented and/or does the chair raise them at the committee's next meeting?	2,00
81	Do action points indicate the owner and due date?	2,00
82	Does the committee provide an effective annual report on its own activities, which is timed to support the preparation of the Governance Statement?	2,00
Role of the Chair of the Committee		
83	Is the chair involved in the appointment of new committee members and the head of internal audit?	3,00
84	Does the chair agree the annual core programme of work and agendas for each meeting?	3,00
85a	Does the chair ensure meetings run effectively and efficiently?	3,00
85b	Does the chair ensure additional meetings are convened as required?	3,00
85c	Does the chair ensure the number of meetings held are sufficient to allow the committee to consider all relevant areas?	3,00
86a	Does the chair ensure committee has access to appropriate resources and support and committee budget is managed?	3,00
86b	Does the chair ensure members work collaboratively?	3,00
86c	Does the chair ensure an effectiveness review is undertaken at least annually (or an external review is commissioned if considered relevant)?	3,00
86d	Does the chair ensure the self-assessment tool is used at least once in every three years?	3,00
86e	Does the chair ensure internal and external audit have free and confidential access if required?	3,00
86f	Does the chair ensure governance needs of sponsor/ALB are considered?	n/a
Overall		
87	Does the committee effectively contribute to the overall control environment of the organisation?	1,00
88	Does the committee seek feedback on its performance from the board and accounting officer?	1,00

89	Are there any areas where the committee could improve upon its current level of effectiveness?
90	Do you have any further comments?



Government Internal Audit Agency

This sheet contains formulae which read from the Response

Colour Rating

The Average Score column shows the average

Improvement

Score definitions are: 1 - Needs to Improve, 2

Standard Measure

Above Standard

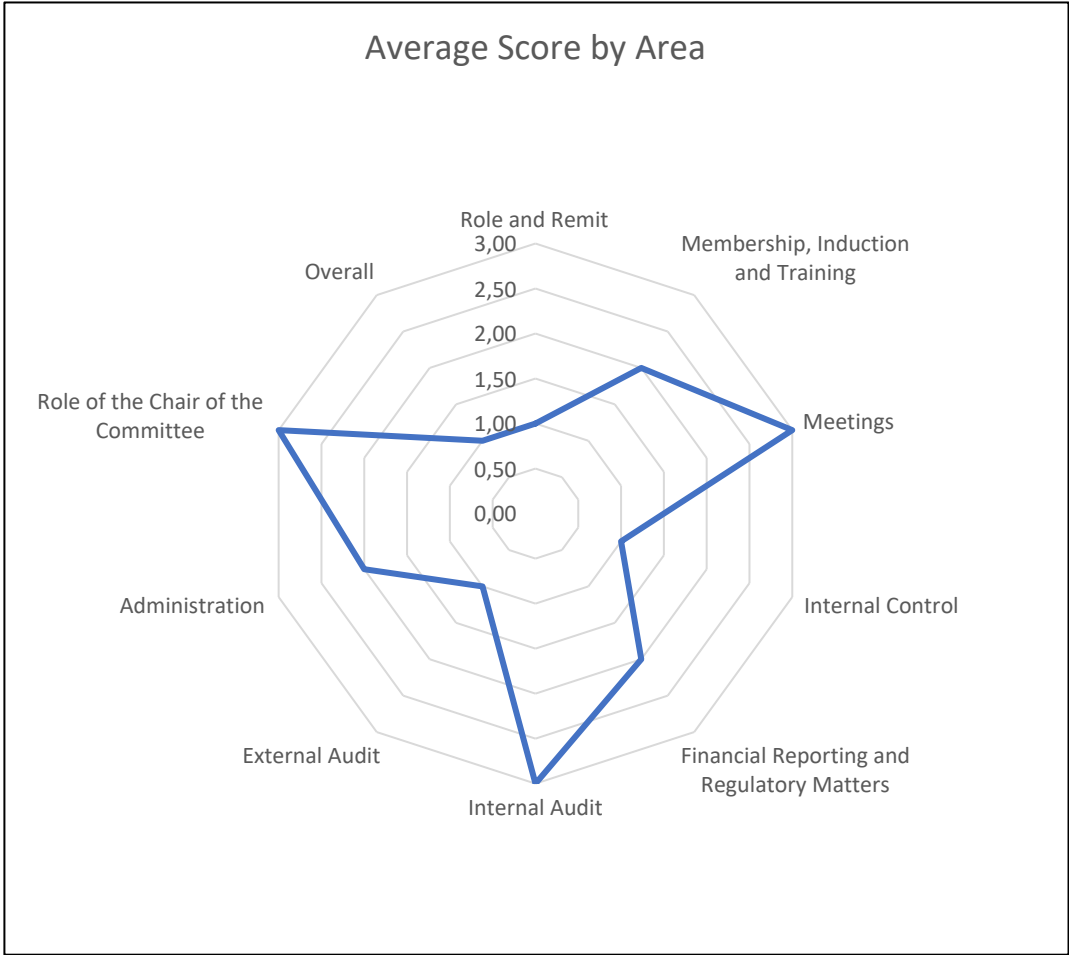
Average score ratings are Improvement Needed - amber, S

Area	Average Score
Role and Remit	1,00
Membership, Induction and Training	2,00
Meetings	3,00
Internal Control	1,00
Financial Reporting and Regulatory Matters	2,00
Internal Audit	3,00
External Audit	1,00
Administration	2,00
Role of the Chair of the Committee	3,00
Overall	1,00
Average Score	1,97

es sheet, so please do not oertype its contents.

Average Score	
Up to 1.60	
1.61 to 2.60	
2.61 to 3.00	

tandard Met - light green, Above Standard - dark green.



INTRODUCTION

Welcome to the **GIAA Audit and Risk Assurance Committee Self-Assessment Tool**.

The purpose of the tool is to help you understand the overall effectiveness of your ARAC, based on the result of each response.

The tool allows you to score your ARAC's performance against a set of criteria and highlight the areas which are above the standard, have met the standard or where improvement is needed.

VIEWING OR UPDATING THE RESPONSES

- 1. Enter responses for each question into the table in the **Responses** sheet. Example responses have been filled in for the first column, **please overwrite these with actual responses**.
- 2. If there are more than 10 responses, right click on the last column in the 'Responses' table and **Insert**. This will add a new column for the additional respondent.
- 3. Responses must be entered as a number from 1 to 3 for most questions. However, we have recognised some questions may not be applicable to all organisations and these have a N/A option which can be used.
- 4. Where a Yes or No answer is required, please answer 3 for Yes and 1 for No.
- 5. Score definitions are: 1 - Needs to Improve, 2 - Standard Met, 3 - Working Above the Standard. Questions 11, 13, 42c, 51c, 51d, 51g and 86e also have a N/A option.
- 6. Questions 89 and 90 are free text boxes for your comments.
- 7. To allow comparison, average scores are shown:
 - at the base of each column in the 'Responses' sheet
 - for each question in the 'Average Scores by Question' sheet
 - for each area in the 'Average Scores by Area' sheet



**Government
Internal Audit
Agency**

This form can be completed by each member in turn or each member can complete their own copy, for the results to be collated into one.
Scores of 1,2 or 3 should be selected from the drop-down menu in the relevant Member column or can be entered directly as a number.
Score definitions are: 1 - Needs to improve, 2 - Standard met, 3 - Working above the standard.
Some questions also have a N/A option. Where a Yes or No answer is required, please answer 3 for Yes and 1 for No.

		Comments	Member	Attendee
Role and Remit				
1	Does the committee have written terms of reference?			
2	Are the terms of reference regularly reviewed?			
3	Do the terms of reference clearly set out the committee's role and are they consistent with the example terms of reference in this ARAC handbook?			
4	Are the terms of reference approved by the committee and the board?			
5	Are the terms of reference made publicly available?			
6	Has the committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?			
7	Do committee members have appropriate authority to require reports on areas of the committee's responsibilities?			
8	Does the organisation's annual report and accounts/Governance Statement mention the committee's existence and its broad purpose?			
Membership, Induction and Training				
9	Has the membership of the committee been formally agreed by the board and/or accounting officer and a quorum set?			
10	Does the committee have at least three members (or the number stated in the agreed terms of reference) who are independent and objective?			
11	Are members appointed for a fixed term?			
12a	Do all members of the committee have a clear understanding of what is expected of them in their role, including: time commitments, the duration of their appointment, training required and how this will be provided?			
12b	Do all members of the committee have a clear understanding of what is expected of them in their role, including: an understanding of the organisation – strategy, operating environment and key risks?			
12c	Do all members of the committee have a clear understanding of what is expected of them in their role, including: role of the board in managing risk and of the committee in supporting the board to provide review and challenge?			
13	Have members received formal appointment letters (setting out their terms of appointment including work required) before their term of office commenced?			
14	Does the committee have the relevant/required range of skills in governance, risk, control, and financial management and is this reviewed on a regular basis?			
15	Does at least one committee member have recent and relevant financial experience?			
16	Is the committee empowered to co-opt members and procure specialist advice to support them when needed?			
17a	Is the Chair a Non-Executive Board member (NEBM) with relevant experience to chair the committee?			
17b	Is at least one other member a NEBM?			
17c	Do governance processes ensure the chair of the board is not a member of the committee?			
18	Are new committee members provided with an appropriate induction, including training to help them understand the public sector accountability framework, if they have not previously worked within central government?			
19a	Does the induction include a programme of engagement with the organisation to help members understand: the organisation, its objectives, business needs, priorities, risk profile and challenges?			
19b	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's vision and purpose?			
19c	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's corporate governance arrangements?			
20	Are regular training and development opportunities (especially for recent developments or emerging risk areas) considered and implemented for committee members?			
21	Has each member formally declared their business interests and/or conflicts of interest and have these been appropriately dealt with?			
22	Are members sufficiently independent of the other key committees of the board?			
23	Has the committee considered the arrangements for assessing the attendance and performance of each member, including the chair?			
Meetings				

Internal Control Agency		Comments	Member	Attendee
24	Does the committee meet regularly and at least four times a year?			
25	Do the terms of reference set out the frequency?			
26	Does the committee calendar meet the organisation's business and governance needs, as well as the requirements of the financial reporting calendar?			
27	Are members attending meetings on a regular basis and if not, is appropriate action taken?			
28	Does the accounting officer attend all meetings and, if not, are they provided with a record of discussions?			
29	Does the director of finance attend all meetings and, if not, are they provided with a record of discussions?			
30	Does the committee have the benefit of attendance of appropriate officials at its meetings, including representatives from internal audit, external audit, finance and if relevant, the sponsoring/sponsored body?			
31	Does the committee meet privately without any non-members present for all or part of a meeting if considered necessary?			
32	Do committee members or the committee chair meet separately with relevant executives as required (especially the accounting officer and any relevant newly appointed executives soon after their appointment)?			
33a	Is a verbal or written report summarising the business taken by the committee provided to the board after each meeting?			
33b	Does the verbal or written report offer views and advice from the committee on issues that require the board or accounting officer to take action?			
Internal Control				
34	Does the committee consider the findings of reviews by internal audit and others, on the effectiveness of the arrangements for governance, risk management and control?			
35a	Does the committee: have an understanding of the overall assurances provided within the organisation (by the three lines)?			
35b	Does the committee: consider adequacy of these assurances, especially for outsourced services?			
36	If the committee does not consider the overall assurance provided to be adequate, does the committee raise these concerns to the executive to commission additional work?			
37a	Does the committee consider how meaningful the Governance Statement is?			
37b	Does the committee consider if all pertinent issues have been included in the Governance Statement from the work the committee has undertaken during the reporting period?			
38	Does the committee satisfy itself that the arrangements for governance, risk management and control have operated effectively throughout the reporting period?			
39	Has the committee undertaken deep dives into significant risks to review and challenge management's actions to manage and mitigate the risk?			
40	Has the committee considered how it should coordinate with other committees that may have responsibility for risk management and corporate governance?			
41	Has the committee satisfied itself that the organisation has adopted appropriate arrangements to counter and deal with fraud, including reporting losses, investigating fraud incidents, and submitting quarterly returns to the Cabinet Office?			
42a	Does the committee receive regular reports on anti-fraud policies?			
42b	Does the committee receive regular reports on whistleblowing processes?			
42c	Does the committee receive regular reports on arrangements for special investigations?			
42d	Does the committee receive regular reports on relevant fraud and whistleblowing cases and near misses?			
43	Has the committee been made aware of the role of risk management in the preparation of the internal audit plan?			
44	Does the committee's terms of reference include oversight of the risk management process to ensure risks are managed and new risks will be identified?			
45	Does the committee review the corporate risk register to ensure it reflects key strategic risks?			
46	Does the committee consider/challenge assurances provided by senior staff on the adequacy and effectiveness of control processes?			
47	Does the committee ensure any significant weaknesses found have been appropriately dealt with?			
Financial Reporting and Regulatory Matters				
48	Is the committee's role in the consideration of the annual report and accounts clearly defined?			
49	Does the committee review the annual report and accounts (including the Governance Statement) and discuss the comprehensiveness, reliability and integrity of assurances in meeting the board and accounting officer's needs?			
50	Does the committee gain an understanding of management's procedures for preparing the organisation's annual report and accounts?			

Internal Audit Agency		Comments	Member	Attendee
51a	Does the committee consider, as appropriate: the suitability of accounting policies and treatments and/or changes in accounting treatment?			
51b	Does the committee consider, as appropriate: assurances regarding the financial systems that produce the accounts?			
51c	Does the committee consider, as appropriate: major judgements made (and if specialists were used to help with the judgements)?			
51d	Does the committee consider, as appropriate: large write-offs?			
51e	Does the committee consider, as appropriate: the reasonableness of accounting estimates?			
51f	Does the committee consider, as appropriate: the narrative aspects of reporting?			
51g	Does the committee consider, as appropriate: any differences of opinion between the auditor and executives?			
52	Is a committee meeting scheduled to receive the external auditor's report to those charged with governance including a discussion of proposed adjustments to the accounts and other issues arising from the audit?			
53	Does the committee review management's letter of representation?			
54	Does the committee have a mechanism to keep it aware of topical legal and regulatory issues?			
Internal Audit				
55	Does the Head of Internal Audit attend meetings of the committee?			
56	Does the committee approve, annually and in detail, the annual internal audit plan (and fee) including consideration of whether the scope of internal audit work addresses the body's significant risks and does not duplicate assurances provided by other lines?			
57	Has the committee approved the internal audit mandate/formal terms of reference/internal audit charter defining internal audit's objectives, responsibilities, authority and reporting lines?			
58	Does internal audit have a direct reporting line, if required, to the committee?			
59	Has the committee considered the information it wishes to receive from internal audit?			
60a	Does the committee receive progress reports from internal audit and review and challenge progress?			
60b	Does the committee review the annual report from the Head of Internal Audit?			
61	Are outputs from follow-up audits by internal audit monitored by the committee and does the committee consider the adequacy of implementation of recommendations?			
62	Does the committee (chair) hold private discussions with the Head of Internal Audit at least once annually?			
63	Is there appropriate co-operation between the internal and external auditors?			
64a	Does the committee review the adequacy of internal audit staffing and other resources?			
64b	Does the committee review internal audit performance measures?			
64c	Does the committee review reports on internal audit quality assurance arrangements?			
External Audit				
65	Does the external audit representative attend meetings of the committee?			
66	Do the external auditors present and discuss their audit plans and strategy with the committee (recognising the statutory duties of external audit)?			
67	Does the committee challenge external audit plans if considered not to cover key risks?			
68	Does the committee (chair) hold periodic (at least annually) private discussions with the external auditor?			
69	Does the committee review the external auditor's annual report to those charged with governance?			
70	Does the committee ensure that executives are monitoring action taken to implement external audit recommendations?			
71	Are reports (including general value for money reports) on the work of external audit presented to the committee?			
72	Does the committee assess the performance of external audit?			
73	Does the committee consider the external audit fee and challenge it if considered inappropriate?			
Administration				
74	Does the committee have a designated secretariat and is the secretariat sufficient to deal with the committee's business?			
75	Is a draft forward workplan for the committee agreed at the start of each financial year to adequately cover all areas of the committee's responsibility?			

		Comments	Member	Attendee
76	Are agenda papers circulated in advance of meetings to allow adequate preparation by committee members and attendees?			
77	Do reports to the committee communicate relevant information at the right frequency, time, and in a format that is effective?			
78	Does the committee issue guidelines and/or a proforma concerning the format and content of the papers to be presented?			
79	Are minutes prepared and circulated promptly (after review by the chair) to the appropriate people?			
80	Is a report on matters arising from committee meetings presented and/or does the chair raise them at the committee's next meeting?			
81	Do action points indicate the owner and due date?			
82	Does the committee provide an effective annual report on its own activities, which is timed to support the preparation of the Governance Statement?			
Role of the Chair of the Committee				
83	Is the chair involved in the appointment of new committee members and the head of internal audit?			
84	Does the chair agree the annual core programme of work and agendas for each meeting?			
85a	Does the chair ensure meetings run effectively and efficiently?			
85b	Does the chair ensure additional meetings are convened as required?			
85c	Does the chair ensure the number of meetings held are sufficient to allow the committee to consider all relevant areas?			
86a	Does the chair ensure committee has access to appropriate resources and support and committee budget is managed?			
86b	Does the chair ensure members work collaboratively?			
86c	Does the chair ensure an effectiveness review is undertaken at least annually (or an external review is commissioned if considered relevant)?			
86d	Does the chair ensure the self-assessment tool is used at least once in every three years?			
86e	Does the chair ensure internal and external audit have free and confidential access if required?			
86f	Does the chair ensure governance needs of sponsor/ALB are considered?			
Overall				
87	Does the committee effectively contribute to the overall control environment of the organisation?			
88	Does the committee seek feedback on its performance from the board and accounting officer?			
89	Are there any areas where the committee could improve upon its current level of effectiveness?			
90	Do you have any further comments?			
Average Score			#DIV/0!	#DIV/0!



Agenda Item

5.1

Audit, Risk & Assurance Committee

Losses and Special Payments 01.10.25 to 31.12.25

Dyddiad y Cyfarfod / Date of Meeting	03/02/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Owen James – Head of Corporate Finance
Cyflwynydd yr Adroddiad / Report Presenter	Sally May - Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Committee / Group / Individuals	Date	Outcome
NWSSP – legal services and Risk Pool	Click or tap to enter a date.	NOTED

Acronyms / Glossary of Terms

WRP 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 & Assurance Committee on the losses and special payments made by the University Health Board (UHB) for the 3-month period from 1 October 2025 to 31 December 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 £11,801k, 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 £15,930k, giving a net cash in position for the period of £4,129k. The significant reimbursements of claims, especially on medical negligence has decreased the amount owed by Welsh Risk Pool and therefore the debtor balance we are anticipating. At 31st December the amount paid but not yet received from Welsh Risk Pool is £27.1m.



2.6 This is £8.9m higher than it was at the end of the 2024/25 financial year and will have a detrimental impact on cash flow if it is not reimbursed by the end of this financial year.

2.7 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.

	01.10.25 - 31.12.25 £000	Previous Periods	Total 25-26 £000
Medical Negligence Claims	9,151	12,119	21,270
Medical Negligence Costs	1,755	2,057	3,812
Medical Negligence Defence Fees	420	799	1,219
Medical Negligence Totals	11,326	14,975	26,301
Redress Medical Negligence Claims	46	13	59
Redress Medical Negligence Costs	7	10	17
Redress Medical Negligence Defence Fees	6	3	9
Redress Medical Negligence Totals	59	26	85
GP Indemnity Claims	28	45	73
GP Indemnity Costs	13	88	101
GP Indemnity Defence Fees	9	13	22
GP Indemnity Totals	50	146	196
Personal Injury Claims	50	23	73
Personal Injury Costs	84	178	262
Personal Injury Defence Fees	83	108	191
Personal Injury Totals	217	309	526
Permanent Injury Benefit	132	334	466
Permanent Injury Benefit Totals	132	334	466
Other:			
Ex-Gratia	7	39	46
Debt Write Off	8	6	14
WRP Penalty Charge	0	0	0
Ombudsman	2	2	4
Employment Matter/Other	0	0	0
Other Totals	17	47	64
TOTAL	11,801	15,837	27,638
Recovered from Welsh Risk Pool	(15,930)	(979)	(16,909)
Net Cash Write-Off/(Recovery)	(4,129)	14,858	10,729

2.8 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.

2.9 At its latest meetings, the WRP committee approved the payment of a further £15,930k of claims (41 claims), this was paid in October and December 2025. 4 further claims reviewed by the committee were deferred, and another 14 claims were deferred until further information was received.

b) Provision as at 31 December 2025

2.10 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.

2.11 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.

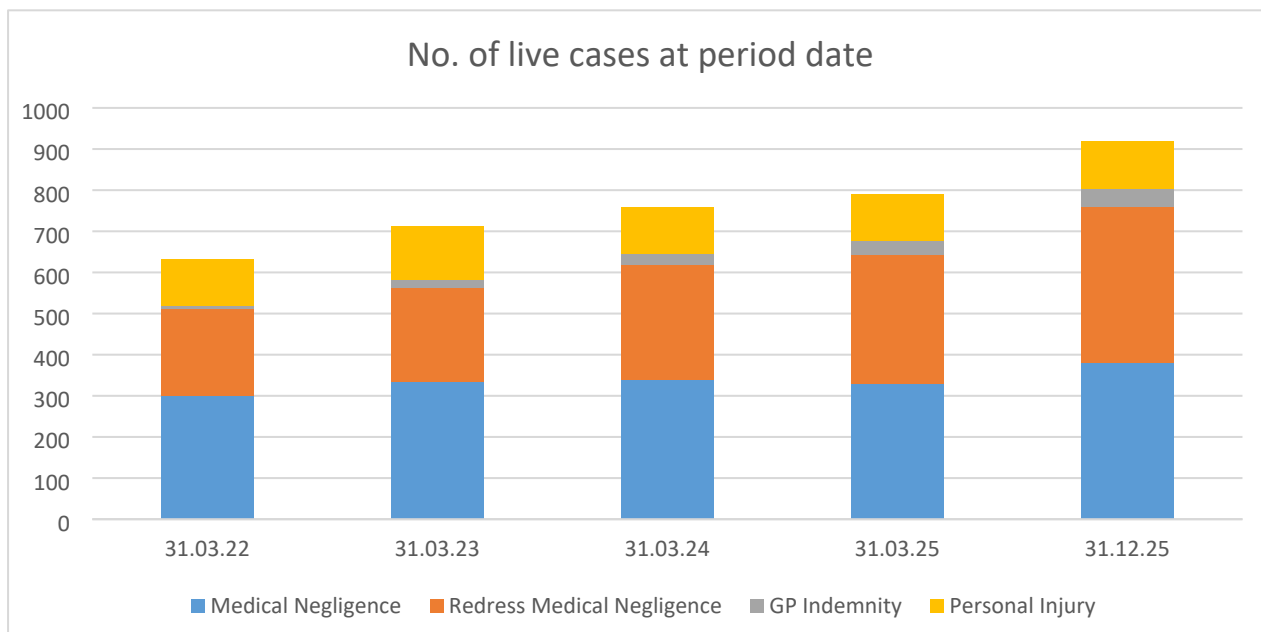
2.12 The total claims provision has increased by £849k since 31 March 2025, this is mainly due to an increase in value of medical negligence claims.

2.13 The net provision at the end of 31st December 2025 was £19,779k which is £4,654k lower than the previous reported period. This is due to the large claims that were paid for medical negligence claims that have been reimbursed by WRP.

	31.12.25	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	136,137	136,729	94,478	72,198	65,127
Redress Medical Negligence claims/costs	792	490	372	385	235
GP Indemnity (Note 1)	2,115	1,670	612	0	0
Personal Injury claims/costs	2,428	1,734	917	701	611
TOTAL CLAIMS/COSTS PROVISION	141,472	140,623	96,379	73,284	65,973
Recoverable from Welsh Risk Pool	(165,486)	(156,234)	(106,450)	(83,623)	(93,074)
NET CLAIMS / COSTS PROVISION	(24,014)	(15,611)	(10,071)	(10,339)	(27,101)
Permanent Injury Benefit	4,235	3,707	3,755	4,077	6,201
NET PROVISION inc Perm Injury Ben.	(19,779)	(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.

2.14 The chart below shows the number of live cases as at period stated. The rate of new cases being opened in 2025/26 has been relatively in line with previous years. However, the rate of cases being closed has been slower due to awaiting WRP reimbursement prior to full case closure. This is reflected in the number of live cases for the period to 31st December 2025 versus prior years.



c) Revenue impact for the year to date

2.15 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.

2.16 The table below shows the year-to-date position for each type of claim. The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases.

	Year to
	31.12.25
	£000
Medical Negligence claims/costs	25,711
Redress Medical Negligence claims/costs	385
GP Indemnity	642
Personal Injury claims/costs	1,220
Recoverable from Welsh Risk Pool	(26,161)
Net claim expenditure (Note 1)	1,797
Permanent Injury Benefit	993
Other	65
Total Net expenditure	2,855

Note 1: The annual budget for net claim expenditure for 2025-26 is £2,019k, with a year-to-date budget of £1,514k, actual expenditure for the year is £1,797k, therefore showing an overspend of £283k. It is important to note that these costs can fluctuate during the year.

WRP Risk Sharing Agreement

- 2.17 The Audit, Risk & Assurance 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.
- 2.18 As previously reported for 2025/26 WRP are reporting a risk of significant overspend of based on the risk sharing agreement, during Month 8 Welsh Government have confirmed funding support up to the forecast will be released any remaining risk beyond the forecast is to be funded by organisations.

3. Key Risks / Matters for Escalation

Net provision

- 3.1 Although the net provision since last reported has decreased due to reimbursements from WRP, there is still significant values owed from WRP, which reflects that the amount being paid out is higher than the value being recovered.
- 3.2 This is largely a timing issue, but there is a need to ensure there is timely completion of learning submitted in order from reimbursements to be approved in a timely manner, reducing value owed from WRP.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Growing Well Living Well Ageing Well Dying Well
	A Healthier Wales



Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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>)	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) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee	If no, please include rationale below:
Cydraddoldeb	Yes: ☒	No: ☐



<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>	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 October 2025 to 31 December 2025.
- **NOTE** the key risks for escalation on the increasing net provision value.
- **NOTE** the amount of claims that have been paid out but we are awaiting reimbursement from Welsh Risk Pool is now £27.1m at the end of December.

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	03/02/2026
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 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
- i) File Note Process

This report provides details of any such transactions within the period 01.10.25 to 31.12.25

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 01.10.25 to 31.12.25

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 01.10.25 to 31.12.25

Table A – Single Tender Actions 01.10.25 to 31.12.25

None for this period.

Table B - Single Tender Actions - Retrospective CTM

None for this period

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

None for this period.

d) Summary of contracts awarded over £500,000

Health 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 01.10.25 to 31.12.25

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
ARJO	555003 Clinical Engineering	272	BEDS
BOC Ltd	555100 PCH PHARMACY	100	Medical Gas
	533041_DENTAL SURGERY YNYSHIR		
	533002_ RESPIRATORY & SLEEP PHYSIOLOGY		
St David Recruitment Services	533890_RGH PATHOLOGY	96	Agency Staffing
	559157 H and N RGH Directorate Office		
	533359_POW SURG UROLOGY		

Top 3 Receipting Areas	Total
533170 YGT PATIENT CATERING	193
555180 YCC CATERING	109
533165 YCR PATIENT CATERING	86

g) Consultancy Contracts

Below is a table detailing consultancy contracts that have been awarded between 01.10.25 to 31.12.25.

There are none for this period.

h) File Notes (retrospective)

Below is a table detailing File Notes that have been completed between to 31.12.25.

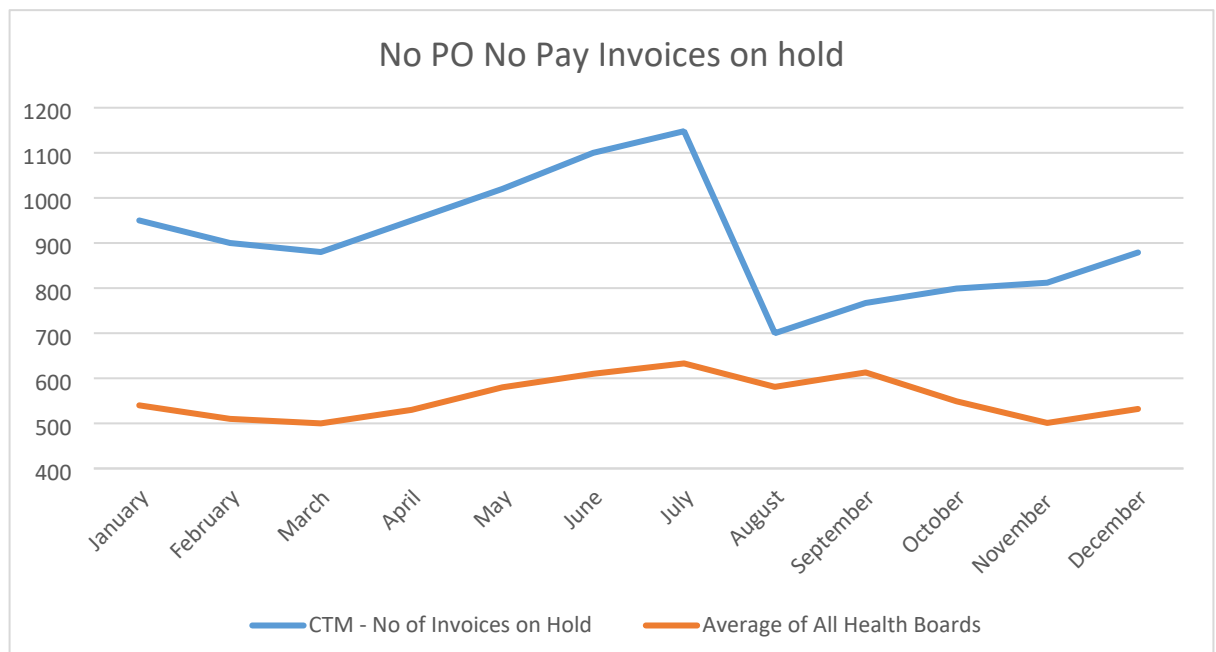
Retrospective no.	Department	Value of PO(ex VAT)	Supplier
CTM-FN-001	Pathology	£68,000	Cyted UK Ltd
CTM-FN-002	Pathology	£200,000	Source Bio Science
CTM-FN-003	Primary Care	£152,865.44	NAPC

CTM-FN-004	Clinical Education	£170,000.00	University of South Wales
CTM-FN-005	Radiology	£7,000.00	National Resources Wales

i) 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, however you will note that in August 2025 the number of No PO No Pay holds fell significantly from nearly 1,200 to 700. However, from that point onwards the number of invoices on hold is increasing over the last 3 months. The top 3 suppliers make up 22% (200 invoices) of No PO No Pay holds. Procurement and finance are working with suppliers and departments to try and sort these issues and pay invoices where appropriate.

2.2 Purchase to Pay (P2P)

The PSPP figures are reported to the end of 31st December 2025.



The Health Board has met its 95% target of paying non-NHS invoices within 30 days to Month 9 2025-26 achieving 95.9% (value 93.3%). 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	22,139	51,418,725	23,270	54,118,296	95.14%	95.01%
Aug-25	22,125	21,528,540	22,842	23,221,715	96.86%	92.71%
Sep-25	21,784	19,157,285	22,538	20,159,890	96.65%	95.03%
Oct-25	22,749	29,802,407	24,140	33,441,590	94.24%	89.12%
Nov-25	19,094	19,398,530	19,840	20,246,401	96.24%	95.81%
Dec-25	19,993	25,607,761	20,888	28,805,298	95.72%	88.90%
Jan-26						
Feb-26						
Mar-26						
YTD	192,742	310,935,691	201,088	333,217,738	96%	93.0%

The NHS invoice position continues to be challenging and shows a position of 75.7% (number) and 97.2% (value) of invoices were paid within 30 days to Month 9 2025-26. 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 17 Patients Property Income Allowances (Appendix 1)
- FP 24 Overseas Patients (Appendix 2)
- FCP Medical Variable Pay and Medical Bank and Agency Standard Operating Procedure (Appendix 3)

The main changes to each of the FCPs are outlined in Appendix 4 to this report.

FP21 Web Quotations and Tendering is out of review date, a draft FCP has been prepared but is currently being reviewed. The revised FCP will be reported to the June 2026 Audit, Risk and Assurance Committee once feedback has been received.

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



**Environmental
/Sustainability Impact (5Rs)**

Impact Assessment

Ansawdd

*Ydych chi wedi ymgymryd â
Sgrinio Asesiad o'r Effaith ar
Ansawdd? /*

Quality

*Have you undertaken a Quality
Impact Assessment Screening?*

Yes: ☐

No: ☒

Outcome:

If no, please include
rationale below:

Cydraddoldeb a'r Gymraeg

*Ydych chi wedi ymgymryd â
Sgrinio Asesiad o'r Effaith ar
Gydraddoldeb a'r Gymraeg? /*

Equality and Welsh Language

*Have you undertaken an Equality
and Welsh Language Impact
Assessment Screening?*

Yes: ☐

No: ☒

Outcome for Equality
(delete as appropriate):

If no, please include
rationale below:

POSITIVE/NEUTRAL
NEGATIVE

Not applicable

Outcome for Welsh
Language (delete as
appropriate):
POSITIVE/NEUTRAL
NEGATIVE

Cyfreithiol / Legal

There are no specific legal implications related to the
activity outlined in this report.

Enw da / Reputational

There is no direct impact on the reputation of the
Health Board as a result of the activity outlined in this
report.

Effaith Adnoddau

(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 **NOTE** the position on procurement matters for the period 01.10.2025 to 31.12.2025;

NOTE the update regarding Purchase to Pay and achievement of PSPP target up to Month 9 of 2025/26

APPROVE the updated FCPs and associated SoP.

Financial Control Procedure: Patient's Property, Income and Allowances (FP17)

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 Committee
Approval / Effective Date:	03/02/2026
Review Date:	03/02/2029
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



Ref: FP17

Policy Title: Financial Control Procedure: Patients Property, Income and Allowances

Page Number: 1



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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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 - 3.4** Recording of Property and Valuables
 - 3.5** General Office Duties
- 4.** Ward Procedure: Long Stay Patients
 - 4.1** On Admission
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 - 4.6** Records of Patient's Clothing
- 5.** Discharge from Hospital
- 6.** Patients Transfers
- 7.** Deceased Patients
- 8.** Unclaimed Property
- 9.** Reporting of Overdrawn Balances
- 10.** Equality Impact Assessment
- 11.** Appendices

1. SCOPE AND PRINCIPLES

- 1.1. The Cwm Taf Morgannwg University Health Board (UHB) has a legal responsibility to safeguard any patient's monies and property that is handed over for safekeeping and to return it to the patient on discharge.
- 1.2. This procedure fulfils the following purposes:
- To ensure that the interests of the patient, the staff and the UHB are fully protected.
 - To guide in the procedures to be adopted for receiving, recording and disposing of property on behalf of the patient.
- 1.3. The procedure covers both short stay and long stay patients. A short stay patient will normally have a known discharge date, which in most cases will not be greater than 6 weeks. Long term patients are usually those in elderly care and mental health care whose length of stay is unknown.

2. DOCUMENTATION

- 2.1. The following forms are referred to within this Financial Procedure. They are either included as appendices or in the case of controlled stationery noted with the issuing source.

Appendix	Name of Form	To be used by:
1	Patient's Property – Disclaimer Form	Wards
2	Investment of Patients' Monies: Court of Protection	Finance
3	Application for cash withdrawal on behalf of patient.	Wards (Long stay Only)
4	Authorisation Form for Patient's Purchases	Wards (Long stay Only)
5	Record of Transfer Form	Wards
6	Bank Transfer Form	Wards/General Office
7	Patient Contact Confirmation Form	Wards/General Office

Controlled stationery	Name of Form	Issued by:	To be used by:
CS 1	Ward Property Book (On Admission)	General Office	Wards
CS 2	Register of Patient's Property	Finance	General Office

Ref: FP17

Policy Title: Financial Control Procedure: Patients Property, Income and Allowances

Page Number: 4

CS 3	Patient's Ledger Sheet	Finance	General Office
CS 4	Request to Open Current Account	Finance	General Office/ Finance
CS 5	Summary of Patient's Private Monies paid from Petty Cash	Finance	General Office/ Finance
CS 6	Payment Request Form	Finance	General Office/ Finance
CS 7	Record of Private Property and Clothing retained on the ward	General Office	Wards (Long stay Only)
CS 8	Form of Indemnity	Finance	General Office/ Finance

Please note that the references CS 1 to CS 8 are to aid in the understanding of this Financial Procedure and are not included as a reference on the forms themselves.

3. WARD PROCEDURE: SHORT STAY PATIENTS

3.1. Planned Admissions

- 3.1.1. Where admission to hospital is planned, the patient is advised in advance not to bring in any valuables. On arrival at the Hospital, the patient must be advised of the conditions relating to personal possessions and should be asked to sign a disclaimer: Patient's Property – Disclaimer Form (Appendix 1).
- 3.1.2. At this point, the patient should also be advised that any valuables or cash may be handed over for safe keeping/banking but should be reminded that the UHB cannot be held responsible for items not deposited for safekeeping. Items taken into safe custody must be recorded on a Ward Property Book (On Admission) Form (CS 1).
- 3.1.3. Patients should also be advised that cash handed over for safekeeping will be receipted and banked as soon as possible and returned in the form of a cheque or bank transfer (Appendix 6). Notice will need to be given prior to its return. The Patient should be asked to sign and complete the Patient Contact Confirmation form (Appendix 7).

3.2. **Emergency Admissions**

- 3.2.1. Where a patient is admitted unconscious or their condition warrants assistance in protecting their valuables, these should be deposited for safekeeping in the General Office. Details must be entered on a Ward Property Book (On Admission) Form (CS 1) and witnessed by two members of staff. In the interest of patient care this may be completed after the patient has been admitted to a ward not necessarily at the point of entry in A&E/AMU.
- 3.2.2. The property (valuables) of a patient who is conscious at time of admission should be handed by the patient to a relative or friend and not given to the Ward staff. The Patient should be asked to sign and complete the Patient Contact Confirmation form (Appendix 7).
- 3.2.3. If a relative or friend is not present the patient should be encouraged by staff to hand over all monies and valuables. Patients may however retain on the Ward any personal articles of small value. Patients should be notified that cash will be banked and returned in the form of a cheque or bank transfer.
- 3.2.4. Patients must be reminded that the UHB cannot be held responsible for items not handed over for safekeeping. Items taken into safe custody must be recorded on a Ward Property Book (On Admission) Form (CS 1). The patient should also be asked to sign a disclaimer: Patient's Property – Disclaimer Form (Appendix 1).
- 3.2.5. The storage of items taken into safe custody should be in accordance with part 3.4 below.
- 3.2.6. If hospital staff have knowledge of patient's property outside the hospital requiring protective action, the appropriate Local Authority should be informed. It is imperative that any knowledge of property in this category should be notified to the Local Authority immediately, since if a patient dies before they receive this notification, they have no power to act.

3.3. **Disclaimers**

- 3.3.1. Notices of disclaimer, Patient's Property - Disclaimer Form (Appendix 1) must be displayed on all Wards and other vantage points throughout the UHB premises highlighting personal possessions not handed in for safekeeping are not the responsibility of the UHB.
- 3.3.2. When children are admitted, the admitting nurse should ensure that the parent/guardian is aware that any mobile phones/tablets/electronic

game equipment brought into the Hospital by children is their responsibility and not that of the UHB.

3.4. Recording of Property and Valuables

3.4.1. Property taken into safe custody at ward level must be recorded by two staff members (nursing staff or ward clerks) on a Ward Property Book (On Admission) Form (CS 1). The Ward Property Book is an item of controlled stationery and is available from the Hospital's General Office. Forms are pre-numbered and in triplicate.

- The first copy is the patient's receipt
- The second copy is for General Office
- The third copy is retained in the book

3.4.2. The book must be retained in a safe place and be available for inspection by authorised personnel. All spoilt copies must be retained in the book, crossed through and marked 'cancelled'. Completed books must be returned to General Office. On return, this book must be examined and checked to ensure all property has been received for safekeeping.

3.4.3. Property handed over for safe custody should be examined, listed and signed for by two members of nursing staff. If possible, the patient should sign agreeing the items listed are correct. The words "gold" or "silver", "diamond", "emerald", etc. must not be used but the description "yellow metal", "white metal", "white stone", "green stone" must be used.

NOTE: Only property handed over for safekeeping should be recorded in the Ward Property Book.

3.4.4. If the patient requests a professional valuation to substantiate the entry as "gold", "silver", etc. this may be done and cost to be borne by the patient and the record amended if necessary.

3.4.5. Where property has been recorded in the Ward Property Book, but before actually taken into safe custody, it can only be returned to the patient, i.e. (not to the relative) after the appropriate receipt has been completed.

3.4.6. Valuables taken into safe custody at Ward level may be kept in the Ward safe. Access to the ward safe should be restricted. Alternatively, property may be taken to General Office to deposit in the UHB safe. If there is no safe on the ward the property must be taken to General Office for immediate deposit in the UHB safe and a signature obtained to

confirm receipt from General Office staff. All cash must be deposited in General Office.

- 3.4.7. Outside office hours, any cash and property taken into safekeeping should be deposited in the ward safes if available. If a night safe is not available, then the property must be deposited in a lockable secure cabinet, property or cash must not be placed in a medication cupboard. The contents must be placed in a sealed envelope and witnessed by two members of staff.
- 3.4.8. When the property is returned or taken to General Office the Ward staff must ensure they obtain a signature from the person receiving the property.
- 3.4.9. In the cases of patients who become incapacitated whilst in Hospital Care and are unable to safeguard their valuables, there is an obligation on the part of the UHB to safeguard their articles. In these cases, all valuables should be taken into safe custody and recorded in the Property Book

3.5. **General Office Duties**

- 3.5.1. General Office should be given the page from the Ward Property Book (On Admission) when property is taken there for safekeeping. A log of all property taken into safe custody must be maintained by each General Office (CS 2). The following action must be followed:
 - Property envelopes must be labelled and sealed giving the full name of the patient, the patient's hospital number (if known), together with Ward Property Book (on Admission) Form reference number and details of the property.
 - Cash receipts must either be recorded on a Collection and Deposit (C&D) sheet or receipted directly into the ORACLE financial system.
 - Cash Receipts must be banked in accordance with the Financial Control Procedure on Cash and Bank.

4. **WARD PROCEDURE: LONG STAY PATIENTS**

This section is only relevant for those wards/hospitals within the UHB who have patients whose duration of stay is deemed to be long term.

4.1. **On Admission**

- 4.1.1. The procedures followed on admission will be the same as for short stay patients (Section 3) but it is likely that the patient may require administration and/or financial support services.

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- 4.1.2. Where a long stay patient requires the UHB to administer money on their behalf the Officer responsible for Patients' Monies will:
- Set up a patient ledger sheet to record all deposits and withdrawals
 - Notify Finance department using a request to open current account form (CS 4).

As a minimum, the patient's full name (first & middle name and surname) should be used on these forms and all future correspondence.

4.2. **Monies deposited including Pensions/Benefits**

- 4.2.1. Where a patient is in receipt of pensions/benefits, it is the responsibility of the patient, patient's families or patient's representatives to notify the Department of Work & Pensions as it may affect their right to pension/benefit.
- 4.2.2. The patient may nominate the UHB to collect the pension on their behalf. Pension monies for those patients will be paid automatically into the UHB's main bank account. Upon receipt of the pension monies Finance staff will notify the Officer responsible for Patients' Monies.
- 4.2.3. Ward staff must not pay out monies to patients but may accompany the delegated officer and act as a witness.
- 4.2.4. Where either cash/cheques are paid on behalf of patients this shall be paid into the General Office and either a Collection and Deposit (C&D) sheet must be completed or the receipt entered directly onto the ORACLE financial system, the receipt should be noted on the patient's ledger sheet.
- 4.2.5. Where a patient is in receipt of a wage for employment, they should inform the Department of Work & Pensions, as it may affect the right to any benefits. For example, a patient may be in receipt of sick pay from an employer. The onus is on the patient to inform the appropriate bodies when their circumstances change. However, with the permission of the patient this may be done by the delegated Officer.
- 4.2.6. The Patients' Monies reconciliations to the ledger will be performed by a Finance Officer on a monthly basis.

4.3. **Investments**

- 4.3.1 Patients' balances will be reviewed bimonthly by the Officer responsible for Patients' Monies within Finance and should any funds be found in excess of patients immediate needs then they should notify the Financial Accountant to move funds to an Investment account. Investments accounts are set up in the patient's name and administered by the UHB.
- 4.3.2. All correspondence and transactions must be directed through the Financial Accounts Section within the Finance Department.
- 4.3.3. Where a patient's affairs are administered by the Court of Protection or its agents then there is a need to ensure that authority has been given to invest the patient's surplus monies. If authority has not been obtained then the delegated Officer should follow the procedure set out in Appendix 2.
- 4.3.4. A Register must be maintained by the Financial Accounts Section, of all patients' investments held. This register must be reconciled with bank statements by the Finance Officer and reviewed by the Head of Corporate Finance (or their representative) on a monthly basis.

4.4. **Patient Spending**

- 4.4.1. Before withdrawals/purchases are made ward staff must check the Officer responsible for Patients' Monies that sufficient funds are available in the patient's account.
- 4.4.2. Small sums of money (i.e. up to £50 may be paid out of petty cash to patients who have money deposited in an account with the UHB, for their day to day needs. Details of all payments out of petty cash must be recorded on a summary of Patient's Private Monies paid from Petty Cash form (CS 5) and distributed as follows:
- Copy to Finance Department (weekly).
 - Copy/copies with petty cash reconciliation weekly/ monthly to Cashiers.
 - Copy Hospital Records.
- 4.4.3. There is an upper limit of £50 on daily withdrawals (Monday – Friday excluding bank holidays) of cash from patients' current accounts even where the patient is capable of managing his/her own affairs. There will be no doubling up to cover weekends or bank holidays.
- 4.4.4 Nurses must not be used as agents for paying patients, or for distributing goods, except in the case of patients who are severely disabled or confused, and for whom it is necessary for the Nurse to receive and care for such goods on the patient's behalf. Form Appendix 3 to be completed.

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- 4.4.5. A completed authorisation form (Appendix 4) must be obtained from the ward when the patient is unable to receive the monies directly and before purchases are made on the patient's behalf or cash is withdrawn.
- 4.4.6. Where a relative or friend assumes responsibility for a patient's affairs whilst in hospital and pension/benefits are receivable, the ward staff must continually assess that the patient is adequately provided for: where neglect is observed, the ward staff must inform Social Services who will nominate a social worker.
- 4.4.7. Patients are expected to pay for their own clothing. If such a payment would reduce the balances on their current and deposit accounts to less than £100, the Officer responsible for patient's monies must confirm that the patient does have other funds available to them.
- 4.4.8. There is an obligation by ward staff to ensure that patients receive value for money from their purchases.
- 4.4.9. Purchases are transacted by one of the following principal methods:
- By ordering commodities direct through the Procurement Department of the UHB. When this method is used the name of the patient should be included on the order, and the invoice will be paid under the normal Accounts Payable procedure. When the transaction is complete, Finance staff will notify the Officer responsible for Patients' Monies to debit the patient's account accordingly. Copy/copies with petty cash reconciliation weekly/monthly to Cashiers.
 - Shopping expeditions may be organised for patients who will be accompanied by escorts. Arrangements must be made in advance with the shop that each patient is invoiced individually where possible. If the shop will not co-operate then the Officer in charge of the expedition should ensure that any charges are in the form of an itemised invoice. In these cases, the Officer in charge must make a record of individual patient's purchases, which should be attached to the invoice and forwarded with the relevant Payment Request Form (CS 6) to the Finance Department for payment.
 - Shopping days may be organised at the Hospitals where contractors attend. Individual invoices must be rendered and payment made via Payment Request Form (CS 6).
- 4.4.10. Whenever possible, patients must authorise deductions from their accounts. Patients capable of understanding the transaction, but unable to sign must have all transactions witnessed.
- 4.4.11. An independent member of staff should examine purchases at Ward level and the articles purchased identified with the patient's name and marked accordingly.

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- 4.4.12. Receipts must be produced for all purchases made on behalf of patients.
- 4.4.13. Payment requests must be made on the appropriate Payment Request forms (CS 6), and signed by the originating officer and authorised by the relevant Senior Nurse Ward Manager or Patient's Monies Supervising Officer.
- 4.4.14. Nursing staff who signs for patient's money are expected to control and monitor the spending whether it is inside or outside the Hospital environment. Patients adjudged by a Medical Officer to be capable of spending and appreciating their own money should be given a daily allowance subject to the limits set out in Section 4.4.2.
- 4.4.15. Patients considered, on medical opinion, as incapable of looking after and spending their money should receive assistance from Nursing Staff with their purchases. Cash withdrawn by these patients may still require safe keeping on the ward. In this instance a record of all cash held should be maintained and monies should be securely stored in a lockable cabinet. A countersignature from a witness should be obtained in these cases.
- 4.4.16. Where possible, cash receipts and other documentation must be obtained for these purchases. A reconciliation of patient's money expenditure incurred by nursing staff should be prepared by the nurse in charge and forwarded with receipt to the Officer responsible for Patients' Monies in order to debit the patient's account.

4.5. Finance Department Responsibilities

- 4.5.1. Details of cheques drawn on behalf of patients will be forwarded monthly to Hospitals by the Finance Department. All debits and credits must be recorded on a patient's ledger spreadsheet. On a monthly basis, Finance will send out details of patient balances to the Officers responsible for Patients' Monies who will confirm agreement with hospital records. Any differences that cannot be resolved should be reported to the Directorate Manager.

4.6. Records of Patient's Clothing

- 4.6.1. Where possible, a record of items and personal clothing retained on the ward should be maintained at ward level by nursing staff or the ward clerk (CS 7). However, if the patient has regular home visits, shopping trips or visitors who could possibly remove items of clothing then the monitoring of clothing becomes difficult for the UHB. In these cases, as part of the risk assessment process, Directorate Managers may use their discretion to decide whether to maintain these records, as they may be constantly out of date. Reasons for non-completion of the records should be documented and approval sought from the Directorate Manager.

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Where the records are maintained visitors/relatives should be reminded to notify nursing staff when items are added or removed.

5. DISCHARGE FROM HOSPITAL

- 5.1. On discharge, any property taken into safe custody should be handed to the patient. The patient should sign the relevant page of the Ward Property Book (CS 1) as evidence of receipt.
- 5.2. In order to cover immediate needs, a sum of money may be released from Petty Cash by General Office to the patient (up to £75) and a signature obtained. If the patient is unable to collect the cash from the General Office, a nominated person may collect it and Form Appendix 3 should be completed. The remaining balance on the account will then be sent direct to the patient's address, by cheque or bank transfer, from the Cashier's Section in Finance. In those instances where an individual does not have a bank account, or no fixed abode, staff may be allowed discretion to pay up to £150 cash on the authorisation of a Senior Nurse or Patient's monies Supervising officer within the UHB. In special circumstances, a higher limit may be agreed, but this must have the approval of the Head of Corporate Finance (or their representative).
- 5.3. Where the patient is incapable of handling money, the cheque/bank transfer may be forwarded to a properly authorised custodian. On this occasion, a letter supporting the change of the cheque/bank transfer recipient will be required from the officer responsible for patients' monies.
- 5.4. In the event of delays in notification of discharge and after every effort has been made and money cannot be returned to the patient or to an authorised custodian within one year of discharge, it should be credited to the UHB's accounts. Should a valid claim be established later, payment may be made and the UHB's accounts debited.
- 5.5. Whenever money or valuables are passed to either: the patient, a relative, a custodian, from one member of staff to another, or transferred to another organisation, a receipt must be obtained.
- 5.6. For long stay patients, prior to the release of the balance of a patient's account or valuables, the Officer responsible for Patients' Monies should ensure that:
 - All receipts and payments have been posted correctly to the patient's personal account up to the time of discharge.
 - All internal transactions have been posted (e.g. transfers, petty cash).
 - The officer should telephone the Finance Department to confirm balances.

- Any bank books, or savings bonds, etc. held in the name of an untraced patient should be returned to the relevant body and a receipt obtained.
- Where a patient's surplus monies are invested and the patient is discharged then the Investment account should be closed. A cheque will be sent to the UHB. Finance will then issue a cheque/bank transfer to the patient/relative.

6. PATIENT TRANSFERS

- 6.1. When a patient is to be transferred to another ward/hospital all belongings (valuables, clothing etc.) should be recorded on a Record of Transfer Form (Appendix 5). The patient should sign the form agreeing the full listing of belongings as being accurate. If the patient is unable to sign the form another nurse or the patient's representative should sign the form as a witness. The form, which is in triplicate should be distributed as follows:
 - One copy to be retained by the patient
 - One copy to be sent with the patient to the other ward/hospital (to be handed over on arrival)
 - One copy to be retained in the book
- 6.2. If the patient has been transferred to a ward /hospital within our UHB the receiving officer/nurse should check all the patient's belongings and sign the form. This form should then be filed by the ward staff. Once the patient has arrived on the ward and the form checked and signed, the UHB has no responsibility for the patient's belongings. As is the case for any new admission, the patient will be offered the opportunity to place valuables in the safe custody of the UHB and the procedure above of completing the Ward Property Book (CS 1) will apply.
- 6.3. For long stay patients transferred to another hospital, outside the UHB, prior to the transfer of the patient being made, any balances held on the patient's account will be paid over by cheque or bank transfer. The receiving organisation must be notified in writing of the balances to be transferred.
- 6.4. Where the UHB holds money on behalf of the patient, ward staff must ensure that General Office and the Financial Accounts Department are informed.

7. DECEASED PATIENTS

- 7.1. Where a patient dies on the ward all belongings will be taken into safe custody and recorded in the Ward Property Book by two members of staff. All valuable property will then be passed to General Office and a signature obtained. Following the death of a patient, the delegated Officer will record:

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- The date of death.
 - If the funeral is to be carried out by the Hospital or privately.
 - The name(s) and address (es) of the next of kin.
- 7.2. Where a person is brought into an A&E and subsequently dies without being admitted into hospital, a record of personal effects should be entered in the A&E Ward Property Book (CS 1) and witnessed by two members of staff. Items should then be passed to the General Office for safe keeping.
- 7.3. Where a person is 'dead on arrival' the responsibility for personal property normally rests with the Police Authority. If the Police do not accept this responsibility, the procedure above will apply.
- 7.4. When the General Office is closed all property belonging to the deceased person should be logged on the Ward Property Book Form and witnessed by two individuals. The property should be held in a secure cabinet until the items can be handed over to General Office. Non valuable items (clothing etc) may be handed over to relatives on proof of identity and a signature in the book obtained. Valuable items should not be handed to relatives until the necessary indemnity form is signed.
- 7.5. For long stay patients where the UHB has been elected to receive their pension monies, the Officer responsible for Patients' Monies should inform the Department of Work and Pensions and notify Finance immediately so that pension receipts will be cancelled. Any pension monies received after the patient's death must be returned as soon as possible.
- 7.6. The UHB may arrange and pay for the funeral of patients who die in Hospital where no arrangements are made by their relatives or when:
- Relatives cannot be traced.
 - Relatives are traceable and cannot afford to arrange for burial.
 - Relatives are traceable, but refuse to take responsibility, e.g. on grounds of distance of relationship.
 - If the UHB is holding money on behalf of the deceased, this should be allocated towards the cost of the funeral.
- 7.7. Where a patient dies intestate and there is a next of kin, if the value of the property held is less than £5,000, the Officer responsible for Patients' Monies must ensure that:
- The relationship of the claimant to the deceased patient is ascertained and that he/she is one of the persons who are entitled to apply for Letters of Administration i.e. Next of Kin for balances up to £5,000, A Form of Indemnity (CS 8) to be sent to the home address of the known next of kin for completion.

- Once the Form of Indemnity (CS 8) is completed by the claimant and independently witnessed, entry is then made in the Hospital Property Book showing release of valuables.
- No transfer of property is made to any person under 18 years, unless the minor's parent(s) or lawful guardian(s) sign the Form of Indemnity. (CS 8)

7.8. For the value of the property held by the UHB exceeds £5,000 then Probate or Letters of Administration will be required.

- 7.9. Where a patient dies intestate and there is no next of kin:
- If the value exceeds £500, the Estate reverts to the Crown and details should be passed to the Treasury Solicitors by the hospital's delegated Officer.
 - If the value is less than £500, it will be credited to the UHB's accounts. Should a valid claim be established later, payment may be made and the UHB's accounts debited.

8. UNCLAIMED PROPERTY

- 8.1. Where a patient a patient has been discharged or deceased but not reclaimed their property, the Hospital's delegated Officer must make every effort to trace the patient or next of kin. If this proves unsuccessful the Directorate Manager should be contacted by the delegated Officer in order that further enquiries can be made. If this is not successful, the articles must be kept for a reasonable time before disposal, i.e.
- Clothing and items of low value – three months
 - Items of value - six years (Limitation Act 1949)
 - A review of all property held in safe custody should take place on an annual basis by the hospital's delegated officer.
- 8.2. Any cash unclaimed, or monies received from the sale of the abandoned or unclaimed property should be credited to the UHB. Should a claimant at a later date claim property that has been sold, the amount due would be payable from the UHB. The delegated Officer, in liaison with their Manager and Finance, must seek expert advice if there is doubt about the value of property to be sold.
- 8.3. Unclaimed bank books, national savings certificate, etc. must be returned by the hospitals delegated Officer to the relevant organisation accompanied by a suitable letter of explanation.

9. REPORTING OF OVERDRAWN BALANCES

- 9.1. Patient's balances should be managed so that patients do not spend money they do not have. Where balances become overdrawn through a failure of controls then every effort must be made to recover the balance.

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Where balances are not recovered they should be recorded as a loss and reported to the Audit Committee.

10. RELATED POLICIES AND LEGISLATION

10.1. The following Financial Control Procedures should be read in conjunction with this policy:

- FP04 Cash & Banking

10.2. This procedure should be read in conjunction with the Standing Financial Instructions and other relevant Financial Control Procedures.

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.

APPENDIX 1

Patient's Property – Disclaimer Form

Name:	Ward:	NHS No:			
_____ has explained to me the procedure for the safe keeping of money and property. I have been offered the opportunity to hand over my personal property and valuables in accordance with that procedure, however, I have decided to keep my valuables in my possession during my stay in hospital and in doing so accept full responsibility for their safe keeping.					
I _____ hereby acknowledge that Cwm Taf Morgannwg University Health Board cannot now accept any responsibility for any loss or damage to my valuables on these premises. All personal property retained by me on the ward or on my person while in hospital is my responsibility and I therefore indemnify the hospital from any liability arising from the loss or damage thereof.					
Signed		Witness By (Name & Signature		Date	
(If patient is unable to sign, friend or relative should sign below)					
Signed		Witness By (Name & Signature		Date	
Does the patient have jewellery?					
YES/NO		If 'Yes' Please State			
Does the patient have electronic devices?					
YES/NO		If 'Yes' Please State			
Does the patient have any cash or any other valuables?					

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WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

YES/NO	If 'Yes' Please State	
I understand that these are my responsibility		Signed: _____ _____
Page Number of Property Book:..... COMPLETED		

Investment of Patient's Monies

Patients who are the responsibility of the Court of Protection

1. Address: Cardiff Civil & Family Justice Centre
2 Park Street
Cardiff
CF10 1ET
United Kingdom
2. The UHB's Hospital Patients' Monies Officer must identify through the patient's file whether the Court Order issued by the Court of Protection already gives the power to invest any surplus income on behalf of the patient. If the UHB possesses this then there is no need to involve the Court of Protection.
3. If the UHB does not possess the power to invest, then the Court of Protection should be contacted via the Patient's Money Control Section and the following details supplied:
 - a. The name of the patient.
 - b. Court of Protection Reference Number.
 - c. Date of birth of the patient.
 - d. Details of allowances received (eg. mobility allowance, retirement, etc.)
 - e. Amount received each week in respect of each allowance.
 - f. Details of how the money is collected.
 - g. Balance in the patient's accounts.
 - h. Where it is invested and the current investment rate.
 - i. Where it will be invested and that investment rate.

APPENDIX 3

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

APPLICATION FOR CASH WITHDRAWAL (MAXIMUM £50)

Patient's Name: _____

Hospital No _____ Ward _____

I authorise the withdrawal of £..... in cash, subject to sufficient funds being in my account.

Signature of Patient _____

Authorisation (Nurse in Charge) _____

Date _____

Amount received £ _____

Signature of patient _____

Date _____

**PLEASE RETURN TO OFFICER RESPONSIBLE FOR PATIENTS' MONIES
AFTER COMPLETION**

AUTHORISATION FORM FOR PATIENT’S PURCHASES

HOSPITAL _____

Please complete ALL parts:

WARD:	
DATE:	
Name of Patient:	
Hospital Number:	

I hereby authorise payment / release of money for the above named patient for his/hers private monies account for the purpose of:

.....

.....

.....

.....

Sum of Money to be released:	
Patient's Signature:	
Witness (if Necessary)	
Date documented in Nursing process:	
Signature of qualified staff:	
Signature of Ward Manager / Senior Staff Nurse:	
Date:	

APPENDIX 5

RECORD OF TRANSFER FORM

Name of Patient _____ Date of transfer _____

Transferring from
Hospital _____ Ward _____

Transferring to
Hospital _____ Ward _____

The following is a correct record of cash and property with the patient on transfer:

_____ Patient or _____ Ward Sister /
_____ Representative _____ Charge Nurse

_____ Witness
(Member of Hospital Staff)

PROPERTY	CASH	£	p
	Notes		
	Coins		
	Other		
	Total		
	Total in words:		

	pounds		

	pence		

I confirm receipt of the item detailed above:

Receiving Officer

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APPENDIX 6

AUTHORISATION OF BANK TRANSFER

Patient's Name: _____

Hospital No: _____ Ward: _____

BANK ACCT NAME: _____

SORT CODE: _____

BANK ACCOUNT NUMBER: _____

Signature of Account Holder: _____

Print Name: _____

Signature of Nurse in Charge: _____

Print Name: _____

Job Title: _____

Date _____

**PLEASE RETURN TO OFFICER RESPONSIBLE FOR PATIENTS' MONIES
AFTER COMPLETION**

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PATIENT CONTACT CONFIRMATION

HOSPITAL _____

Please complete ALL parts on admission:

WARD:	
DATE:	
Name of Patient:	
Hospital Number:	
Next of Kin name:	
Next of Kin address:	
Patients signature	
Date of signing	

Financial Control Procedure: Overseas Patients (FP24)

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 Committee
Approval / Effective Date:	03/02/2026
Review Date:	03/02/2029
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



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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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1. SCOPE AND PRINCIPLES

- 1.1. The procedure details the principles underlying the Cwm Taf Morgannwg University Health Board's (UHB's) Overseas Patient systems and the processes required to operate these principles.
- 1.2. This procedure should be read in conjunction with the UHB's Standing Financial Instructions and other relevant Financial Control Procedures, in particular FP10 Private Patients and FP7 Income & Debtors, together with operational policies on the management of overseas patients within the Health Board.
- 1.3. The UHB has a legal obligation to ensure that those not eligible for free NHS treatment are appropriately charged for the cost of their treatment. The main qualifying criterion for eligibility is that of residency. People who therefore do not normally live in the UK are not automatically entitled to free NHS care.
- 1.4. The purpose of the procedure is to detail responsibilities to ensure that all overseas patient attendances and services provided to overseas patients who do not qualify for free NHS care are brought to the attention of the UHB and notified to the Finance Department, so that appropriate charges can be levied.
- 1.5. This procedure should be read in conjunction with Welsh Government Guidance on Implementing the Overseas Visitors Hospital Charging Regulations 2009, and other related documents published alongside the Guidance.
- 1.6. The UHB must ensure that treatment which is **immediately necessary** is provided to any patient, regardless of whether payment has been made. Treatment provided in an Emergency Department/A&E is free of charge although any subsequent inpatient or outpatient treatment becomes chargeable. Patients seeking **urgent** or **non-urgent** treatments must pay for that treatment in advance. The definitions for **immediately necessary**, **urgent** and **non-urgent** treatments are provided within the Health Board's Operational Policy.
- 1.7. The UHB has a legal obligation to establish if the patients to whom they provide treatment are entitled to receive that treatment free of charge. If not, charges should be levied irrespective of a patient's circumstances.

2. IDENTIFICATION AND ELIGIBILITY

- 2.1. All Cwm Taf Morgannwg University Health Board staff have the responsibility to identify, without discrimination, all potential patients who may be liable for charges. The Overseas Officer should be contacted immediately if there is any doubt whether a patient is eligible for NHS treatment or if there is any indication that they may be liable for charges.
- 2.2. Ultimately, it is the patient's responsibility to provide proof of eligibility. Charges can be imposed until such time that the documentation is provided.
- 2.3. Treatments provided at points of entry within Unscheduled Care (A&E, Minor Injuries, GP Out of Hours etc) are non-chargeable. However, any patients requiring subsequent outpatient care or admittance to a ward will require that their eligibility for free treatment be assessed.
- 2.4. If there is any indication that a patient may not be eligible for free treatment, staff must contact the Overseas Officer who will then undertake any further assessment, to include an interview with the patient, to establish any charges that should be levied. It is the responsibility of the patient to prove their entitlement to access NHS care. Failure to prove this eligibility will usually result in charges being incurred.
- 2.5. In instances where there is an indication that the patient has submitted false information intending to access treatment then the matter should be reported to the Health Board's Local Counter Fraud Specialist.
- 2.6. A schedule of charges to be levied shall be maintained by the Finance Manager for Costing, who shall provide it to the Medical Records Department accordingly.

3. BILATERAL HEALTHCARE AGREEMENTS

3.1. Treatment for EU Countries

- 3.1.1. EU citizens lawfully living in Wales before the 31st December 2020, will be able to use the NHS in Wales, provided they have registered and obtained settled or pre-settled status to be able to continue to live in the UK and access NHS services free of charge.
- 3.1.2. The cost of emergency treatment for EU nationals is only reclaimable with an EHIC number. Where such patients are identified, it is important that the EHIC number is obtained. Where EHIC cards are provided, they should be photocopied (in the event of a dispute). If a patient does not have their EHIC number, there is an agreed process across the EU to obtain an emergency number. There is a telephone number that can be given to the patient in hospital to arrange this. Any queries regarding

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the application of the policy should be directed to the Patient Flow Manager in the Contracting Department.

- 3.1.3. The Overseas Officer will assume responsibility for collecting all income for overseas patients via the Welsh Government, with support from the Contracting Section of the Finance Department.

3.2. **Non-EU Countries with Bilateral Agreements**

- 3.2.1 The UK has agreed citizens' rights agreements with Norway, Iceland, Liechtenstein and Switzerland. Citizens of these countries lawfully living in Wales before the 31st December 2020, will continue to be able to use the NHS in Wales following registration of their S1 form.
- 3.2.2. There are a number of individual countries where the UK has bilateral healthcare agreements in place. Some of these agreements only cover nationals of a country visiting the UK and others cover all residents of a country who visit the UK.
- 3.2.3. Each instance will have to be examined on its own merit as different eligibility criteria will apply from country to country. For example, some agreements will only allow the treatment necessary for an overseas visitor to return home whilst others will allow all treatments other than when the person has travelled to the other country for the purpose of obtaining healthcare.
- 3.2.4. The Overseas Officer as part of the eligibility assessment, will determine the rules that apply in relation to the country in question and the level of cover being provided, and will take the appropriate action with regard to whether the patient is eligible for free treatment or should be charged.

4. **NOTIFICATION OF CHARGES**

- 4.1. The Medical Records Department will be responsible for collecting all income for overseas patients. Once the status of the patient has been established, the Medical Records Department will arrange for the patient to sign an Undertaking to Pay Form (Appendix 1). The procedure for elective overseas patients will be the same as for private patients (see FP10) except that estimated bills will be produced and income collected prior to treatment starting or as soon as possible thereafter but should be prior to discharge.
- 4.2. A Notification of Income (NOI) form will be forwarded to the Senior Finance Officer - Debtors in the Finance Department, with the Undertaking to Pay attached, for an official invoice to be raised.

- 4.3. The consultant may be required to complete medical reports for the patient's medical insurer to secure medical cover and payment.
- 4.4. It is important that the Overseas Officer informs those patients liable for charges that failure to settle the debt will result in information being sent to the UK Border Agency which could result in future entry restrictions into the UK.
- 4.5. Invoices issued by the Finance Department relating to overseas patients will include the warning that failure to settle the debt will result in the UK Border Agency being informed and this may affect future UK entry. This warning will also be included on all subsequent follow up letters issued by the UHB or its representatives.
- 4.6. On a monthly basis the Senior Finance Officer - Debtors will forward information on outstanding overseas patient debts which have been outstanding for two months and longer and are £500 or more to the UK Border Agency.

5. PAYMENT ARRANGEMENTS

- 5.1. Wherever possible payment should be received prior to the treatment or, if this is not possible, prior to discharge. Patients wishing to pay by cash should deposit the money in General Office where a receipt will be issued in accordance with the Financial Control Procedure FP 4 on Cash & Banking.
- 5.2. If the patient has not already paid, an invoice will be raised by finance staff in accordance with the Financial Control Procedure FP 7 on Income & Debtors upon receipt of a duly authorised NOI Form from Medical Records.
- 5.3. Budget holders The follow up of unpaid invoices will be in line with FP 7 on Income & Debtors. This may include the use of overseas debt collection agencies where appropriate. The matter should also be reported to the Health Board's Local Counter Fraud Specialist. Invoices over £500 and outstanding for over two months will be notified to the UK Border Agency.
- 5.4. In the event of documentation being received after an overseas visitor has paid for treatment, the Medical Records Department will liaise with the Finance Department to ensure monies are refunded accordingly.
- 5.5. Where a patient dies without making payment to the UHB, the debt becomes recoverable from the deceased's estate.

6. EQUALITY IMPACT ASSESSMENT

- 6.1. 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.

UNDERTAKING TO PAY FORM

OVERSEAS PATIENTS

A: To be completed in all cases where undertaking to pay is required

Family Name:	
Given Name(s):	
Date of Birth (DD/MM/YYYY):	
Nationality:	
Passport Number:	
Visa Permit Number (if applicable):	
Social Security Number (if applicable):	
ID Number (if applicable):	
UK Address: (including temporary)	Overseas Address: (if applicable)
Tel (home): Tel (work):	Tel (home): Tel (work):
Email (personal):	
Email (work):	

B: To be completed in addition to A, if a person giving the undertaking to pay is not the patient

Family Name:	
Given Name(s):	
Date of Birth (DD/MM/YYYY):	
Nationality:	
Passport Number:	
Visa Permit Number (if applicable):	
Social Security Number (if applicable):	
ID Number (if applicable):	
UK Address: (including temporary)	Overseas Address: (if applicable)
Tel (home):	Tel (home):
Tel (work):	Tel (work):
Email (personal):	
Email (work):	

C: DECLARATION

I understand the reasons I have been asked to complete this form and I undertake to pay (insert NHS Body's name)

such sums as may be due to them in accordance with the NHS Charging Regulations currently in force in respect of NHS hospital treatment provided for the person named at A above.

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I also understand that **failure to pay NHS treatment for which charges have been levied, may result in a future immigration application that the person at A makes to enter or remain in the UK being denied.** Necessary personal information about the person at A may be passed via NHS Wales to the UK Border Agency for this purpose.

Signed:

Date: (DD/MM/YYYY)

/ /

Financial Control Procedure: Medical & Dental Variable Pay

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 Committee
Approval / Effective Date:	03/02/2026
Review Date:	03/02/2029
Version:	v.2

Target Audience:

People who need to know about this document in detail	Executive Directors Assistant Directors Care Group Managers Directorate Managers Medical Workforce NWSPP Payroll
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



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

1. SCOPE AND PRINCIPLES

- 1.1. This document sets out the controls over the University Health Boards (UHB) Medical Variable Pay (MVP) following transfer from the interim manual process to Locum's Nest automated system. This document replaces the MVP document dated July 2025.
- 1.2. This document clearly defines the use of ADHs, WLIs and agency expenditure.
- 1.2. This FCP provides a consistent assurance and governance around the Locums Nest process for the monitoring, verification and payment setting out clear roles and responsibilities for engaging, approving, paying and monitoring. The Strategic Workforce Planning Team are responsible for the process providing oversight.

2. PROCESS

2.1. **Planned Activity Backfill**

In addition to covering vacant posts, long term absence and rota gaps, M&D staff also provide "backfill" for planned activity, for example, out-patient clinics and theatre lists of staff on annual leave. These will be remunerated at the ADH rate; if the doctor is accommodating this work in uncontracted sessions.

2.2. **Cover arrangements**

Should it be established there is a gap to cover for all the above scenarios, it must be covered via the Bank, which should be sought via the Locums Nest system and only sent out to agency as a last resort. The DM will be responsible for monitoring the process to ensure bank has been exhausted before sourcing agency cover.

- 2.3. The UHB must use the approved framework agreement "Crown Commercial Services (CCS) Framework RM6281 in order to procure all medical and dental agency workers. National Framework for the Provision of Clinical and Healthcare Staffing - CCS (crowncommercial.gov.uk)
- 2.4. No agency locum bookings may be made outside the Locums Nest process. No Bank bookings may be made outside the Locum's Nest process. No WLIs may be made without the approval from the COO's office.

3. ADDITIONAL DUTY HOURS (BANK SHIFTS)

- 3.1. Bank shifts are processed via Locum's Nest. These have approvals and controls within the automated system.
- 3.2. ADH cover immediate needs, a sum of money may be released from cover can be provided by both substantive Medical and Dental staff or by bank only workers. Both substantive staff and bank only workers are engaged to undertake ADHs on a bank worker terms of engagement.
- 3.3. If a doctor is covering on call during the daytime, and is already in work, then no additional payment is made. If the doctor is covering during the daytime or out of hours, when they are on leave or uncontracted to work, then this activity is remunerated as per the ADH rate card. (This is covered in point 3.5 below).
- 3.4. If undertaking additional DCC in what should be SPA time, a claim is for the time period to which the SPA has been displaced.
- 3.5. The worker confirms that by working any additional shifts, the working pattern has not breached the rest break and rest period requirements of the Working Time Directive.
- 3.6. A standard rate card has been developed for all Medical and Dental ADH cover. These are the rates (up to which) are payable to the Doctor. These rates include rolled up annual leave (WTR) payments. The rates in the table below are resident rates. The non-resident rate on call (NROC) is remunerated at 50% of the rate below.

Grade	Hourly rates	Hourly rates
	In hours 7am-7pm Monday to Friday excluding Bank Holidays (consultants – 9am-5pm)	Out of Hours 7pm-7am Monday to Friday (Consultants - 5pm-9am) Plus Saturdays, Sunday and Bank Holidays
F1	£40	£50
F2	£45	£60
STL(CT/ST1- ST2/3)	£60	£70
STH (ST3/4- ST8)	£70	£80
Specialty Doctor	£70	£80
Consultant	£100*	£125

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

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

- 3.7. The ADH rates includes annual leave but does not include employer's on-costs, such as NI and pension. Unpaid breaks (30 minutes after 6 hours) are automatically deducted by Locum's Nest. In the event a break cannot be taken, the manager is to authorise so this time is paid as a break could not be taken.

The Health Board will ensure that there is clarity on the deduction of a 30-minute unpaid rest break via Locum's Nest. This will allow workers who are unable to get a full 30-minute rest break to edit it on the system and leave a comment explaining the reasons. This allows timesheet approver and payment approver to clearly see a break has been edited on the Locums Nest system and to scrutinise prior to approving. This must be completed and approved at the end of the shift and not before the shift has been worked.

The Health Board encourages breaks to be taken for the wellbeing of all workers. Monitoring and reporting of breaks will be undertaken on a regular basis to ensure that proper provisions are in place for breaks to be taken, and any trends and themes will be reported to MWPP: Delivery Group.

- 3.8. Where there is a requirement for any rates up to 5% outside the ADH rate card for additional duty hours, rates must be authorised in advance by the CG MD. For any rates over 5% outside the ADH rate card must be authorised in advance on the Locums Nest system by the EMD Office.

The DM or Service Manager will create a rate escalation on the Locum's Nest system for CGMD/EMD Office approval and send an email to CTM.MedicalDirectorsOffice@wales.nhs.uk with justification for the escalation. In the absence of the EMD Office, authorisation in advance could be sought from the on-call Exec OOH.

- 3.9. ADH rates which are above the agreed rate card are reported via the MWPP Delivery Group, chaired by the Deputy Medical Director. The Care Groups are accountable for any escalations of ADH rates above the agreed rate card and for ADH spend.
- 3.10. The ADH shift will be remunerated at the rota grade required on the roster and not the grade of the individual. However, consultants doing

extra daytime shifts to cover junior rota gaps will be remunerated at the consultant in-hours ADH rate of £100.

- 3.11. All ADH claims must be submitted via Locum's Nest. Once a shift has been worked by a Bank worker the shift must be confirmed in Locum's Nest by the worker and the hours worked amended if necessary. There is a two-step approval process. Firstly, the timesheet is signed off (to confirm the hours have been worked by the locum) in Locum's Nest by a senior clinician on duty or a rota co-ordinator. Then authorisation for payment is given in Locum's Nest by the DM or Service Manager in accordance with the Scheme of Delegation. Under no circumstances can the same person sign off both the timesheet and the payment.
- 3.12. Where there is a pattern of regular ADHs then the DM would review the underlying reason(s) for the additional demand and develop plans with the CG, Finance Business Partner and the Head of People for a more sustainable and affordable workforce solution.

4. AGENCY

- 4.1. CGs must not under any circumstances engage with locum agencies directly.
- 4.2. All shifts must be advertised through the CTM Medical Bank using the Locums Nest system. If a shift remains unfilled by a bank worker 14 days before its scheduled start date, a Level 1 authoriser may request that the shift be escalated to agency. This request will then be reviewed and either approved or declined by a Level 2 authoriser.

Please note: this escalation can only occur once all bank applications have been reviewed and actioned.

- 4.3. Agencies will submit bids for cascaded shifts via the Locums Nest system. If a proposed worker's rate falls within the agreed rate card, a Level 1 authoriser may proceed to accept and book the worker directly. If the proposed rate exceeds the rate card, the system will automatically lock the booking. In such cases:
 - Up to 5% above the rate card requires approval from the Care Group Medical Director (CGMD).
 - More than 5% above the rate card requires approval from the Executive Medical Director (EMD).

Once the appropriate approval has been granted and the rate unlocked by a rate approver, the Level 1 authoriser can then proceed to book the worker into the shift.

- 4.4. This will ensure any risks identified with continuing are appropriately considered and mitigated, e.g. any impacts on patient care and use of long-term agency arrangements. Each Care Group is required to keep a central file of these decisions for audit purposes.
- 4.5. All agency locums who were previously booked on DE will continue to be paid DE. Any requests for the engagement of a Non-DE by the care group will need EMD approval via CTM.MedicalDirectorsOffice@wales.nhs.uk. Each Care Group is required to keep a central file of those decisions for audit purposes.
- 4.6. The agency rates noted in the table are the total rates, including WTR payments (up to which) is paid to the agency doctor. It does not include agency commission or employers NI. The rate is exclusive of VAT (on non-DE bookings only).
- 4.7. Travel to work costs and accommodation expenses are not paid to agency locums.

Grade	Hourly rates
F1	£40
F2	£45
STL(CT/ST1-ST2/3)	£60
STH (ST3/4- ST8)	£70
Specialty Doctor	£70
Consultant	£100*

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

- 4.8. Where there is a requirement for any rates to be escalated. The following must be followed
- Any rate up to 5% outside the agency rate card must be authorised in advance by the CGMD on the Locums Nest system.
 - Any rate over 5% outside the agency rate card must be authorised in advance by the EMD on the Locums Nest system. The care group must submit in email to CTM.MedicalDirectorsOffice@wales.nhs.uk justification for rate escalation.
- 4.9. Breaks (30 minutes after 6 hours) are automatically inserted on the workers weekly timesheet submitted on the Locums Nest system. In the event a break cannot be taken, a worker can edit break length on their timesheet for the approving manager to authorise so this time is paid as a break could not be taken. This will be monitored via reports from Locums Nest and any issues or themes will be escalated by the People Directorate to MWPP:Delivery Group.

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- 4.10. Agencies will confirm a worker is compliant on the Locums Nest system. However, on occasion may ask for a waiver. This must be dated and important points regarding compliance checks submitted for agency locums are as follows:
- Under no circumstances can DBS, Occupational Health and Right to Work checks be varied.
 - GMC / GDC restrictions and a positive DBS check (Overseas Police Check) must be reported to the Executive Medical Director's Office for consideration and a decision on the waiver; and possibly granting a waiver. Any waiver would be recorded by CG.
 - Other gaps in compliance checks such as statutory training requirements are reported to the Care Group Medical Director for consideration and a decision.
- 4.11 Following completion of a shift by an agency locum, a two-stage verification process must be undertaken to confirm hours worked and authorise payment:
- Timesheet Verification: A senior clinician on duty or the rota coordinator must verify and sign off the timesheet within the Locums Nest system to confirm that the shift was worked as scheduled.
 - Payment Authorisation: Authorisation for payment must then be completed within Locums Nest by the Directorate Manager (DM) or an appropriately delegated individual, in accordance with the Scheme of Delegation.
- Please note: Under no circumstances may the same individual complete both the timesheet verification and the payment authorisation stages.
- 4.12. A Level 1 approver may be any individual within the department who has access to the Locums Nest system—this may include, for example, a rota coordinator or a medical secretary.
A Level 2 approver must be either a Directorate Manager (DM) or a Service Manager.
- 4.13. All agency locums booked via the DE process will be paid by Cwm Taf Morgannwg. The payments will be processed weekly by the Payroll Services of NWSSP, via an automated extract from Locums Nest to Payroll.
- 4.14. Agencies are asked to produce a weekly consolidated invoice for commission re agency workers. It will include downloads of the backing data from the Locums Nest system which will be checked against submitted timesheets on a weekly basis and fed into an AP feed by the SWP team. Payments will be made via the Accounts Payable Services of NWSSP.

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

5. WAITING LIST INITIATIVES (WLI)

- 5.1. A Waiting List Initiative (WLI) is additional work that is agreed to be undertaken in order to support waiting lists and meet Welsh Government targets.
- 5.2. The WLI rate is only applicable to Medical & Dental consultants in line with the Amendment to the Consultant Contract (Wales) 2003 and only when the activity is clearly defined as a WLI. The WLI rate is set out annually in the Welsh Health pay circular.
- 5.3. WLIs are for Waiting List Initiatives that are designated on the priority list by WG or the UHB and confirmed as such by the (deputy) COO. All other backfill sessions will be at the standard agreed ADH rate, not the WLI rate
- 5.4. WLI sessions will be added to the Locums Nest system by the service, selecting the shift type as WLI. The rate as per the Welsh Pay Circular will automatically populate and the Bank worker will be matched into the shift.
- 5.5. All WLI sessions must be authorised by the COO office on the Locums Nest system. This information will be monitored via MWPP:Delivery Group using data from the Locums Nest system.
- 5.6. All non-Consultant grades involved in what may be considered WLI sessions, will be remunerated as set out in the ADH rate card (v. 3.6 above). WLIs are not paid to grades other than Consultants.
- 5.7. NWSSP process WLI payments alongside ADH payments using the monthly pay extract automatically sent from Locums Nest system to NWSSP.

6. MONITORING ARRANGEMENTS

- 6.1. Bank and agency requirements will be monitored by the CGs on a daily basis to ensure that any ADHs or agency locums approved are for posts that are within the agreed funded establishment.

- 6.2. Agency and bank rates which are up to 5% and over 5% above the agreed rate card are reported monthly via the MWPP: Delivery Group, chaired by the Deputy MD. The CGs are accountable for any breaches of the agency rates above the agreed rate card and for agency spend.
- 6.3. Agency, bank and WLI breaches which are above the 10% rates cards and WG cap are reported to the Audit & Risk Committee on a bi-monthly basis.

7. PAYROLL AUTHORISATION RECORDS

- 7.1. All payroll authorisation and monitoring records will be:
 - Properly controlled
 - Readily accessible for use, and
 - Properly archived or otherwise disposed of
- 7.2. This will be managed through Locums Nest Systems with a direct link to NWSSP Payroll and NWSSP Accounts Payable.
- 7.3. The actions taken to achieve the above should be in accordance with the NWSSP's and Health Board's Records Management Policy. These policies should be read in conjunction with other relevant FCPs.
- 7.4. No payments can be authorised or paid outside of the prescribed process.
- 7.5. For both Bank and Agency, there is a two stage approval process: timesheet approval confirming the hours were worked; and approval for payment.
- 7.6. Timesheet approvers can be a range of staff, including medical secretaries and rota co-ordinators.
- 7.7. Payment approvers can only be DMs and Deputy DMs.

8. EQUALITY IMPACT ASSESSMENT

- 8.1. 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.

APPENDIX 1

Flow Chart



In hours process of
filling shifts using ban

Changes to FCP's

FP17 Patients Property Income Allowances:

Medical Records Department changed to Overseas officer.

Baseline questions within identification section removed due to many updates in legislation.

FP24 Overseas Patients:

Combined Policy Statement, Scope and Aims into one section Scope and Principles to be consistent with other FCP's.

Appendix 7 – Patient Contact Confirmation form introduced (Appendix 7). Document referenced in section 3.1.2, 3.2.2 and 3.3.2. The form captures contact information in the event of the need to send an indemnity form to Next of Kin/family.

Merged Related Policies and related legislation sections.

FP Medical and Variable Pay:

Titles amended to Executive

Acronym table updated

Section 1 - Scope and Principle updated following transfer from interim manual process to Locum's nest automated system.

Section 2 – Retinue updated to Locums nest. Process updated to reflect covering vacant posts, long term absence, rota gaps, backfill to be remunerated at the ADH rate. Cover for these scenarios should be made through Bank, via the Locums Nest System.

Section 3 – Additional Duty Hours. Updated to reflect use of Locums Nest. Updated tables of hourly rates 3.6. Clarification on 30 minute break time – para 3.7. Updated % for rates outside the ADH rate and authorisation process.

Section 4 – Updated section on use of Agency Staff and their engagement, updated details on compliance of workers, detail on two stage verification process to confirm hours worked and authorisation of payments.

Section 5 – Waiting list initiatives and how to manage on Locum Nest.

Section 6 - Monitoring arrangements updated to report to the MWPP Delivery Group.

Section 7 – Payroll Authorisation Records updated for change to Locums Nest from Retinue. Details new approval process.

Medical Bank and Agency Locums Standard Operating Procedure (SOP) November 2025

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16. Transition from Agency to Perms
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Appendix

1. Process Map
2. Reason codes
3. WLI SOP
4. Worker Terms of Engagement

Acronyms

Listed below is a glossary of acronyms used within the document for ease of reference and understanding.

ACRONYMS	
ADH	Additional Duty Hours
COO	Chief Operating Officer
CG	Care Group
CTM	Cwm Taf Morgannwg
DCC	Direct Clinical Care
DE	Direct Engagement
DM	Directorate Managers
EMD	Executive Medical Director
F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
LTFTT	Less Than Full-Time Trainee
MD	Medical Director
M&D	Medical and Dental
MVP	Medical Variable Pay
MWPP	Medical Workforce Productivity Programme
MWPP:PEG	Medical Workforce Productivity Programme: Performance and Escalation Group
NHS	National Health Service
NI	National Insurance
Non DE	Non-Direct Engagement
NROC	Non-resident on call
NWSSP	NHS Wales Shared Service Partnership
SPA	Supporting Professional Activities
SLE	Single Lead Employer
StL	Specialty Trainee (Lower)
StH	Specialty Trainee (Higher)
UHB	University Health Board
WLI	Waiting List Initiative
WTR	Working Time Regulations

1. Introduction

- 1.1 The purpose of this document is to outline the standard procedure for sourcing, approving and managing temporary medical staffing through bank and agency system, ensuring safe clinical cover, cost efficiency and compliance with relevant standards.
- 1.2 The provision of bank and agency locums in CTM is via Locum's Nest. This document sets out the operational management arrangements to ensure the effective management and provision of the system. It should be read in conjunction with the Financial Controls Procedure (FCP).
- 1.3 The SOP also sets out the standards that will be implemented across CTM (CTMUHB), and should be read in conjunction with other relevant CTM UHB policies, namely:
 - Job planning guidance
 - Working Time Regulations
 - Recruitment
 - Fixed Term Contract
 - Annual Leave
 - Managing attendance at work
 - Study Leave & Professional Leave

2. Scope and Definitions

2.1 Scope

This SOP applies to:

- Strategic Workforce Planning Team
- Departmental Managers/clinical leads
- Bank and agency workers
- Finance and People
- NWSSP Recruitment and Payroll
- Approved staffing agencies
- COO Office
- Executive Medical Directors Office

2.2 Definitions

Bank staff: workers registered with CTM UHB's internal bank, providing flexible cover on a temporary basis.

Agency staff: workers supplied by agreed external agencies subject to contract terms and NHS Wales guidelines.

3. Roles and Responsibilities

The Strategic Workforce Planning Team will be responsible for the compliance, oversight and smooth running of the Locum's Nest system to meet the needs of CTM UHB. This will be in conjunction with a number of key stakeholders who are responsible for different elements of processing and compliance. The monitoring of the activity from the system will be reported to the MWPP: Delivery Group.

All of the following must adhere to FCP and SOP processes including rates.

Role	Responsibility
CGs	Responsible for timesheet approval and maintaining authorisers, at the right level, as the payroll approver, in accordance with the Scheme of Delegation
CG Rota Co-ordinator/ Medical Secretary	Requesting bank and agency shift cover and approving shifts worked/timesheets
CG DM/Service Manager	Responsible for escalating rates and for shift approval for payments
CGMD	Rate Escalation approval for rates of up to 5% of the rate card in accordance with the Scheme of Delegation.
Strategic Workforce Planning Team	Responsible for contract and Quarterly Reviews with Locums Nest. Actioning any audit recommendations for improved processing and outcomes Providing data for monitoring at MWPP:Delivery Group
Workforce Efficiency Co-ordinator and team	Adding and removing users Adding and removing bank workers Approving agency invoices for payment Manually adjusting rates as Locums Nest are unable to Handling complaints and queries Handling payroll queries Reconciling and arranging payments
EMD Office	Rate escalation approval for rates of above 5% of the rate card in accordance with the Scheme of Delegation
NWSSP Payroll	To process all monthly paid workers payments automatically from Locum's Nest system extract on 6 of

	every month. For weekly paid workers an extract is automatically produced and sent to NWSSP Payroll each Monday at 11am.

4. Procedure

All M&D should be rostered using the appropriate system to ensure efficient and effective medical cover to meet the needs of the service. Medical and Dental Rostering should be undertaken to optimise cover of the right skills at the right time in the right number to minimise staffing gaps and high cost cover. CTM have a Bank First policy.

5. Principles

Where staffing gap is identified due rota gap, vacancy, sickness or escalation in demand, which cannot be filled via the internal roster, in the first instance consideration should be given to the most efficient and cost effective way to cover the gap.

Where there is an established vacancy with appropriate funding, efforts should be made by Care Groups and services to fill the post via recruitment, as appropriate, and in line with workforce plans as quickly as possible to minimise increased variable pay.

Where a gap needs to be covered, priority must be given to advertise for bank cover through the Locum's Nest and only escalate to agency when:

- All other alternatives have been exhausted
- No suitable bank cover is available
- The clinical risk is imminent
- Approval is granted to request agency through the appropriate escalation process

For noting, when embarking on any requests for bank and agency workers you should be aware there is no obligation by either party to offer or accept any work.

6. M&D Bank

A bank shift can only be covered by an existing CTM UHB employee under a worker contract, A Resident Doctor employed by the Single Lead Employer (SLE) or from a bank only worker also under a worker contract. All eligible bank workers will be shown on the Locum's Nest system.

6.1 To submit a bank request you will need to use the Locum's Nest system and log in to [Locum's Nest](#). Process maps to support you with this process are shown at appendix 1.

6.2 No Bank bookings should be made outside the Locum's Nest process.

- 6.3 If you do not have an existing account you can contact support@locumsnest.co.uk for an account to be set up.
- 6.4 A bank worker can only be sourced from the workers on the Locum's Nest system who have a valid ESR number. Those bank workers that were processed via Patchwork transferred over to Locum's Nest on 26 June 2025. All new locums will need to apply through the Trac system and go through the standard compliance checks via the NWSSP Recruitment Team.
- 6.5 The process to recruit onto Locum's Nest Bank.
- CV's are downloaded from the Locums Nest system by Workforce Efficiency Co-ordinator and team and sent to CGs for consideration.
 - CGs will assess CVs within 5 working days and confirm to Workforce Efficiency Co-ordinator and team any they wish to proceed with or to decline.
 - Declined applicants are sent an message by the Locums Nest system by the with the reason why the application being declined.
 - An approved applicant is sent a hidden Trac link by the Workforce Efficiency Co-ordinator and team to a generic M&D bank vacancy.
 - Workforce Efficiency Co-ordinator and team move applicant to appropriate CG vacancy on the Trac system.
 - NWSSP carry out mandatory Pre-Employment Checks and these are recorded on the Trac system.
 - Upon completion of checks notification will be sent from the Trac system to the Workforce Efficiency Co-ordinator and team to enrol the applicant on the CTM payroll and activate the Locums Nest profile using a generated ESR number.

7. Additional Duty Hours (Bank shifts)

- 7.1 ADH cover can be provided by employed M&D staff, resident doctors employed by the SLE or by bank only workers. Employed staff, resident doctors employed by the SLE and bank only workers are engaged to undertake ADHs on a bank worker terms of engagement (for noting this is a separate contract to a substantive staff contract of employment and for bank work they are classed as a 'worker'). Upon signing up to CTM M&D bank, workers are issued with terms of engagement (appendix 4).
- 7.2 All bank shifts must be put on onto Locum's Nest. Once logged into the system you will need to include:
- role and grade
 - speciality
 - dates and times of shift(s)
 - location
 - reason for cover *

* a list of reason codes are held within the system for reporting and monitoring purposes. This is to simplify and standardise the reasons and streamline the process to improve clarity in data reporting. Definitions of the 'reason' codes and guidance of when they can be used is shown in appendix 2. It is of utmost importance to select the correct reason

code for a shift. This will enhance the accuracy of data collection and reporting, aiding in more effective decision-making.

- 7.3 The shifts will need to be published on the system for a worker to pick up and go through the 2-step approval within 28 days of the shift being worked.
- 7.4 To add a shift onto the system, users will go to <https://webapp.locumsnest.co.uk/> and log in using their credentials.
- 7.5 Once logged in, user will choose 'Match' tab, click on the date the shift required will start and click on '+ Add a new shift' and complete all shift details requested and click 'NEXT'.
- 7.6 User will add shift start date and time, end date and time, choose a cost code, a reason for vacancy and whether to initiate the bulk shift posting function (to cover a gap longer than 1 shift) or a standalone shift and click 'NEXT'.
- 7.7 User will add eligible grades for the shift. More than one may be selected. The system will automatically add the appropriate rate from CTM Rate card.
- 7.8 User will click on 'PUBLISH' and shift will become visible to all bank workers.
- 7.9 Bank workers will apply to cover the shift. CG will review applications and proceed with most suitable candidate. A candidate may be pre-matched to the shift, but the shift will be visible to other bank workers until the matched worker accepts.
- 7.10 If a user does not have an account, please email support@locumsnest.co.uk who will set up an account linked to appropriate cost codes and locations. the Workforce Efficiency Co-ordinator and team will need to approve all requests and levels of authorisation for new users via email.
- 7.11 Only during the out of hours period (evenings, weekends and bank holidays) can the creation of shifts be put onto the Locum's Nest system retrospectively. Any retrospective shifts should be recorded on the system up to a maximum of 48 hours after the shift has been worked by a payment approver.
- 7.12 No direct bookings – all shifts should be advertised on CTM M&D Bank before being cascaded to agencies using the process above.
- 7.13 For any doctor covering on call during the daytime, and is already in work, no additional payment is made but this should be recorded on the appropriate rostering system. If the doctor is covering during the daytime or out of hours, when they are on leave or uncontracted to work, then this activity is remunerated as per the ADH rate card and this should be recorded as a standard ADH on the Locum's Nest system.
- 7.14 If undertaking additional DCC in what should be SPA time, a claim is for the time period to which the SPA has been displaced.
- 7.15 The worker confirms that by working any additional shifts, the working pattern has not breached the rest break and rest period requirements of the Working Time

Directive. This is addressed in the terms of engagement issued to all CTM M&D Bank Workers upon signing up to Locums Nest.

- 7.16 All shifts must be paid using the standard rate card which is uploaded into the Locum's Nest system. These are the rates (up to which) are payable to the Doctor. These rates include rolled up annual leave (WTR) payments. The rates in the table below are resident rates. The non-resident rate on call (NROC) is remunerated at 50% of the rate below.

Grade	Hourly rates	Hourly rates
	In hours 7am-7pm Monday to Friday excluding Bank Holidays (consultants – 9am-5pm)	Out of Hours 7pm-7am Monday to Friday (Consultants - 5pm-9am) Plus Saturdays, Sunday and Bank Holidays
F1	£40	£50
F2	£45	£60
STL(CT/ST1- ST2/3)	£60	£70
STH (ST3/4- ST8)	£70	£80
Specialty Doctor	£70	£80
Consultant	£100*	£125

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

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

- 7.17 The ADH rates includes annual leave but does not include employer's on-costs, such as Employers NI and pension.
- 7.18 Where there is a requirement for **any** rates up to 5% outside the ADH rate card for additional duty hours, the DM or Service Manager will create a rate escalation on the Locum's Nest system for CGMD approval in advance of the shift being worked. For any rates over 5% outside the ADH rate card, the DM or Service Manager will create a rate escalation on the Locum's Nest system for approval from the EMD Office in advance of the shift being worked. An email with justification behind any escalation must also be sent to the EMD office by the CGMD/CGD. In the absence of the EMD Office, authorisation in advance could be sought from the on-call Exec OOH.

- 7.19 ADH rates which are above the agreed rate card are reported via the MWPP Delivery Group, chaired by the Deputy Medical Director. The Care Groups are accountable for any escalations of ADH rates above the agreed rate card and for ADH spend.
- 7.20 The ADH shift will be remunerated at the rota grade required on the roster and not the grade of the individual. However, consultants doing extra daytime shifts to cover junior rota gaps will be remunerated at the consultant in-hours ADH rate of £100.
- 7.21 All ADH claims must be submitted via Locum's Nest. Once a shift has been worked by a Bank worker the shift must be confirmed in Locum's Nest by the worker and the hours worked amended if necessary. There is a two-step approval process. Firstly, the timesheet is signed off (to confirm the hours have been worked by the locum) in Locum's Nest by a senior clinician on duty or a rota co-ordinator. Then authorisation for payment is given in Locum's Nest by the DM or Service Manager in accordance with the Scheme of Delegation. Under no circumstances can the same person sign off both the timesheet and the payment.
- 7.22 Where there is a pattern of regular ADHs then the DM would review the underlying reason(s) for the additional demand and develop plans with the CG, Finance Business Partner and the Head of People for a more sustainable and affordable workforce solution.

Breaks

- 7.23 CTM UHB encourages breaks to be taken for the wellbeing of all workers. Monitoring and reporting of breaks will be undertaken on a regular basis to ensure that proper provisions are in place for breaks to be taken, and any trends and themes will be reported to MWPP: Delivery Group.
- 7.24 Unpaid breaks of 30 minutes after 6 hours are automatically deducted by Locum's Nest. In the event a break cannot be taken, the manager is to authorise so this time is paid as a break could not be taken.
- 7.25 While an automatic 30-minute unpaid rest break will be deducted from each shift via Locum's Nest. Workers who are unable to get a full 30-minute rest break will be able to edit it on the system and leave a comment explaining the reasons. This allows timesheet approver and payment approver to clearly see a break has been edited on the Locums Nest system and to scrutinise prior to approving. This must be completed and approved at the end of the shift and not before the shift has been worked.
- 7.26 Any amended timesheets submitted without a valid reason entered for the amendment should be declined by the service for the worker to resubmit with justification for the amendment.

8. M&D Agency

Use of Medical and Dental agency should be a last resort when other options have been explored and exhausted. Any existing agency locum bookings previously made and extensions to these bookings already requested by the Care Group which

have already been approved will be automatically added to the Locums Nest system.

Creation of request for agency cover

- 8.1 CGs must not under any circumstances engage with locum agencies directly.
- 8.2 All shifts must be advertised through the CTM Medical Bank using the Locums Nest system. If a shift remains unfilled by a bank worker 14 days before its scheduled start date, or is a short notice shift a Level 1 authoriser may request that the shift be escalated to agency by clicking on 'Tier 1 cascade'. This request will then be reviewed and either approved or declined by a Level 2 authoriser.

Please note: this escalation can only occur once all bank applications have been reviewed and actioned.

- 8.3 Agencies will submit bids for cascaded shifts via the Locums Nest system. If a proposed worker's rate falls within the agreed rate card, a Level 1 authoriser may proceed to accept and book the worker directly. If the proposed rate exceeds the rate card, the system will automatically lock the booking.

Where there is a requirement for **any** rates up to 5% outside the agency rate card, the DM or Service Manager will create a rate escalation on the Locum's Nest system for CGMD approval in advance of the shift being worked. For any rates over 5% outside the rate card, the DM or Service Manager will create a rate escalation on the Locum's Nest system for approval from the EMD Office in advance of the shift being worked. An email with justification behind any escalation must also be sent to the EMD office. In the absence of the EMD Office, authorisation in advance could be sought from the on-call Exec OOH.

Once the appropriate approval has been granted and the proposal is unlocked by a rate approver, the Level 1 authoriser can then proceed to book the worker into the shift. EMD office require email justification via Care Group as well as automated request from Locums Nest System

- 8.4 This will ensure any risks identified with continuing are appropriately considered and mitigated, e.g. any impacts on patient care and use of long-term agency arrangements. Each Care Group is required to keep a central file of these decisions for audit purposes.
- 8.5 All agency locums who were previously booked on DE will continue to be paid DE. Any requests for the engagement of a Non-DE will need EMD approval. The Care Group is responsible for this.
- 8.6 The agency rates noted in the table are the total rates, including WTR payments (up to which) is paid to the agency doctor. It **does not** include agency commission. The rate is exclusive of VAT (on non DE bookings only).
- 8.7 Travel to work costs and accommodation expenses are not paid to agency locums.

Grade	Hourly rates
F1	£40
F2	£45
STL(CT/ST1-ST2/3)	£60
STH (ST3/4- ST8)	£70
Specialty Doctor	£70
Consultant	£100*

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

- 8.8 Breaks (30 minutes after 6 hours) are automatically inserted on the workers weekly timesheet submitted on the Locums Nest system. In the event a break cannot be taken, a worker can edit break length on their timesheet for the approving manager to authorise so this time is paid as a break could not be taken. This will be monitored via reports from Locums Nest and any issues or themes will be escalated by the People Directorate to MWPP: Delivery Group.
- 8.9 Agencies will confirm a worker is compliant on the Locums Nest system. However, on occasion may ask for a waiver. This must be dated and important points regarding compliance checks submitted for agency locums are as follows:
- Under no circumstances can DBS, Occupational Health and Right to Work checks be varied.
 - GMC / GDC restrictions and a positive DBS check (Overseas Police Check) must be reported to the Executive Medical Director's Office for consideration and a decision on the waiver; and possibly granting a waiver. Any waiver would be recorded by CG.
 - Other gaps in compliance checks such as statutory training requirements are reported to the Care Group Medical Director for consideration and a decision.
- 8.10 Where excessive shift lengths continue, the Health Board could liaise with Locum's Nest to establish if controls can be included in the system that requires additional authorisation for shifts above a certain length.
- 8.11 Only during the out of hours period (evenings, weekends and bank holidays) can the creation of shifts be put onto the Locum's Nest system retrospectively. Any retrospective shifts should be recorded on the system up to a maximum of 48 hours after the shift has been worked by a payment approver.

9. Direct/Non-Direct Engagement Candidates

- 9.1 All agency locums are to be engaged via Direct Engagement (DE and will be paid by the CTM. The payments will be processed weekly by the Payroll Services of NWSSP, via an automated extract from Locums Nest to Payroll.
- 9.2 In exceptional circumstances consideration may be given to booking non-DE. Any requests for the engagement of a non-DE candidate the Directorate Manager/Service Manager will need approval from the EMD office and the CGMD.

In these occasions, Where a non-DE agency locum is booked payments will be made via the Accounts Payable Services of NWSSP.

10. Reviewing CVs

How to view a candidate application:

- Log onto Locums Nest system Select the 'pending applications' icon on the dashboard.
- Click on the names of the candidate to view passport page.
- Agencies supply the CV, references and all mandatory documents when submitting a worker on the Locums Nest system and confirm all documents have been viewed.
- Once the CG review the CV can 'book' the successful candidate the rate, if, above CTM Rate Card requires authorisation. (Please refer to point 4).
- CVs are stored on Locums Nest system as part of the doctor's information and are accessible by the department throughout the placement. There is no requirement for the department to keep a copy of the CV on any internal system.

11. Compliance Process:

CV's are supplied to the departments for review as stated above. Once the department agree to book the candidate and the rate has been authorised agencies will undertake full compliance checking of the Doctor and confirm they have done this in Locums Nest

Compliance documents required to be seen by the agency before the Doctor can start:

- GMC
- DBC
- Two references
- Right to work
- Fitness to work
- Mandatory Training
- Verified ID
- Proof of Address

12. Interview (If Required)

Agency locums can be interviewed if required by the department prior to offering them the role. Locums can be contacted via the 'contact doctor' button within their profile on Locums Nest

13. Induction

All agency staff who work in an area that is new to them will receive an induction/orientation from the department.

14. Cancellation of Shifts:

14.1 By Agency Locums:

Agency workers must notify their agency if they are unable to undertake a shift. This will enable the CG or Temporary staffing team to try and source a replacement. If the agency worker does not inform their agency of their failure to attend a shift, this will be classed as a 'Did Not Attend (DNA)' and could be reported to the GMC.

All short notice cancellations and DNAs are recorded by the Locums Nest System, these are monitored by CG's. Agency workers who repeatedly cancel or DNA shifts will be reported to their agency and in certain circumstances to the GMC.

Following any cancellations, the reason for the cancellation must be recorded on the Locums Nest system which produces an email alert for the CG. Care Group of the cancellation and put the shift back out on Bridge.

Outside office hours the agency notifies the on-call manager.

14.2 By Care Group (CG):

The CG are entitled to cancel booked shifts with reasonable notice. Best practice is 2/3 days' notice for ad-hoc shifts and for long term placements where the candidate is already in post would be 7 days.

Any cancellation of a shift **MUST** be actioned through the appropriate roster system and on the Locums Nest system, as quickly as practically possible.

15. Timesheet Approval

15.1 All timesheets must be completed by the locum and approved by the Rota co-ordinator on the Locums Nest system to ensure the correct rates and hours are paid. Subsequently, approval for payment is approved by Directorate Managers or Service Managers.

15.2 Any timesheets submitted in **excess of 72 hours** a week will require approval from the CGMD. Doctors are required to submit timesheets on a weekly basis, all timesheets must be received by the CG by 9am on a Monday.

15.3 The CG must approve/reject all timesheets and payments by 5 pm on a Monday. All approved timesheets will be paid on the Friday of that week.

15.4 How to approve a locum timesheet:

- An email will be sent to the Level 1 approver via the Locums Nest system to notify that a timesheet is to be approved.
- Via Locums Nest go to the dashboard, select Timesheets Pending Approval.
- Confirm the total hours are correct including breaks. Compare the Locums Nest timesheet with Health Roster to confirm they match.

- Any timesheet that is submitted in excess of 72 hours will require escalation to the CGMD prior to authorisation.
- All Non-resident on-call will be remunerated at **50%**, any claims above this will require escalation to the appropriate rate escalation approver prior to approval.
- Confirm the rate and total costs are correct
- Select Approve or Dispute.
- If disputed enter detail of the disputed hours or expenses in the free text box to instruct the agency to address any discrepancies.
- Once the reason has been entered select dispute to finalise the action.

15.5 Following completion of a shift by an agency locum, a two-stage verification process must be undertaken to confirm hours worked and authorise payment:

- Timesheet Verification: A senior clinician on duty or the rota coordinator must verify and sign off the timesheet within the Locums Nest system to confirm that the shift was worked as scheduled.
- Payment Authorisation: Authorisation for payment must then be completed within Locums Nest by the Directorate Manager (DM) or Service Manager in accordance with the Scheme of Delegation.

Please note: Under no circumstances may the same individual complete both the timesheet verification and the payment authorisation stages.

15.6 A Level 1 approver may be any individual within the department who has access to the Locums Nest system—this may include, for example, a rota coordinator or a medical secretary. A Level 2 approver must be either a Directorate Manager (DM) or a Service Manager.

15.7 Clear guidance should be available to staff emphasising the importance of timely and accurate timesheet submissions by the employee (and not the rota coordinator) 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 Locums Nest app should be provided to shift workers.

16. Payment

16.1 All agency workers will be paid for hours worked and will be paid weekly. Providing, approved timesheets have been received and payment approved by a DM or SM by 5pm on the Monday of the same week. Doctors are required to submit timesheets on a weekly basis as noted in point 16.2.

16.2 Direct Engagement workers:

Payment will be made by BACS transfer to a bank or building society. This will be managed by CTMUHB Payroll Department. All payslips will be sent to the individual's home address.

16.3 Non-Direct Engagement Workers:

Agencies will invoice the 'total charge' to CTM UHB via the CTM.Agency@wales.nhs.uk email. The Workforce Efficiency Co-ordinator and team reconcile the hours worked with the timesheets and arrange payments.

- 16.4 For both DE and Non-DE workers, agencies are asked to produce a weekly consolidated invoice for commission re agency workers and sent to the CTM.agency@wales.nhs.uk inbox. It will include downloads of the backing data from the Locums Nest system which will be checked against submitted timesheets on a weekly basis and fed into an AP feed by the Workforce Efficiency Co-ordinator and team. Payments will be made via the Accounts Payable Services of NWSSP

17. How to raise a concern:

Should any problems be identified during engagement regarding performance, capability or conduct, these are required to be recorded on the Datix system. The call handler should be listed as the Medical Workforce Efficiency Co-ordinator (MVEC).

Once a Datix incident has been received the MVEC will email a copy of this to the agency. The doctor will be given the opportunity to provide a response. The response will be received from the agency and recorded on Datix by the MVEC. The CSG may advise that this doctor is to be placed on the Do Not Use (DNU) list.

**Please note a doctor will not be placed on the DNU list without the appropriate Datix entry.*

18. Maternity Leave

It is the responsibility of the Agency worker to notify their agency if they are pregnant to ensure that agencies can inform the Workforce Efficiency Co-ordinator and team to organise the relevant Health and Safety requirements risk assessment. This must be done as early in the pregnancy as possible.

19. Sickness

If an Agency worker is unable to present for a booked shift due to sickness, they must inform their agency as soon as they are able in order to give plenty of opportunity for Agencies to find a suitable replacement.

If the sickness is Covid related the worker may be entitled to Statutory Sick Pay ONLY if the relevant statutory requirements are met and ONLY if they cannot attend a shift they have already booked

20. Pension

Agency workers may automatically join Nest Pension Scheme if they are eligible. They have the option to opt out of the pension scheme by informing payroll directly.

21 WAITING LIST INITIATIVES (WLI)

- 21.1 A Waiting List Initiative (WLI) is additional work that is agreed to be undertaken in order to support waiting lists and meet Welsh Government targets.
- 21.2 The WLI rate is only applicable to Medical & Dental consultants in line with the Amendment to the Consultant Contract (Wales) 2003 and only when the activity is clearly defined as a WLI. The WLI rate is set out annually in the Welsh Health pay circular. The system will not allow WLI sessions to be booked by Non Consultants.
- 21.3 WLIs are for Waiting List Initiatives that are designated on the **priority** list by WG or the UHB and confirmed as such by the (deputy) COO. All other backfill sessions will be at the standard agree ADH rate, not the WLI rate.
- 21.4 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. WLI sessions will be added to the Locums Nest system by the service, selecting the shift type as WLI with the reason selected as WLI. The rate as per the Welsh Pay Circular will automatically populate and the Bank worker will be matched into the shift.

- 21.5 All WLI sessions must be authorised by the COO office on the Locums Nest system in accordance with SOP issued by the COO Office. This information will be monitored via MWPP: Delivery Group using data from the Locums Nest system.
- 21.6 All non-Consultant grades involved in what may be considered WLI sessions, will be remunerated as set out in the ADH rate card (v. 3.6 above). WLIs are not paid to grades other than Consultants.
- 21.7 NWSSP process WLI payments alongside ADH payments using the monthly pay extract automatically sent from Locums Nest system to NWSSP
- 21.8 Locum's Nest will only allows the 'waiting list' reason code to be selected for WLI sessions. Where this is not possible, management should remind staff of the need for accurate coding and ongoing monitoring should take place to identify non-compliance.
- 21.9 This is in conjunction with the WLI SOP produced by the COO office – Appendix 3

22 Monitoring Arrangements

- 22.1 Bank, agency and WLI activity will be monitored by the CGs on a daily basis to ensure that any costs approved are for posts that are within the agreed funded establishment.
- 22.2 Agency and bank rates which are above the agreed rate card are reported monthly via the MWPP: Delivery Group, chaired by the Deputy MD. The CGs are accountable for any breaches of the agency rates above the agreed rate card and for agency spend.
- 22.3 Agency, bank and WLI breaches which are above the 10% rates cards are reported to the Audit & Risk Committee on a bi-monthly basis.
- 22.4 Retrospective shifts created by CGs will be analysed and monitored 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. Agency shifts can only be added retrospectively by a payment approver.
- 22.5 Booking practices will also be monitored at MWPP: Delivery Group to track the use of direct bookings versus the worker system application. Deviations from the established process should be flagged and addressed promptly.
- 22.6 Monthly reviews of Locum's Nest data will be shared by the Head of People Analytics to MWPP: Delivery Group to identify shift bookings that are considered excessive, such as greater than 12 hours. A further analysis by CG and Directorate will help to target areas where long shifts are being recorded 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.
- 22.7 Management should produce and analyse periodic reports on the level of use of reason codes for hourly shifts. Particular attention should be paid to those departments that regularly book shifts using the 'establishment vacancies' code to determine what work has been taken to tackle vacancy issues.
- 22.8 Ongoing monitoring of WLI will take place to identify any non-compliance. Reports will be shared by the Head of People Analytics to the MWPP: Delivery Group
- 22.9 Monitoring of shifts coded as sessional should take place to ensure they reconcile back to COO agreed WLI activity.
- 22.10 A suite of reports that can be routinely received and analysed to identify noncompliance with the FCP.
- 22.11 Management should produce and analyse periodic reports on the level of use of reason codes for hourly shifts. Particular attention should be paid to those departments that regularly book shifts using the 'establishment vacancies' code to determine what work has been taken to tackle vacancy issues.

- 22.12 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.

23 Payroll Authorisation Records

- 23.1 All payroll authorisation and monitoring records will be:
- a) Properly controlled
 - b) Readily accessible for use, and
 - c) Properly archived or otherwise disposed of
- 23.2 This will be managed through Locums Nest Systems with a direct link to NWSSP Payroll and NWSSP Accounts Payable.
- 23.3 The actions taken to achieve the above should be in accordance with the NWSSP's and Health Board's Records Management Policy. These policies should be read in conjunction with other relevant FCPs.
- 23.4 No payments can be authorised or paid outside of the prescribed process.
- 23.5 For both Bank and Agency, there is a two-stage approval process: timesheet approval confirming the hours were worked; and approval for payment.
- 23.6 Timesheet approvers can be a range of staff, including medical secretaries and rota co-ordinators.
- 23.7 Payment approvers can only be DMs, Deputy DMs or Service Managers.
- 23.8 Approver limits are set up in Locum's Nest to align to the revised FCP. Authorisers are set up in groups that align to their approval level, with no authorisers being able to approve at both below 10% escalated rates and above escalated rates. Rate approvers should also not be the same staff who can authorise timesheets for payment.
- 23.9 Only current and relevant staff are set up with authorisation access. Periodic reviews of rate authorisers and their access should take place to ensure appropriateness.

24 Equality Impact Assessment

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

Transition from agency to Health Board contract process:

An agency doctor can transfer from an agency to a Health board contract following agreement from the directorate and or application process. The directorate are required to complete a form to invoke clause 7.3 which will start the eight week

notice period to ensure the Health Board are exempt from incurring any introductory fees.

A copy of the form can be requested via CTM.Agency@wales.nhs.uk.

Workers rights

Right/Protection	Employee	Worker	Self-Employed
Right not to be unfairly dismissed (after 2 years' service) (ERA 96)	Yes	No	No
Right to receive written statement of terms and conditions *(ERA 96)	Yes	No	No
Itemised payslip (ERA 96)	Yes	Yes	No
Statutory minimum notice (ERA 96)	Yes	No	No
Statutory redundancy pay (after 2 years' service) (ERA 96)	Yes	No	No
Protection from discrimination in the workplace (EA 10)	Yes	Yes	No
National minimum wage (NMW 98)	Yes	Yes	No
Protection from unlawful deduction from wages (ERA 96)	Yes	Yes	No
Paid annual leave (WTR 98)	Yes	Yes	No
Right to daily and weekly rest breaks (WTR 98)	Yes	Yes	No
Pension auto-enrolment	Yes	Yes	No
Right to be accompanied to formal meeting in accordance with ACAS Code of Practice.	Yes	Yes	No
Rights under the Data Protection Act 1998	Yes	Yes	Yes
Whistleblowing protection (ERA 96)	Yes	Yes	Yes
Right to receive statutory sick pay	Yes	Yes	No
Statutory maternity, paternity, adoption leave and pay	Yes	Yes	No
Unpaid time off to care for dependents	Yes	No	No
Right to request flexible working	Yes	Yes	No
Time off for ante-natal care	Yes	No	No
Time off for trade union activities	Yes	No	No

TUPE	Yes	No	No
Health and safety in the workplace	Yes	Yes	Yes

25. Ending a placement.

It is vital the Workforce Efficiency Co-ordinator and team are informed when a locum placement ends. Failure to do this will result in inaccurate financial projection reporting. Rota Co-ordinators can email **CTM.Agency@wales.nhs.uk** to ensure a placement is ended on Locums Nest system and terminated on CTM payroll.

Appendix 1	Process map  In hours process of filling shifts using ban
Appendix 2	Reason codes in Locums Nest System • Vacancy – A staff member has left; role hasn't been filled. Please give the name of the last postholder. • Sickness – All levels of sickness. • Parental Leave – Maternity, Paternity and Adoption leave. • Rota Gap – LTFT, OH Restrictions, RTW, Supernumery, Induction. • Planned Activity Backfill – Extra Session, High Acuity. • Special Leave – Compassionate, Carer, Jury Duty, Armed Forces • Critical Incident – Major Incident • WLI – A WLI that has approval from the COO office.
Appendix 3	WLI SOP:  WLI SoP November 2025 iteration FINAL.1
Appendix 4	Bank Worker Terms of Engagement  TERMS OF ENGAGEMENT FOR A



Agenda Item

6.1

Audit, Risk & Assurance Committee

Local Counter Fraud Update Report

Dyddiad y Cyfarfod / Date of Meeting	03/02/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Evans, Head of Local Counter Fraud Services
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Evans, Head of Local Counter Fraud Services
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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



1. Situation / Background

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

2. Specific Matters for Consideration

- 2.1 The report provides detail on tasks and actions undertaken with the four strategic counter fraud work areas.
- 2.2 The detail on the Investigations are being taken at the (CLOSED) In Committee meeting of the Committee due to potentially identifiable information.

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 (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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: N/A
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: N/A
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 to review the report for discussion.

6. Next Steps

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



Cwm Taf Morgannwg University Health Board

Audit & Risk Committee – 3rd February 2026

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	25
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	56
Prevent and Deter		
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	143	92
Hold to Account		
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result.	290	206
TOTAL	581	379

4. STRATEGIC GOVERNANCE

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

5. INFORM AND INVOLVE

The Counter Fraud Team have proactively sought to increase attendance at fraud awareness sessions throughout Quarter 3. The Team have actively sought to directly engage teams to offer training bespoke to risks faced in their roles. This work has resulted in 14 presentations delivered to 193 attendees with further sessions planned

for Q4. There was a 42% increase in contact to the Counter Fraud Team throughout the quarter with this trend expected to continue as progress is consolidated.

6. PREVENT AND DETER

An outcome report on the evaluation of internal controls within NHS Wales relating to the NHS Counter Fraud Authority led Procurement Local Proactive Exercise centred around due diligence and contract management has been published and is included at Appendix 2 for review.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 3 to this report. A summary of basic investigation KPI data is presented at outset of the appendix.

Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table.

The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries.

A table of Closed Cases is also presented to review outcomes of investigations.

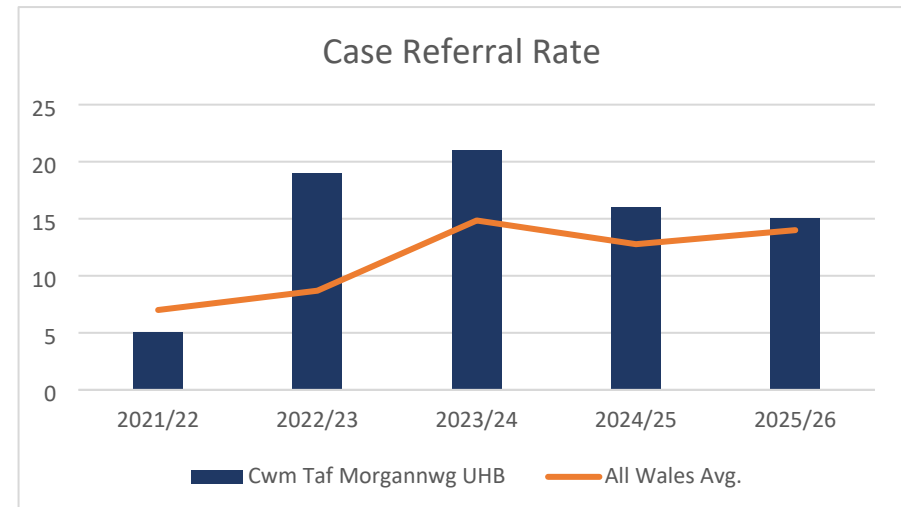


Item 6.1b – Appendix 1

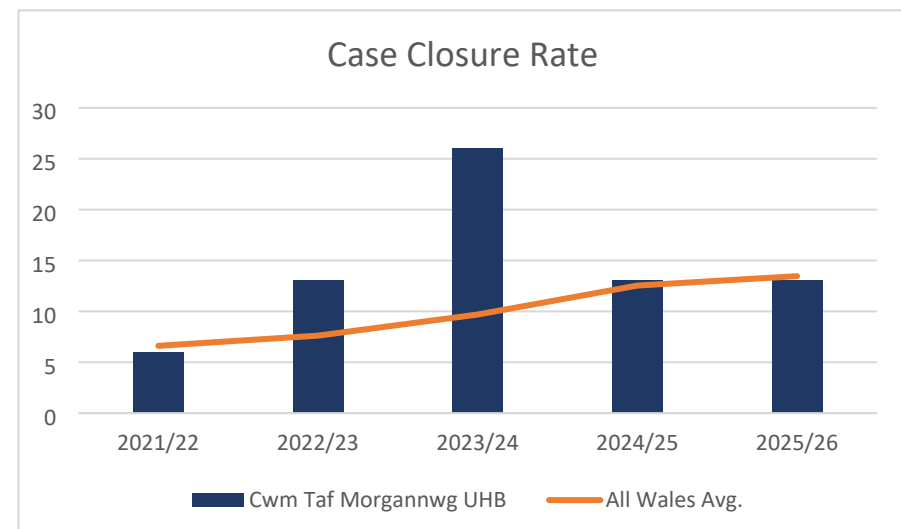
Counter Fraud Benchmark Report

Counter Fraud Benchmarking Statistics – Half Year

Case Referral Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	5	7.0
2022/23	19	8.7
2023/24	21	14.8
2024/25	16	12.8
2025/26	15	14.0



Case Closure Rate	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	6	6.6
2022/23	13	7.6
2023/24	26	9.7
2024/25	13	12.5
2025/26	13	13.5



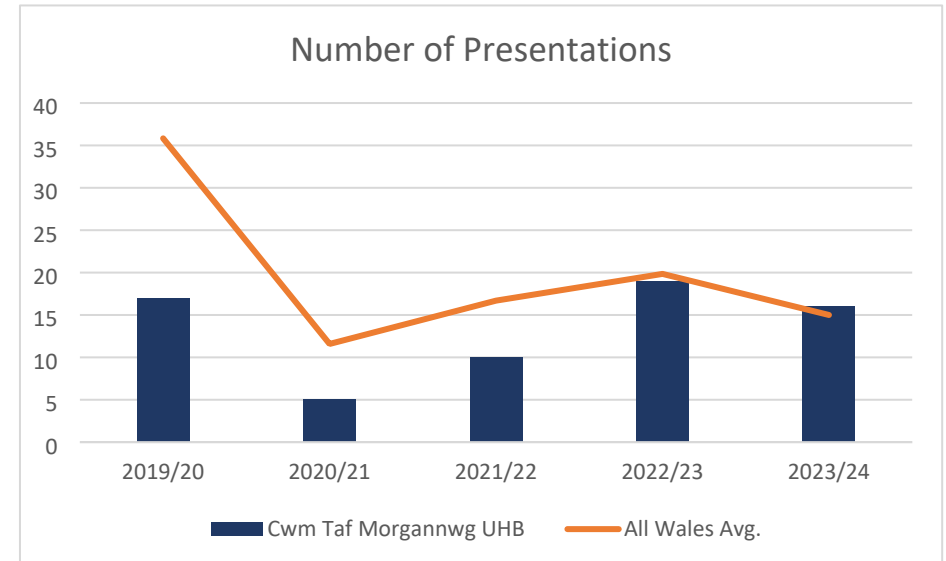
***4 Investigations Transferred to other NHS bodies for action**

Counter Fraud Benchmarking Statistics – Half Year

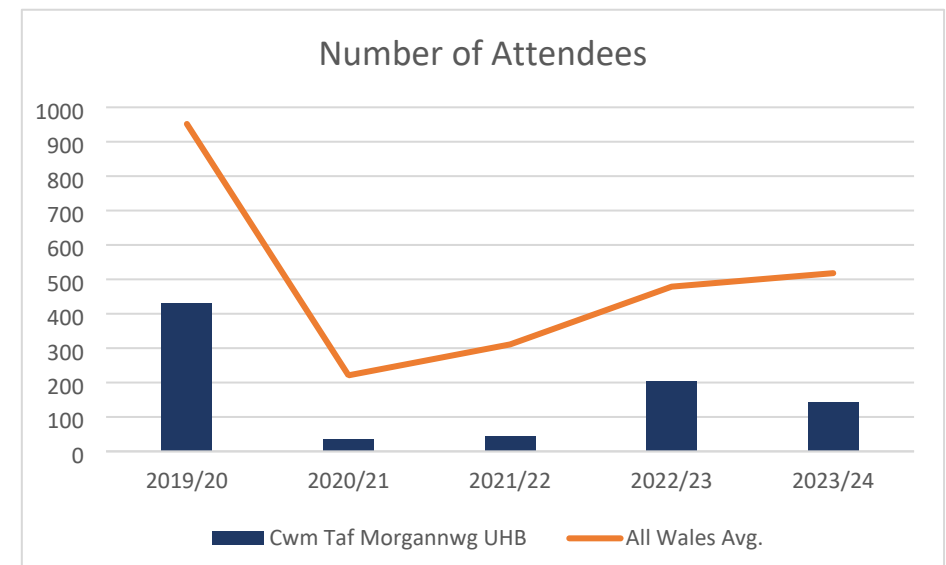
Sanctions	2021/22			2022/23			2023/24			2024/25			2025/26		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Cwm Taf Morgannwg UHB	1	0	6	0	0	4	0	1	2	0	1	1	0	1	1
All Wales Avg.	0.3	2.3	1.6	0.3	1.4	2.1	0.4	1.0	2.1	0.3	1.8	1.9	0.0	1.3	1.9
All Wales Total	4	30	21	4	18	27	5	13	27	4	24	25	0	17	25

Counter Fraud Benchmarking Statistics – Half Year

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

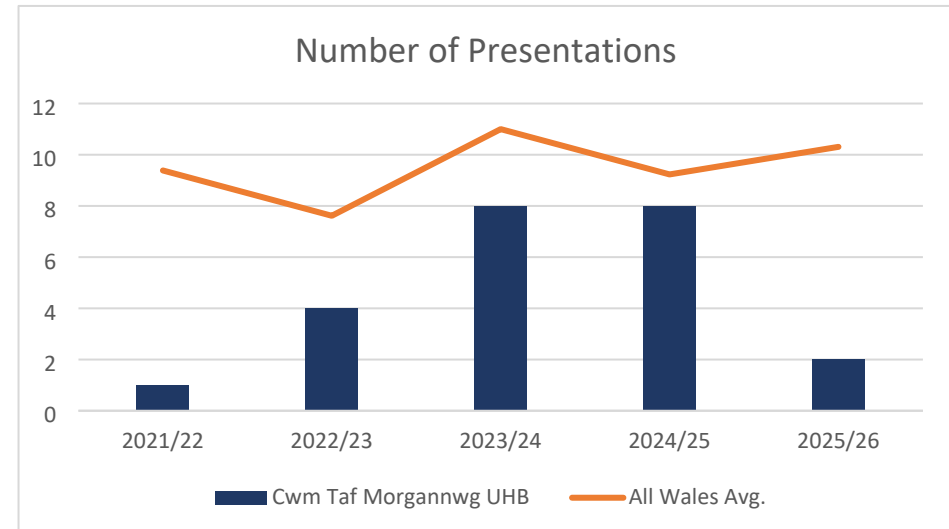


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2019/20	432	952
2020/21	37	221
2021/22	45	311
2022/23	204	479
2023/24	143	518

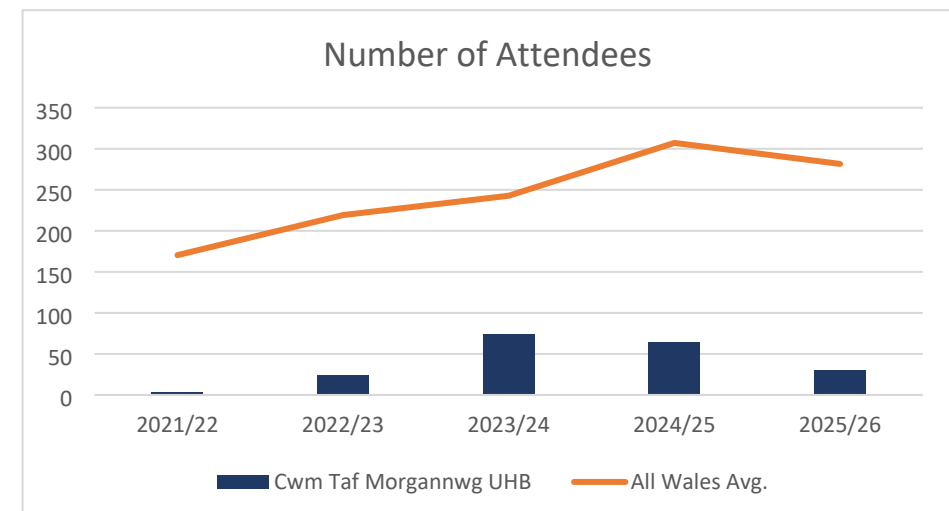


Counter Fraud Benchmarking Statistics – Half Year

Number of Presentations	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	1	9
2022/23	4	8
2023/24	8	11
2024/25	8	9
2025/26	2	10

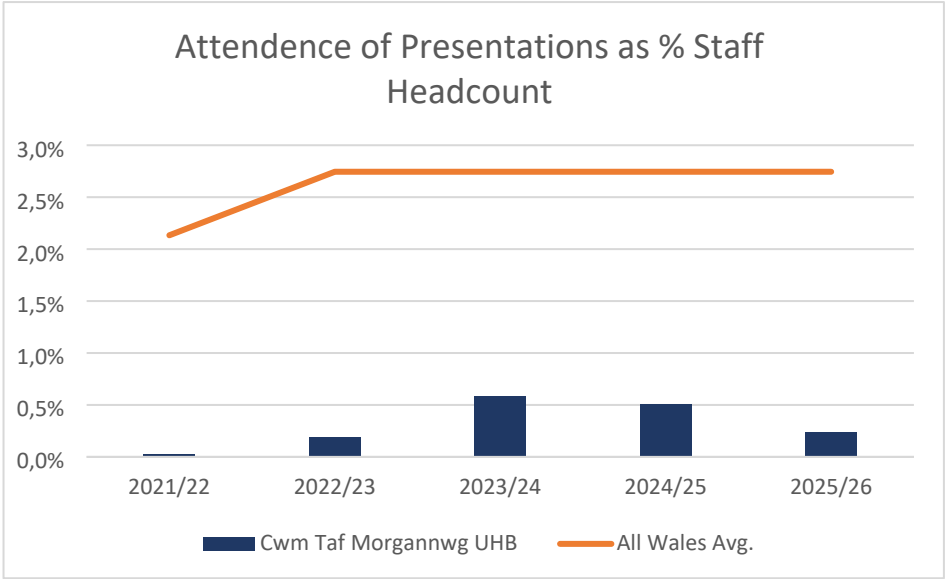


Number of Attendees	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	3	170
2022/23	24	219
2023/24	74	243
2024/25	64	307
2025/26	30	282



Counter Fraud Benchmarking Statistics – Half Year

Attendance of Presentations as % Staff Headcount	Cwm Taf Morgannwg UHB	All Wales Avg.
2021/22	0.0%	2.1%
2022/23	0.2%	3%
2023/24	0.6%	3%
2024/25	0.5%	3%
2025/26	0.2%	3%





Agenda Item

7.1a

Audit, Risk & Assurance Committee

AUDIT RECOMMENDATIONS TRACKER UPDATE REPORT

Dyddiad y Cyfarfod / Date of Meeting	3 rd February 2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown, Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	19 th January 2026	Management sign off

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

Internal Audit Activity Limited Assurance Overdue Activity Comparison.

Internal Audit Areas of suggested focus

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 November is included as a comparator for the January 2026 ARAC position. The actions are also split by the priority of High, Medium and Low as assigned at the finalisation of the Audit Review.

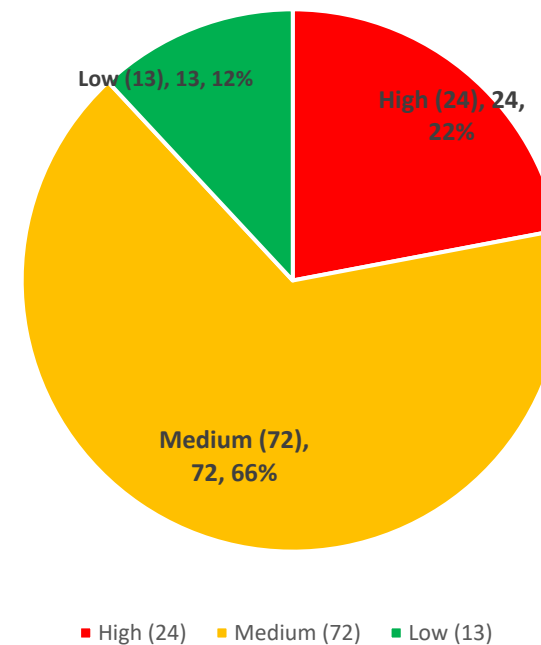
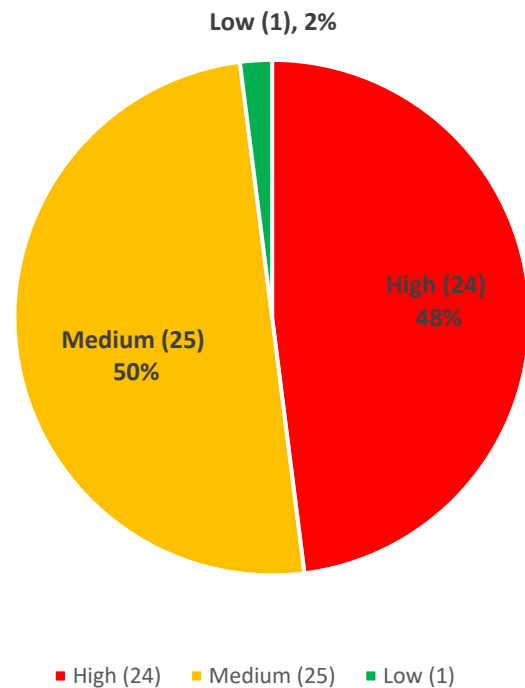
The following Internal Audit Reviews have the longest overdue audit actions against the original due date for Limited Assurance rated reports:

November 2025

January 2026

Limited Assurance reports. Overall overdue Internal Audit open inspection actions by action priority as at November 2025

Limited Assurance reports. Overall overdue Internal Audit open inspection actions by action priority as at 13th January 2026



Internal Audit/2023/146. Interventions Not Normally Undertaken (INNU)_Final Internal Audit Report October 2023.

8 open actions overdue for between 683 - 865 days

Internal Audit/2024/162. 4-hour Emergency Department Performance Reporting_Final Internal Audit Report February 2024.

2 open actions overdue by 591 days

Internal Audit/2024/170. Gastro-Intestinal Pathways – Demand Management_Final Internal Audit Report April 2024.

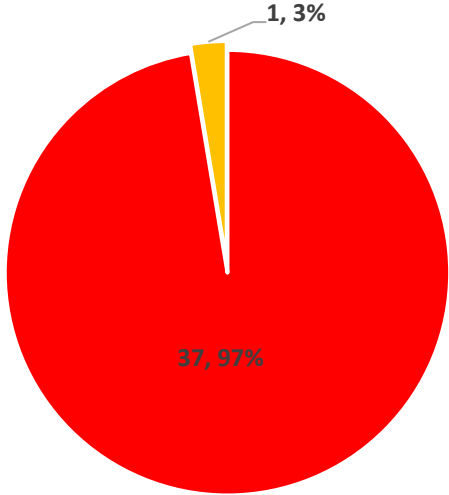
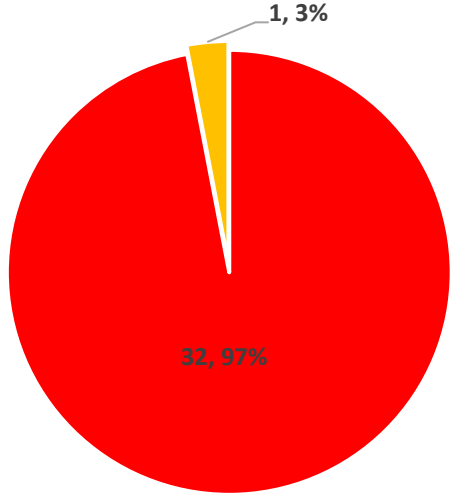
7 Open actions overdue by between 378 and 623 days

Whilst these audits remain on the dashboard as areas of suggested focus, there has been updates provided and some audit recommendations completed and awaiting approval for closure.

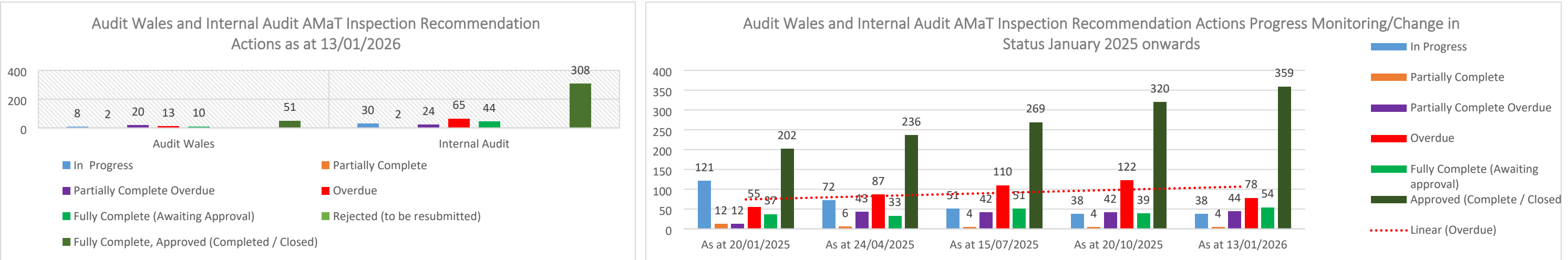
Narrative Commentary – There has been an improvement in the number of updates being provided this period as well as notable increase in the actions updated and marked as fully complete and awaiting approval.

Overdue Limited Assurance Actions – Breakdown by Executive Portfolio

Overdue actions that fall within the portfolio of the Chief Operating Officer	17 (Reduction of 6)
Overdue actions that fall within the portfolio of the Executive Director of Finance	5 (Reduction of 2)
Overdue actions that that are split between the functions under the portfolios of the Medical Director and Executive Director for People	4 (Reduction of 11)
Overdue actions that fall within the portfolio of the Strategy and Transformation	1
Overdue actions that fall within the portfolio of the Executive Medical Director	3

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 November is included as a comparator for the January 2026 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:
November 2025	January 2026	
Overall overdue Audit Wales open Inspection Recommendation Actions by Action priority as at 20/10/2025  ■ High (37) ■ Medium (1) ■ Low (0)	Overall overdue Audit Wales open Inspection Recommendation Actions by Action priority as at 13/01/2026  ■ High (32) ■ Medium (1) ■ Low (0)	Audit Wales/2021/144 - Audit Wales Quality Governance Follow Up Review. 1 open action overdue by 1565 days from original due date Audit Wales/2022/12 - Transformational Leadership Programme Board – Baseline Governance Review. 1 Open action overdue by 1019 days Audit Wales/2024/196 - Follow up review: Temporary Closure of the Ysbyty Cwm Cynon Minor Injuries Unit. 2 open actions overdue by between 958-1019 days
Narrative Commentary - The number of overdue actions exceeding their original due date has remained the same during this reporting period limited progress, Increased focus is required in ensuring that all leads are updating actions regularly and the right leads are assigned.		No updates provided for Audit Wales/2021/144 and Audit Wales/2024/196 for the past 5 reporting periods. Audit Wales/2022/12 - Discussion ongoing with Audit Wales to negotiate closure.

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.

2. Specific Matters for Consideration

- 2.1 This report has been prepared using the agreed, 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 Please note that in Appendix 1, where the "AMaT Progress Status" column shows 'Partially Complete' or 'In progress' – these are still overdue actions from their original planned implementation date, however, they are displaying the latest status from a current review date that is recorded in the AMaT system.
- 2.3 Since AMaT is a live system, please note that the data presented in this report was captured and analysed up to January 13th 2026.
- 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. All reports are presented by the **original due date**. Revised due dates are noted in the narrative.
- 2.5 *Graph 1* shows a direct comparison on the Health Board's position between reporting periods of overdue, Limited Assurance Internal Audit Reports. As evidenced in the graphs, ongoing increased efforts of the teams to provide updates and close overdue actions with an increased focus on the highest priority can be noted.
- 2.6 *Graph 3* on the Internal Audit dashboard bring 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 both performance dashboards indicate those audits of which actions have the longest number of overdue days based on their original implementation

date. Whilst the 3 most overdue audits remain the same this reporting period, there is evidence of ongoing increased effort to address the audits with excessive overdue status.

- 2.7 As can be seen in the table **Overdue Limited Assurance Actions – Breakdown by Executive Portfolio**, there has been a notable reduction in the number of overdue Limited Assurance Actions.
- 2.8 This period there has been increased efforts to meet with teams and increase focus on the original recommendation and action. This has afforded teams the opportunity to acknowledge, identify and cleanse those audit actions which may have been met despite work continuing to make further improvements.
- 2.9 This encouraging effort has seen the number of recommendations proposed for closure this period to reach 54. 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 to track the progress of ongoing Audit Recommendations.
- 2.10 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 **54 total completed actions** proposed for **closure** this period with a further **12 new** actions added across both Audit Wales and Internal Audit.
- 2.11 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.

3. Tracker Updates

- 3.1 **Internal Audit (NWSSP)** - Since the last meeting the following changes and updates are noted:
 - **2 New** Internal Audit Reviews have been added to the Audit Recommendations Tracker including **3** new actions.
 - **12** Internal Audit Reviews have been completed and **44** audit recommendation actions are proposed for **CLOSURE**.
- 3.2 **External Audit (Audit Wales)** Since the last meeting the following changes and updates are noted:
 - **1 New** External Audit Reviews have been added to the Audit Recommendations Tracker with 9 new actions.
 - **1** Audit Wales Reviews have been completed and 10 audit recommendations actions which are proposed for **CLOSURE**.
- 3.3 **Health Inspectorate Wales (HIW)** – The latest position report for HIW was shared at the last Audit, Risk and Assurance Committee on January

20th 2026. Since the last report there has been **2 new** inspections added to AMaT and **43 recommendation actions**. **37** actions were proposed for closure.

4. Key Risks / Matters for Escalation

- 4.1 Continued momentum will be encouraged to highlight and focus on the original recommendation to cleanse overdue actions. When updating an action progress, it is always helpful to refer to the original management action that was agreed as often it can be that the original ask has been completed and the action can close. It is evident that on some occasions there is a tendency to update based on the previous update which can lead to the original action being left open for longer than necessary.
- 4.2 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.

5. Assessment

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



**Environmental Sustainability
Impact (5Rs)**

Impact Assessment

Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** Have you undertaken a Quality Impact Assessment Screening?

Yes: ☐

No: ☒

Outcome:

If no, please include rationale below:

Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** Have you undertaken an Equality Impact Assessment Screening?

Yes: ☐

No: ☒

Outcome:

If no, please include rationale below:

Cyfreithiol / Legal

Yes (Include further detail below)

There may be an adverse effect on the organisation if CTMUHB does not fully implement learning and improvements identified as part of Audit arrangements.

Enw da / Reputational

There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.

Effaith Adnoddau (Pobl /Ariannol) /**Resource Impact** (People / Financial)

There is no direct impact on resources as a result of the activity outlined in this report.

6. Recommendation

- 6.1 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 – CTMUIHB August 2021 (Document reference: 123A2017)	New	01/08/2021	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	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: 2014A2022)	New	01/08/2022	Claire Thompson, Executive Director of Strategy & Transformation	N/A	5	5	
Audit Wales/2021/149	Structured Assessment 2021 – CTMUIHB 2021, October 2021 (Document reference: 1920A2021)	New	01/10/2021	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/2021/18	Structured Assessment 2022 – CTMUIHB 2022, February 2023 (Document reference: 1313A2023)	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/2021/23	Orthopaedic Services in Wales – Tackling the Waiting List Backlog, Report of the Auditor General for Wales, March 2023	New	01/03/2023	Gethin Hughes, Chief Operating Officer	N/A	3	3	
Audit Wales/2024/168	Review of Performance Training 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/2024/196	Follow up review: Temporary Closure of the Ybryd Cwm Cynon Minor Injuries Unit – Cwm Taf Morgannwg University Health Board (Document reference: 438A2024)	New	01/07/2024	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	N/A	1	2	
Audit Wales/2024/205	CONFIDENTIAL Audit of Accounts Report Addendum – CTMUIHB 2023-24, October 2024 (Document reference: 499A2024)	New	01/08/2024	Sally May, Executive Director of Finance	N/A	7	7	
Audit Wales/2024/212	Primary Care Follow Up Review – CTMUIHB 2023-24, November 2024 (Document reference: 460A2024)	New	30/11/2024	Gethin Hughes, Chief Operating Officer	N/A	6	11	
Audit Wales/2024/213	Review of Cost Savings Arrangements – CTMUIHB 2023-24, October 2024 (Document reference: 4542A2024)	New	31/10/2024	Sally May, Executive Director of Finance	N/A	8	8	
Audit Wales/2025/234	Structured Assessment 2024, CTMUIHB 2024, November 2024 (Document reference: 4579A2024)	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 / Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care / Gethin Hughes, Chief Operating Officer / Philip Daniels, Executive Director for Public Health	N/A	13	14	
Audit Wales/2025/271	CONFIDENTIAL Audit of Accounts Report Addendum, CTMUIHB 2024-25, July 2025 (Document reference: 4999A2025)	New	01.07.2025	Sally May, Executive Director of Finance / Gareth Watts, Director of Corporate Governance & Board Secretary	N/A	5	5	
Audit Wales/2025/280	Tackling the Planned Care Challenges, June 2025 (Document reference: 4666A2025)	New	01.08.2025	Gethin Hughes, Chief Operating Officer	N/A	6	9	
Internal Audit/2020/65	Directorate review: Acute Medicine and A&E Directorate, Final Internal Audit Report July 2020 (Review reference: CTMU-2302-23)	New	29/07/2020	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-2308-49b)	New	24/01/2020	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	1	1	
Internal Audit/2022/161	Continuing Health Care and Funded Nursing Care, Final Internal Audit Report February 2022 (Review reference: CTMUIHB-2123-38)	New	14/02/2022	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	1	1	
Internal Audit/2022/167	Radiology Service Review Final Internal Audit Report October 2022 (Review reference: CTMUIHB-2223-60)	New	24/10/2022	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	5	5	
Internal Audit/2022/195	Follow up Medical & Dental Rotating, Final Internal Audit Report June 2022 (Review reference: CTM-2122-31)	New	15/06/2022	Dom Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People	Reasonable Assurance	1	1	
Internal Audit/2021/100	Welsh Risk Pool Claims, Final Internal Audit Report May 2023 (Review reference: CTMUIHB-2223-34)	New	31/05/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	3	3	
Internal Audit/2021/107	Decommissionation, Final Internal Audit Report August 2023 (Review reference: CTMUIHB-2223-25)	New	08/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	5	5	
Internal Audit/2021/113	National Incident Framework, Final Internal Audit Report August 2023 (Review reference: CTMUIHB-2223-65)	New	08/08/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	8	8	
Internal Audit/2021/117	Performance Reporting – Integrated Performance Report, Internal Audit Report July 2023 (Review reference: CTMUIHB-2223-15)	New	28/07/2023	Claire Thompson, Executive Director of Strategy & Transformation / Stuart Morris, Director of Digital	Reasonable Assurance	2	2	
Internal Audit/2021/124	Follow up Concerns, Final Internal Audit Report May 2023 (Review reference: CTM-2123-39)	New	31/05/2023	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	4	4	
Internal Audit/2021/146	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUIHB-2223-11)	New	11/10/2023	Gethin Hughes, Chief Operating Officer	Limited Assurance	8	8	
Internal Audit/2021/148	IT Infrastructure, Final Internal Audit Report October 2023 (Review reference: CTM-2124-19)	New	09/10/2023	Stuart Morris, Director of Digital	Reasonable Assurance	5	5	
Internal Audit/2021/162	4-hour Emergency Department Performance Reporting, Final Internal Audit Report February 2024 (Review reference: CTMUIHB-2324-03)	New	06/02/2024	Gethin Hughes, Chief Operating Officer	Limited Assurance	15	15	
Internal Audit/2021/163	IT Service Management, Final Internal Audit Report February 2024 (Review reference: CTMUIHB-2324-18)	New	08/02/2024	Stuart Morris, Director of Digital	Reasonable Assurance	11	12	
Internal Audit/2021/169	Management of Controlled Drugs, Final Internal Audit Report April 2024 (Review reference: CTMUIHB-2324-06)	New	11/04/2024	Dom Hurford, Executive Medical Director	Reasonable Assurance	17	18	
Internal Audit/2024/170	Cadwin Intellectual Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUIHB-2324-02)	New	12/04/2024	Gethin Hughes, Chief Operating Officer	Limited Assurance	7	7	
Internal Audit/2024/187	Leadership and Management Development Programme Internal Audit Report, June 2024 (Review reference: CTMUIHB-2324-51)	New	06/06/2024	Hywel Daniel, Executive Director for People	Reasonable Assurance	4	7	
Internal Audit/2021/188	Welsh Risk Pool Claims Final Internal Audit Report, June 2024 (Review reference: CTMUIHB-2324-16)	New	11/06/2024	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	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/2024/199	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: CTMUIHB-2324-15)	New	16/09/2024	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	7	8	
Internal Audit/2024/202	Follow up: Reasonable Offer Final Internal Audit Report - October 2024 (Review Reference - CTM-2324-15)	Re-inspection	02/10/2024	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	4	4	
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: CTMUIHB-2425-08)	New	10/12/2024	Dom Hurford, Executive Medical Director / Hywel Daniel, Executive Director for People	Limited Assurance	21	36	
Internal Audit/2024/214	Energy Management 2024/25 (Review Reference CTMUIHB-SSU-2425-19)	New	12/12/2024	Sally May, Executive Director of Finance	Reasonable Assurance	4	4	
Internal Audit/2025/230	Vaccination Policy Implementation, 2024/25 (Review Reference CTM-2425-22)	New	31/01/2025	Philip Daniels, Executive Director of Public Health	Limited Assurance	3	3	
Internal Audit/2025/231	Regional Integration 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/2025/232	Medical Job Planning, 2024/25 (Review Reference: CTM-2425-17)	New	31/01/2025	Dom Hurford, Executive Medical Director	Limited Assurance	3	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: CTMUIHB-2223-17)
Internal Audit/2025/250	Duty of Candour, March 2025 (Review reference: CTMUIHB-2324-10)	New	31/03/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	10	11	
Internal Audit/2025/251	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/2025/252	Service User Experience, 2024/25 (Review reference: CTM-2425-13)	New	09/05/2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Substantial Assurance	1	1	
Internal Audit/2025/253	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/2025/255	New Personal 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/2025/256	Estates Condition, 2023/24 (Review reference: CTM-SSU-2324-02)	New	17/04/2025	Sally May, Executive Director of Finance	Limited Assurance	6	6	
Internal Audit/2025/257	Capital Systems, 2024/25 (Review reference: CTM-SSU-2425-18)	New	12/04/2025	Sally May, Executive Director of Finance	Limited Assurance	7	7	
Internal Audit/2025/258	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/2025/259	Follow up: 4-hour Emergency Department Performance, March 2025 (Review reference: CTM-2425-08)	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: CTMUIHB-2324-03)
Internal Audit/2025/263	Electronic Whiteboards, 2024/25 (Review Reference CTM-2425-11)	New	15.05.2025	Gethin Hughes, Chief Operating Officer	Reasonable Assurance	10	10	
Internal Audit/2025/266	Welsh Risk Pool, 2024/25 (Review reference: CM-2425-14)	New	30.06.2025	Richard Hughes, Interim Executive Director of Nursing, Midwifery & Patient Care	Reasonable Assurance	6	6	
Internal Audit/2025/267	End of Life Care Management, 2024/25 (Review reference: CTM-2425-04)	New	13/06/2025	Gethin Hughes, Chief Operating Officer	Limited Assurance	4	4	
Internal Audit/2025/270	Decarbonisation (Follow Up), 2025/26 (Review reference: CTM-2526-30)	Re-inspection	14.08.2025	Claire Thompson, Executive Director of Strategy & Transformation	Limited Assurance	4	4	Decarbonisation Internal Audit Report, April 2024 (Review reference: CTMUIHB-2324-29)
Internal Audit/2025/278	PCH Financial and Technical, 2024/25 (Review Reference: SSU-CTM-2425-38)	New	08.10.2025	Sally May, Executive Director of Finance	Substantial Assurance	2	2	
Internal Audit/2025/279	Follow-up: Vaccination Policy Implementation, 2025/26, Review reference CTM-2526-29)	Re-inspection	13.11.2025	Philip Daniels, Executive Director of Public Health	Limited Assurance	1	1	Vaccination Policy Implementation, 2024/25 (Review reference: CTM-2425-22)

Audit Recommendations Tracker
AMaT Actions - Status Key

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

Inspection Code	Inspection Date	Inspection Title	Recommendation	Reference Number	Action	Executive Lead	Original Due Date	DAYS OVERDUE (FROM ORIGINAL DUE DATE)	Current / Revised Due Date	Action Rating	AMAoT Progress Status	Comments/Updates
Audit Wales/2021/144	01.08.2021	Audit Wales Quality Governance Follow Up Review - Audit and Risk Committee Update – CTMUHB_August 2021 (Document reference: 12342017)	Audit Wales/HW 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/M03/1	Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings. Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs.	Executive Director of Nursing, Midwifery & Patient Care	01.10.2021	165	31.10.2024	High	Partially complete (Overdue)	April, June, October 2025, January 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2022/12	01.08.2022	Transformational Leadership Programme Board – Baseline Governance Review – CTM Regional Partnership Board 2021-22_August 2022 (Document reference: 293442022)	Transformational Leadership Programme Board – Baseline Governance Review R4 Risk Management Our work found areas of risk management that need to be improved, particularly in relation to regional workforce planning. The TLPB should strengthen regional risk management arrangements by improving the identification and prioritisation of shared risks and ensuring mitigating actions are robust and clearly articulated.	Audit Wales/2022/12/M03/1	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	1019	31.03.2025	High	Partially complete (Overdue)	January 2026 Update - Propose to close: Since this review was undertaken in 2022 there has been significant involvement in terms of regional working an example of which is the approval of the Regional Partnership Agreement for Services and Support for Older People. People Living with Frailty and Their Carers at the Board meeting in July 2023, which captured risk sharing agreements/arrangements. Claire's Team also work closely with Matt Jenkins, Integrated Services Director, CTM Regional Partnership Board, who puts the programme wrap around the regional working. **Pending agreement with Audit Wales colleagues and therefore status currently remains unchanged. We anticipate that with the development of a shared risk register, the approach to risk management of the Regional Integration Fund and the other mechanisms put in place. Since this risk was formed both the Section 31 Agreement and strengthening of regional strategy and governance generally over the last number of years), as well as the forthcoming cycle of regional Population Needs Assessment and Area Plan we will have addressed this recommendation and be able to close this at the next update cycle. December 2025 update - Regional Integration Director reviewing programme governance framework to assess if this meets the recommendation. October 2025 Update - The Regional Partnership Agreement which was developed under developed under Section 33 of the National Health Services (Wales) Act 2006 and Part 9 of the Social Services and Wellbeing (Wales) Act 2014 has been signed off by each of the four statutory organisations over summer 2025.
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cyron 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/M01/1	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	1019	31.01.2025	High	Overdue	January, April, June, October 2025, January 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/196	01.07.2024	Follow up review: Temporary Closure of the Ysbyty Cwm Cyron 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/M01/2	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	958	31.01.2025	High	Overdue	January, April, June, October 2025, January 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2023 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R5 We found opportunities for the Health Board to enhance its arrangements for monitoring the delivery of corporate plans and strategies, and reporting progress to the Board. The Health Board, therefore, should enhance its arrangements by ensuring: a) plans and strategies contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; b) plans and strategies provide greater detail on which Executive Directors are responsible for the delivery of key actions / deliverables to enable appropriate accountability; and c) reports are aligned to performance reports to enable the Board to assess the extent to which the implementation of key actions / deliverables is having a positive impact on Health Board performance.	Audit Wales/2023/18/M06/1	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	928	30.06.2023	High	Partially complete (Overdue)	December 2025 Update - Propose to close as whilst the health board is continuing to evolve its Integrated Performance Report, this will be an live piece of work and the audit actions linked to this recommendation have been completed. **Pending agreement with Audit Wales colleagues and therefore status currently remains unchanged. October 2025 Update - Executive Director of Strategy and Transformation is working with executive colleagues to refresh the integrated performance report.
Audit Wales/2023/18	01.02.2023	Structured Assessment 2022 – CTMUHB 2022_February 2023 (Document reference: 3313A2023)	Structured Assessment 2022 R3 Strengthening performance management arrangements The Health Board has a number of longstanding performance challenges across many areas in both planned care and urgent and emergency care, resulting in it being excluded 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/M03/1	The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. However the Health Board recognises that given the nature of its business and its complexities that this remains a very large report and it can be challenging to identify the most significant issues. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability. Whilst creating opportunities for members to select the "most important indicators" will enable the Board to align measures to strategic priorities etc, the Executive Leads will also draw the Board's attention to areas of concern and/or where performance is comparatively worse than other Health Boards in Wales.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Director of Digital	30.09.2023	836	31.12.2023	High	Partially complete (Overdue)	December 2025 Update - Propose to close as complete - robust structures for reporting performance are established through Operational Management Board and Improving Care Board into committees and Board. Ministerial Objectives and Priorities are now included in Integrated Performance Report (IPR) on the front page. Work to evolve the IPR will continue and will be ongoing process. Key priorities are focused on Ministerial Objectives. **Pending agreement with Audit Wales colleagues and therefore status currently remains unchanged. October 2025 Update - Executive Director of Strategy and Partnerships is working with other executive colleagues to refresh the integrated performance report.
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/M03/1	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 Cyron 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	743	01.01.2024	High	Partially complete (Overdue)	December 2025 Update - A SOP on Management and Preparations for Elective Orthopaedic Surgery' has been developed and signed off by the executive board. This has allowed for increased scrutiny of patients who are not currently 'fit for surgery, or waiting to be deemed fit for surgery, ensuring that there is clear focus on these patients, allowing Health Screening Questionnaires to be sent out at the point of registration and the need for pre assessment appointments. Partially complete with the view to close action following further evidence shared and sign off by DCOO. October 2025 - progress against this action is being made within the care group, no specific update at the moment
Audit Wales/2023/149	01.10.2023	Structured Assessment 2023 – CTMUHB 2023_October 2023 (Document reference: 3920A2023)	Structured Assessment 2023 R6 Performance Management Framework The Health Board has appropriate arrangements in place to manage operational performance; however, it lacks a documented performance management framework. In order to enhance its arrangements further, the Health Board should prepare a written framework that clearly sets out roles, responsibilities, and frequency for reviewing performance at service, management, committee, and Board levels (High Priority).	Audit Wales/2023/149/M06/1	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	712	01.02.2024	High	Partially complete (Overdue)	December 2025 Update - request discussion to close action based on Integrated Performance Report (IPR) established and reporting Welsh Government directions. Standard Operating Procedure in place for producing IPR information. Exec responsibilities are clear. Draft performance framework exists and is being followed. Linked to Strategy Deployment Framework (approval to be sought in Q4). October 2025 Update - work is underway on a Strategy Deployment Framework which will include the health board's approach to performance.
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/M04/1	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 CO for performance and governance structure across CTMUHB. • 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.	Chief Operating Officer	01.04.2024	652	01.04.2024	High	Partially complete (Overdue)	December 2025 Update - PROMS and PREMS discussed with the value based healthcare team and are a priority to role out this in orthopaedics. Date to be confirmed. further updates for the full actions to be provided at next rotation. Further evidence and updates to be provided and pending DCOO sign off for closure. October 2025 Update - No further update around the introduction of PROMS/PREMS, weekly performance meetings ongoing, with funding now allocated for a validation team to support the waiting list teams until the end of the financial year. Development and roll out of an "Orthopaedic Optimisation" pathway will ensure that only patients who are fit for surgery are on an active waiting list.
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/M02/1	• 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. HEIW People analytics tools and dashboards/NHS England and wider sources 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 NDS/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 for People	01.05.2024	622	31.03.2025	High	Partially complete (Overdue)	December 2025 Update - Annual budget setting with Care Groups in place with alignment to Head of People. Establishment reporting in place for Medical and Dental staff group which is being rolled out to other areas. Working with HEIW on establishment reporting to enable HEIW to utilise methodology. Working nationally on processes for establishment control Community of Practice to progress. Dates on options to be confirmed. October 2025 Update - M&B establishment reporting (with CG and Finance) is now in place. Nursing and Midwifery establishment reporting is planned to commence from 1 November 2025 with support from a temporary HEIW funded post.
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/M06/1	• 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. HEIW People analytics tools and dashboards/NHS England and wider sources 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 NDS/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 for People	01.10.2024	469	31.03.2025	Medium	Partially complete (Overdue)	December 2025 Update - A horizon scan document has been developed. This is being shared with key stakeholders for comment on content, ease of use and value during January 2026. The document will include census analysis, population needs assessment, evidence based practice, benchmarking information, case studies and lessons learned, changes to policy, standards, education and training, new roles, advanced and extended practice, labour market changes and generational/demographic changes, where possible and information is available. We will continue to build and update at regular intervals.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 6 - The Health Board should review its current data admin accounts and remove any access from staff who do not need it. This action should include the removal of any duplicate accounts. Also, the Health Board should regularly review (i.e. monthly) its privileged access accounts so that access is maintained only for the appropriate personnel.	Audit Wales/2024/205/M06/1	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 NDS/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	410	29.11.2024	High	Partially complete (Overdue)	January 2026 Update - Work is being carried to review generic system and service accounts including privileged access accounts which will give us a documented approach for active accounts and be the baseline for review going forward. This will be fed into the Cyber Security & Availability Board. November 2025 Update - Accounts Addendum Review Report for 2024-2025 states "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. Update agreed with Executive Director of Finance when signing off the return for the 2024-2025 Accounts Addendum report.
Audit Wales/2024/205	01.08.2024	CONFIDENTIAL Audit of Accounts Report Addendum - CTMUHB 2023-24_October 2024 (Document reference: 4395A2024)	Matter arising 7 - The Health Board should migrate its RAA financial server system to up-to-date and fully supported infrastructure.	Audit Wales/2024/205/M07/1	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	410	29.11.2024	High	Overdue	January 2026 Update - The audit action has now been transferred to Digital. Digital will take ownership of organising the migration. Conversations and planning will commence. January, April, June, October 2025 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R1 - 2024 New Recommendation - The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer term by improving the coverage of primary care matters in its routine Annual Report.	Audit Wales/2024/212/M01/1	A Primary Care Dashboard will be finalised by end of January 2025.	Chief Operating Officer	31.01.2025	347	31.01.2025	High	Partially complete (Overdue)	January 2026 Update - Regular reports on Primary Care Transformation Programme as well as other key strategic changes are scheduled for Board. Moved to partially complete pending sign off by DCOO. October 2025 Update - Primary Care – no updates at this time.
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/M03/1	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	347	31.01.2025	High	Partially complete (Overdue)	January 2026 Update - A baseline of Primary and Community Care expenditure has been completed and shared at Primary Care Transformation Board and will inform the Strategic Clinical Services Plan. Moved to partially complete pending evidence of baseline expenditure and sign off by DCOO. October 2025 Update - No update at this time to provide.
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/M03/2	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	288	31.03.2025	High	Partially complete (Overdue)	January 2026 Update - A baseline of Primary and Community Care expenditure has been completed and shared at Primary Care Transformation Board and will inform the Strategic Clinical Services Plan. Moved to partially complete pending evidence and sign off by DCOO October 2025 Update - No update at this time to provide.

Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R4- 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	Audit Wales/2024/212/M05/1	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	288	31.03.2025	High	Partially complete (Overdue)	January 2026 Update - Partly complete. Action a & b - Single evaluation form has been introduced for clusters to use. A process for considering cluster initiatives is due to be finalised in January 2026. The other actions are still work in progress as part of the wider Transformation Programme. Action d - The single communications officer post was evaluated and not felt to be good value for money. Instead funding is being made available to the central communications team to add additional resources into the team. This will give resilience. October 2025 Update - No update at this time to provide.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R4- 2018 Open Recommendation - Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a) work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b) centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	Audit Wales/2024/212/M05/4	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	288	31.03.2025	High	Partially complete (Overdue)	January 2026 Update - requires further review of actions and proposed closure following April 2025 update, update to be provided ahead of the next Committee. October 2025 Update - No update at this time to provide.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R5- 2018 Open Recommendation - We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. The Health Board should: a) review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	Audit Wales/2024/212/M06/1	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	288	31.03.2025	High	Overdue	January 2026 Update - still remains as work in progress. To be reviewed ahead of next update to demonstrate progress. October 2025 Update - No update at this time to provide.
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/M02/1	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 GIBRE 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, Midwifery & Patient Care	31.03.2025	288	31.03.2025	High	Overdue	June, October 2025, January 2026 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)	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/M04/1	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	31.03.2025	288	31.03.2025	High	Partially complete (Overdue)	December 2025 Update - Propose to close. The revised committee structure supports a robust approach for reporting on the 'CTM2030: Building Healthier Communities Together' strategy with that being a focus of the Strategic Development Committee. The IMFR delivery is also a routine focus at the Operational Delivery Committee. **Pending agreement with Audit Wales colleagues and therefore status currently remains unchanged. October 2025 Update - the Executive Director of Strategy and Transformation is working in conjunction with other executive members to refresh the Integrated Performance Report.
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/M011/1	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 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 Delivery Committee (ODC) with clear timelines and performance metrics.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Executive Director of Nursing, Midwifery & Patient Care	30.04.2025	258	30.04.2025	High	Partially complete (Overdue)	December 2025 Update - Propose to close. The revised committee structure supports a robust approach for monitoring 'CTM2030: Building Healthier Communities Together' strategy with being a key focus of the Strategic Delivery Committee. The IMFR delivery is also a routine focus at the Operational Delivery Committee. **Pending agreement with Audit Wales colleagues and therefore status currently remains unchanged. October 2025 Update - all three components of CTM2030 report into the Strategic Development Committee. Integrated community and primary care programme reports into Operational Delivery Committee.
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/M05/1	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, Midwifery & Patient Care	31.05.2025	227	31.05.2025	High	Overdue	June, October 2025, January 2026 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)	R5.2 including appropriate milestones and targets to help the reader understand when it is aiming to achieve priorities.	Audit Wales/2025/234/M06/1	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	31.05.2025	227	31.05.2025	High	Overdue	June, October 2025, January 2026 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/M012/1	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 & Transformation Executive Director of Nursing, Midwifery & Patient Care	30.06.2025	197	30.06.2025	High	Overdue	June, October 2025, January 2026 Update - An update against this recommendation has not been provided on these occasions.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R3- 2018 Open Recommendation - The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry, and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	Audit Wales/2024/212/M04/1	R3 - The Health Board has a Primary Care Academy in place and workforce planning will be an essential remit for this. This will be an objective for 2025/26 onwards.	Chief Operating Officer	31.07.2025	166	31.07.2025	High	Overdue	January 2026 Update - Through the Training Academy work has commenced to pull together a workforce but it is not yet finalised. October 2025 Update - No update at this time to provide.
Audit Wales/2025/234	23.01.2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	R8 - The Health Board should develop and report on population outcome measures to demonstrate the impact of its strategy delivery.	Audit Wales/2025/234/M010/1	R8 - As part of the work overseen by the Creating Health Programme Board, the development of a data dashboard to monitor and report on population outcome measures is underway. To make this reporting meaningful however, both strategic and operational data sets will need to be developed using data from a number of different internal and external resources.	Director of Corporate Governance & Board Secretary Executive Director of Finance	31.07.2025	166	31.07.2025	High	Overdue	January 2026 Update - An update against this recommendation has not been provided on this occasion. October 2025 Update (17/10/25) - A proposed reporting framework has been presented to the Creating Health Programme Board on 16.10.25. Approval of this will be finalised by the end of October and implemented. Details of this will follow.
Audit Wales/2025/280	01.06.2025	Tackling the Planned Care Challenges_June 2025 (Document reference: 4666A2025)	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 specialities to assess the risk of, or actual harm, to patients caused by long waits. 6.2 Report the risks and actual incidence of harm resulting from delays in access to treatment to the Quality, Safety and Experience Committee.	Audit Wales/2025/280/M06/1	6.1 - DATIX process followed and investigated, and action taken accordingly. Incidents on DATIX are reviewed and presented monthly at Care Group Quality, Safety and Experience Committee. 6.2 - Reviewed via Planned care Quality, Safety and Experience Committee and escalated as appropriate.	Chief Operating Officer	31.08.2025	135	31.08.2025	High	Partially complete (Overdue)	December 2025 Update - All recommendations now in place. Will progress to fully complete on receipt of evidence to COO business team for sign off by DCOO and closure.
Audit Wales/2024/212	30.11.2024	Primary Care Follow-Up Review - CTMUHB 2023-24_November 2024 (Document reference: 4606A2024)	R1- 2024 New Recommendation - The Health Board should support Board members to form a strategic view on the overall effectiveness and efficiency of primary care services and whether the organisation's actions in this area are improving the sustainability of services in the longer term by improving the coverage of primary care matters in its routine Annual Report.	Audit Wales/2024/212/M01/2	The requirement to expand the coverage of primary care matters in CTMUHB Annual Report for 2024-2025 and beyond has been captured in the forward planning for the Annual Report development.	Chief Operating Officer	30.09.2025	105	30.09.2025	High	Partially complete (Overdue)	January 2026 Update - Regular reports on Primary Care Transformation Programme as well as other key strategic changes are scheduled for Board. Primary Care Transformation Board, chaired by the CEO, is an established transformation Board, providing regular strategic oversight and monitoring. This board enables regular updates and monitoring, helping board members to strategically assess primary care service effectiveness and sustainability, and ensure these areas are addressed in the organisation's Annual Report. Proposed for closure pending DCOO sign off. October 2025 Update - No update to provide at this time.
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/M011/2	R9.2 - Acute Clinical Services Plan - the detail of this will be developed over the next 18 months through a process of systematic public engagement.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Executive Director of Nursing, Midwifery & Patient Care	30.09.2025	105	30.09.2025	High	Overdue	December 2025 Update - Work continues on the 5 year 'do nothing' scenario to support this work. October 2025 Update - There has been an evolution in the remit of this work, from Acute Clinical Services Plan to Strategic Clinical Services Plan to recognise the breadth of the programme. Work is also underway on the sustainability review which sets out the 'do nothing' and case for change.
Audit Wales/2025/280	01.06.2025	Tackling the Planned Care Challenges_June 2025 (Document reference: 4666A2025)	Monitoring impact of additional funding R3. The Health Board should strengthen its reporting on the impact of the additional Welsh Government planned care funding.	Audit Wales/2025/280/M03/1	Planned care recovery funding tracked monthly. Detailed by intervention, proposed funding and activity and this is then tracked monthly against actual activity and spend. Submission to WG is made monthly.	Chief Operating Officer	31.10.2025	74	31.10.2025	High	Partially complete (Overdue)	December 2025 Update - Above actions now in place, propose closure following evidence of WG submissions as evidence of strengthened reporting and sign off by DCOO.
Audit Wales/2025/234	23.01.2025	Structured Assessment 2024_CTMUHB 2024_November 2024 (Document reference: 4579A2024)	R1 - The Health Board Should Strengthen arrangements for monitoring, reviewing and updating Health Board policies and routinely report progress to the relevant Committee of the Board	Audit Wales/2025/234/M01/1	R1 - A detailed Project Initiation Document for a review of Non-Clinical Policy Management process has been developed. The project objectives are: 1. To establish a baseline compliance position for Non-Clinical Written Control Documents 2. To ensure that Non-Clinical Written Control Documents are appropriately defined (i.e. policy, procedure, guideline etc. 3. To explore an automated approach for the management of Written Control Documents to support monitoring, review prompts, version control and document storage. 4. To review the policy states on the internal and external websites to ensure ease of access for users where applicable for documents. R7 - The wellbeing objectives are currently embedded throughout the CTM 2030 strategy as cross cutting themes in each programme. However we acknowledge that it would be beneficial to clearly set these out separately.	Director of Corporate Governance & Board Secretary Executive Director of Finance Executive Director of Strategy & Transformation Director of Corporate Governance & Board Secretary	31.12.2025	13	31.12.2025	High	Overdue	January 2026 Update - An update against this recommendation has not been provided on this occasion. October 2025 Update - The project to review the non-clinical policies is underway in compliance with the objectives set out in the Project Initiation Document with an update being received at the Executive Management Board on the 29th September. The revised 'Policy on Policies' is currently out for consultation and now provides a more simplified policy and process to follow. The new master library is in development and the new system for monitoring is established as a structure but not yet being populated. The front facing policy page for staff has been designed and ready for population. The declassification of documents from the archive SharePoint site is underway but has required a significant amount of resource time and therefore the impact on the original timeframe of the 31st June, October 2025, January 2026 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)	R7 - The Health Board should set out how each individual well-being objective aligns to the national well-being objectives and well-being objectives of its partners.	Audit Wales/2025/234/M09/1	In order to demonstrate how the wellbeing objectives map across to the national objectives and those of our partners, a task and finish group will be established in March to develop this work. A report will be produced that sets out our wellbeing objectives and our progress against them, from which we can monitor progress annually. This will be reflected in a written output which will allow stakeholders to access current information.	Executive Director of Finance Executive Director of Strategy & Transformation	31.12.2025	13	31.12.2025	High	Overdue	

Inspection Code	Inspection Date	Inspection Title	Overall Assurance Rating	Recommendation	Reference Number	Action	Executive Lead	Original Due Date	DAYS OVERDUE (FROM ORIGINAL DUE DATE)	Current / Revised Due Date	Action Rating	AMAT Progress Status	Comments/Updates
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	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 details 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/M04/1	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	563	01.03.2024	High	Overdue	December 2025 Update - Following implementation of the policy the care groups will establish an appropriate reporting mechanism, including appropriate governance and audits ensuring that the policy is being adhered to. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	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/M06/1	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	683	01.03.2024	Medium	Overdue	December 2025 Update - A data work stream will be established post policy sign off. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	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/M07/1	Daily report to be added to the performance runs with formal monthly reporting via Planning Performance and Finance.	Chief Operating Officer	01.03.2024	683	01.03.2024	Medium	Overdue	December 2025 Update - Following a policy implementation and subsequent SOP a reporting mechanism will be established to monitor compliance. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	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/M08/1	Review and update of waiting list 'holding names' to be undertaken	Chief Operating Officer	01.03.2024	683	01.03.2024	Low	Overdue	December 2025 Update - This will require further consideration following the implementation of the policy. All patients that are deemed INNU will need agreement through the IPR (individual patient funding requests) process. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	Interventions Not Normally Undertaken 1.2 A Standard Operating Procedure in relation to INNUs should be developed to provide guidance on consistent application of the INNU policy.	Internal Audit/2023/146/M02/1	Standard Operating Procedure to be developed as part of the working group and provided to all service groups.	Chief Operating Officer	01.01.2024	743	01.01.2024	High	Overdue	December 2025 Update - A SOP will be as part of the overarching policy and will be developed by the Medical Directorate office and circulated for implementation. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	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 WHSC 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/M03/1	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	743	01.01.2024	High	Overdue	December 2025 Update - Following implementation of the SOP and policy, care groups will have the required measures and criteria to ensure appropriate monitoring and record keeping through RTT monitoring. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	Interventions not Normally Undertaken 1.3 The policy, and an associated SOP, should provide greater clarity on whether the IPR process can be used for those interventions that are listed as 'Do Not Do' and the relevant process to follow.	Internal Audit/2023/146/M05/1	Application of the above actions	Chief Operating Officer	01.01.2024	743	01.01.2024	Medium	Overdue	December 2025 Update - Following implementation of the appropriate policy there will be a review of this compliance. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2023/146	11.10.2023	Interventions Not Normally Undertaken (INNU), Final Internal Audit Report October 2023 (Review reference: CTMUHB-2223-11)	Limited Assurance	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/M01/1	CTMUHB Policy updated and circulated through service groups. Training will be carried out where required across service groups.	Chief Operating Officer	01.09.2023	865	01.09.2023	High	Overdue	December 2025 Update - Currently waiting Medical Directorate office to update the policy, which will then be shared and implemented across CTMUHB. October 2025 Update - Work is in progress on this and is currently being developed between the MD office and CDO office. Process will follow the national guidance provided.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting, Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	Limited Assurance	2.12aP 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/M03/1	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	591	01.06.2024	High	Partially complete (Overdue)	December 2025 Update - CAS Cards have been implemented and communicated to teams. These have been standardised through digital engagement with leads. Minutes can be viewed as evidence upon request. moved to partially complete, awaiting confirmation of safety briefings as evidence noting cas cards importance. October 2025 Update - The care group have worked at pace and continue to complete actions and improvements across the care group. Therefore, CDO Business Manager agreed with service director to review actions and improvements that have taken place over the previous 6 months to align to audit actions and share an update and any relevant evidence for the next audit updates to committee.
Internal Audit/2024/162	06.02.2024	4-hour Emergency Department Performance Reporting, Final Internal Audit Report February 2024 (Review reference: CTMUHB-2324-03)	Limited Assurance	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/M06/1	Ensure standardised approach to training across all ED, monitor through Directorate Performance Meetings.	Chief Operating Officer	01.06.2024	591	01.06.2024	High	Partially complete (Overdue)	December 2025 Update - Standardised training has been developed and rolled out, with ongoing training refreshers that will be picked up by the team. Evidence of training can be provided upon request. October 2025 Update - The care group have worked at pace and continue to complete actions and improvements across the care group. Therefore, CDO Business Manager agreed with service director to review actions and improvements that have taken place over the previous 6 months to align to audit actions and share an update and any relevant evidence for the next audit updates to committee.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	Limited Assurance	5. There should be a consistent approach to reviewing and monitoring referral and demand activity across the Gastroenterology and Colorectal (C) services. This could be supported further by the use of the Medical Records reports that outline delayed and unvetted referrals. Regular reporting at a Care Group level should take place to enable management to effectively review and understand the efficiency of referral throughput and assist with the planning of services. Consideration should be given to other ways in which the data currently collected can be used to identify potential issues in processes and inform decision making to improve service delivery.	Internal Audit/2024/170/M07/1	1. Inbed new CTM leadership structure. 2. Continue to work with our informatics teams to build purpose dashboards that support DMC and monitoring of productivity and efficiencies.	Chief Operating Officer	31.12.2024	378	31.03.2025	Medium	Overdue	December 2025 Update - Draft Endoscopy dashboard has been prepared. GI senior team is working with CTM informatics teams to refine the dashboard before full scale implementation October 2025 Update - New GSG Directorate Management structure has now been embedded. From an endoscopy perspective a new service manager is in post with extensive restructuring resulting in 2 dedicated deputy service managers, with one of each covering gastroenterology and endoscopy. From a medical leadership perspective, 2 deputy clinical directors have been appointed for surgery and we are in the process of appointing a new deputy clinical director for gastroenterology and endoscopy with further changes to the medical leadership structure for gastroenterology and endoscopy forthcoming. Extensive DMC modelling has been undertaken for endoscopy and gastroenterology alongside the chief information officer and head of planning. The new management team have developed close working relationships with informatics and the development of a new endoscopy dashboard to support in monitoring of productivity and efficiencies is ongoing with the head of informatics. Efficiencies are reported on a care group level within the weekly RTT meeting, the weekly cancer performance meeting as well as quarterly operational assurance meetings. An informatics task and finish group is also in place for endoscopy and gastroenterology services to explore ways in which data is collected and to drive further optimisation.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	Limited Assurance	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/M04/1	1. Complete and roll out new CTM LGI SOP. 2. Produce referral and setting process in line with SOP.	Chief Operating Officer	30.09.2024	470	31.03.2025	Medium	Partially complete (Overdue)	December 2025 Update - This has now gone live pan CTM WCP will be evidence for this as an electronic data base. Proposed for closure following sign off by DCOO. October 2025 Update - Work ongoing regarding referral and vetting processes.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	Limited Assurance	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 reviewed 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/M05/1	1. Understand go live date for E Refs for LGI/Surgery. 2. Link in with Records/Digital team.	Chief Operating Officer	30.09.2024	470	31.03.2025	Medium	Partially complete (Overdue)	December 2025 Update - Now gone live Pan CTM. Electronic referral process will capture the recommendation requirements. Proposed for closure following evidence of reminders to clinicians of importance of signing triage forms once complete and sign off by DCOO. October 2025 Update - Go live date to be confirmed in line with ongoing work.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	Limited Assurance	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 (C) Pathway GP Referral Trigger 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 referral, the triage and triage process and timeframes for undertaking the various stages in the process. The draft SOP should be agreed at an appropriate level within the Health Board. Where there are variations in service delivery, such as the Nurse Led Rapid Access One Stop Colorectal Clinic based at PCH, then a separate SOP should be formalised for use.	Internal Audit/2024/170/M01/1	A CTM Standardised LGI SOP to be developed, reviewed and agreed.	Chief Operating Officer	30.06.2024	562	31.03.2025	High	Partially complete (Overdue)	December 2025 Update - SOP has been developed and will be ratified through the Gastro and Surgical business meetings Feb/March 2026. Final SOP can be shared following sign off. Possible for closure ahead of the next update on receipt of the evidence and sign off by DCOO. October 2025 Update - Work is ongoing in regard to the CTM standardised LGI SOP.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	Limited Assurance	1.2 Specific guidance should be developed and made available in relation to: • GP's 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/M02/1	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	562	31.03.2025	Medium	Partially complete (Overdue)	December 2025 Update - SOP has been developed and will be ratified through the Gastro and Surgical business meetings Feb/March 2026. Proposed closure following next update on receipt of evidence and sign off by DCOO. October 2025 Update - Work will commence in line with the CTM Standardised SOP no further updates for now.
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-24/25-03)	Limited Assurance	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/M06/1	1. To become part of the GI Directorate agenda - date of first meeting to be confirmed. 2. Replicate endoscopy peer review in line with JAG guidelines.	Chief Operating Officer	30.06.2024	562	31.03.2025	High	Overdue	December 2025 Update - Endoscopy services continue to undertake ad hoc reviews of endoscopy referral vetting, with oversight from the Clinical Director or Deputy Clinical Director (with responsibility for Endoscopy). Corrective action is undertaken as required, with feedback provided to the individual undertaking the vetting. Standardisation of vetting using a pan CTM approach in line with JAG guidelines continues as part of the broader work programme, driven by the vetting task and finish group with Consultant representation from across Gastrointestinal and General Surgery divisions. As of 2025, this will become a standing item on the pan CTM Endoscopy User Group agenda and feedback will be provided via formal fora such as the Consultant Business Meeting. October 2025 Update - Work is currently ongoing as part of a broader programme within endoscopy. There is a vetting task and finish group in place for endoscopy. Peer review quality assurance exercises in the broader sense are planned up during monthly gastro consultant business meetings, as well as during the newly established pan CTM endoscopy user group (with clinical leads, nursing unit managers and the gastro/endo leadership team in attendance).
Internal Audit/2024/170	12.04.2024	Gastro-Intestinal Pathways – Demand Management, Final Internal Audit Report April 2024 (Review reference: CTMUHB-2324-02)	Limited Assurance	2. Work should continue to explore the feasibility of integrating the WPMS 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 LGI/Surgery 2. Set up meeting with Records and Digital Team	Chief Operating Officer	30.04.2024	623	31.03.2025	Medium	Partially complete (Overdue)	December 2025 Update - Electronic referrals have already gone live within Colorectal pan CTM. Referrals are all on WCP. Proposed for closure following sign off by DCOO. October 2025 Update - Go live date to be confirmed in line with ongoing work.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-08)	Limited Assurance	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/M02/1	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	288	31.03.2025	Medium	Partially complete (Overdue)	December 2025 Update - The FCP and SOP have been revised to take account of the new provider (Locum's Nest). Although not formally launched, training has been given to clinical directorate staff on the use of the Locum's Nest system. Once the FCP and SOP are formally agreed, they will be made accessible on the M&D intranet pages with training provided. October 2025 Update - The FCP and SOP have been revised to take account of the new provider (Locum's Nest) which is only for a six month period. Although not formally launched, training has been given to clinical directorate staff on the use of the Locum's Nest system. Once the FCP and SOP are formally agreed, they will be made accessible on the M&D intranet pages with training provided. However, a tender is about to be issued for a new provider - and this will be a different service model, and will require a further revision of the FCP and SOP to reflect this. M&D Agency moved onto Locum's Nest in September 2025. AHP and HSS agency supply is not managed as the Locum's Nest contract but an interim manual process in the Staff Bank.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-08)	Limited Assurance	1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedures. 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 / 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/M01/2	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	319	28.02.2025	High	Partially complete (Overdue)	December 2025 Update - The SOP will be sent out for wider consultation along with the FCP before the end of December 2025. October 2025 - The SOP has been revised to take account of the new provider (Locum's Nest) which was introduced for a temporary period whilst a longer term solution is sought. This FCP covers Bank, WUs and Agency. This SOP takes into account all Audit recommendations. The tender for a new provider will be launched in October. This tender will seek a managed service provider and therefore a different model to the temporary arrangement, so a further updated SOP will be developed.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-08)	Limited Assurance	1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedures. 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 / 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/M01/3	Controls will be reviewed with Retinue to align to the FCP and SOP.	Executive Medical Director Executive Director for People	28.02.2025	319	28.02.2025	High	Partially complete (Overdue)	December 2025 Update - The FCP and SOP have been revised to take account of the new provider (Locum's Nest). They are being sent out for wider consultation before the end of December 2025. October 2025 Update - The FCP and SOP have been revised to take account of the new provider (Locum's Nest) which is only for a six month period. However, a tender is about to be issued for a new provider - and this will be a different service model, and will require a further revision of the FCP and SOP to reflect this. M&D Agency moved onto Locum's Nest in September 2025. AHP and HSS agency supply is not managed via the Locum's Nest contract but an interim manual process in the Staff Bank.
Internal Audit/2024/211	10.12.2024	Additional Medical Pay – Additional Duty Hours & Waiting List Initiatives, December 2024 (Review reference: CTMUHB-24/25-08)	Limited Assurance	1.1 An updated Standard Operating Procedure (SOP) should be developed, setting out a consistent approach to the application of the Financial Control Procedures. 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 / 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/M01/1	The FCP will be updated to reflect the changes in the audit.	Executive Medical Director Executive Director for People	31.01.2025	347	28.02.2025	High	Partially complete (Overdue)	December 2025 Update - Further update - The FCP has been revised to take account of the new provider (Locum's Nest) which was introduced for a temporary period whilst a longer term solution is sought. This FCP will be submitted to Audit Committee for approval in December 2025. This FCP covers Bank, WUs and Agency. This FCP takes into account all Audit recommendations. The tender for a new provider will be launched in October. This tender will seek a managed service provider and therefore a different model to the temporary arrangement, so a further updated FCP will be developed.
Internal Audit/2025/232	11.01.2025	Medical Job Planning, 2024/25 (Review reference: CTM-3425-17)	Limited Assurance	1. Lack of personal & service outcomes. The e-job planning system enables personal outcomes to be linked to service outcomes. We tested a sample of 32 fully signed off job plans: • 17/32 job plans had no personal outcomes relating to SPA activity recorded. • 67/32 job plans had service outcomes recorded. We also noted that 4/32 job plans contained little or no detail in relation to the SPA activity to be undertaken.	Internal Audit/2025/232/M01/1	To ensure all job plans record personal and service outcomes that are linked.	Executive Medical Director	30.09.2025	105	30.09.2025	High	Overdue	December 2025 Update - Progress was noted at the December UNC and it is likely that agreement is going to be reached early in the new year. October 2025 Update - The revision of the SPA guidance is still being discussed with the UNC.

Internal Audit/2025/232	31.01.2025	Medical Job Planning_2024/25 (Review reference: CTM-2425-17)	Limited Assurance	2. Creation and annual review of job plans The national and Health Board job planning guidance requires the annual job planning review to be undertaken 'in good time' but does not specify a timescale by which a job plan must be completed for new starters. To meet WG targets, the Health Board has aimed to complete 60% of job plans by August 2024, and 85% by December 2024. Our analysis of the data, based on 'job plan start date' recorded in Allocate, has shown that of the 680 consultants and SAS doctors: • 204 (30%) had a signed off job plan that started within the last year, so the targets have not been achieved. • 171 (25%) had a signed off, but out of date job plan, some of which date back to 2019. • 21% were at discussion, appeal, sign off or lockdown stage. • 24% have never had a signed off plan. Our analysis of the 171 job plans that were out of date identified 10 that were last agreed before 2021, 22 signed off in 2021, and 75 in 2022.	Internal Audit/2025/232/M02/3	• Arrange job plan review meeting with consultant / SAS doctor to review and facilitate sign-off of rolled forward job plan.	Executive Medical Director	30.09.2025	105	30.09.2025	High	Overdue	December 2025 Update - The figures for signed off job plans has increased to 44%.
Internal Audit/2025/232	31.01.2025	Medical Job Planning_2024/25 (Review reference: CTM-2425-17)	Limited Assurance	2. Creation and annual review of job plans The national and Health Board job planning guidance requires the annual job planning review to be undertaken 'in good time' but does not specify a timescale by which a job plan must be completed for new starters. To meet WG targets, the Health Board has aimed to complete 60% of job plans by August 2024, and 85% by December 2024. Our analysis of the data, based on 'job plan start date' recorded in Allocate, has shown that of the 680 consultants and SAS doctors: • 204 (30%) had a signed off job plan that started within the last year, so the targets have not been achieved. • 171 (25%) had a signed off, but out of date job plan, some of which date back to 2019. • 21% were at discussion, appeal, sign off or lockdown stage. • 24% have never had a signed off plan. Our analysis of the 171 job plans that were out of date identified 10 that were last agreed before 2021, 22 signed off in 2021, and 75 in 2022.	Internal Audit/2025/232/M02/1	• To agree and update guidance with a timescale for completing job plans for new starters.	Executive Medical Director	30.06.2025	197	30.06.2025	High	Overdue	December 2025 Update - No further updates.
Internal Audit/2025/257	12.04.2025	Capital Systems_2024/25 (Review reference: CTM - SSU-2425-18)	Limited Assurance	1. Capital Procedures The Health Board adopted a project checklist to standardise the approach to managing capital projects, but the audit observed incomplete forms and inconsistent compliance. Noting that the checklist did not provide <i>proforma</i> for all aspects, variability in substantive information was also observed. Increased provision of <i>proforma</i> documents would further enhance standardisation (key items have been separately reported). Additionally, arrangements could be improved via the introduction of complementary capital procedures to outline expectations, such as predefined requirements for project initiation documents and risk registers based on value or other metrics, rather than case-by-case decisions. Accessibility to project information was hindered by workforce pressures and absences. Implementing a standardised, centralised file structure should ensure information is easily accessible, supporting continuity and efficiency in project management.	Internal Audit/2025/257/M04/1	The project checklist will be reviewed and incorporated into a wider capital procedure document.	Executive Director of Finance	31.08.2025	135	28.02.2026	Medium	Partially complete	December 2025 Update - Extension agreed with DoF to February completion (via January ECMG)
Internal Audit/2025/257	12.04.2025	Capital Systems_2024/25 (Review reference: CTM - SSU-2425-18)	Limited Assurance	4. Financial Vetting Financial vetting of contractors, even for small construction projects in the public sector, is essential to ensure the project's success and safeguard public resources. Vetting helps confirm that contractors have the financial stability to complete the project without delays caused by insolvency or cash flow issues. From our sample of 8 projects, we identified an absence of retained financial vetting on 3 projects and reliance was placed on using frameworks for the remaining 6 projects. Management should establish clear guidelines that supports the following: • Minimum financial criteria contractors must meet. • Situations where reliance on external frameworks is acceptable. • Documentation requirements for retained financial vetting.	Internal Audit/2025/257/M04/1	To define an agree the level of financial vetting and incorporate this requirement into capital procedures.	Executive Director of Finance	31.08.2025	135	28.02.2026	Medium	In progress	December 2025 Update - Extension agreed with DoF to February completion (via January ECMG)
Internal Audit/2025/257	12.04.2025	Capital Systems_2024/25 (Review reference: CTM - SSU-2425-18)	Limited Assurance	5. Technical Vetting Ensuring that contractors retain appropriate insurances (including public liability insurance) is not just about protecting the Health Board it is about safeguarding the public, minimising risk, and ensuring responsible use of public funds while upholding legal and ethical standards. From our sample of 9 projects we identified that insurances were not fully evidenced on 2 projects and reliance was placed on using frameworks for 4 projects. Management should establish clear guidelines that supports the following: • Minimum insurance coverage amounts based on project size and risk. • Frequency of insurance validation (e.g., annually). • Frameworks to provide evidence of insurance checks for all engaged contractors.	Internal Audit/2025/257/M05/1	Reminders to be issued to ensure that appropriate insurances are maintained/evidenced prior to works commencing. These requirements will also be included within the Capital procedures	Executive Director of Finance	31.08.2025	135	28.02.2026	Medium	In progress	December 2025 Update - Extension agreed with DoF to February completion (via January ECMG)
Internal Audit/2025/257	12.04.2025	Capital Systems_2024/25 (Review reference: CTM - SSU-2425-18)	Limited Assurance	6. Contract Strategy Procurement and contract thresholds are set out in the Health Board Standard Financial Instruction (11.11) as detailed below: [table removed for AMAT purposes] From the sample of nine projects over £25,000, purchase orders were in place for all but lacked formal contracts for contractors in 4 cases. Of these, 1 had a Service Level Agreement with a framework provider, 1 had an unsigned installation Quality Plan, and two had no measures, having been deemed straightforward projects. Approval to wire from SF1 requirements was not evidenced. To address this gap, a contract strategy should be developed at the start of each project to ensure appropriate safeguards and improve compliance with 10%.	Internal Audit/2025/257/M06/1	Incorporate contract strategy requirements into capital procedures.	Executive Director of Finance	31.08.2025	135	28.02.2026	High	In progress	December 2025 Update - Extension agreed with DoF to February completion (via January ECMG)
Internal Audit/2025/257	12.04.2025	Capital Systems_2024/25 (Review reference: CTM - SSU-2425-18)	Limited Assurance	7. Internal Approval As outlined within the All Wales Procure to Pay e-Manual, the approval and award sections state: "Obtaining internal ratification of the outcome of a competition process from the Project Team or Board is a separate and prior step to requesting approval to award a contract, in line with the organisation's Scheme of Delegation." From our audit sample of 9 projects, two lacked formal agreements for appointment prior to raising purchase orders, due to unclear internal processes regarding the use of frameworks. Additionally, no documentation was provided for one other project. The Health Board should clearly define the process to follow for requesting approval to award.	Internal Audit/2025/257/M07/1	To agree a standardised process for appointments and incorporate this into the capital procedures.	Executive Director of Finance	31.08.2025	135	28.02.2026	Medium	In progress	December 2025 Update - Extension agreed with DoF to February completion (via January ECMG)
Internal Audit/2025/270	14.08.2025	Decarbonisation (Follow Up)_2025/26 (Review reference: CTM-2526-30)	Limited Assurance	5. Carbon consideration in decision making 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/2025/270/M03/1	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.	Executive Director of Strategy & Transformation	31.12.2025	13	31.12.2025	Medium	Overdue	December 2025 Update - Governance programme are being reviewed, including for the decarbonisation programme, to ensure climate action and risks are accounted for when making strategic decisions.
October 2025 Update - There is a review of organisational governance processes and this action will be highlighted as part of that process.													

Cwm Taf Morgannwg University Health Board

Audit, Risk & Assurance Committee Internal Audit Progress Report

February 2026

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 19 January 2026. 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 Report summary

- 2.1 The current position of our programme of work for the Health Board and the JCC is summarised as:

Table 1: Summary of position

Status	CTM Number	JCC Number	Note
Final	7	1	-
Draft	2	-	-
Work in progress	10	-	Two are concluding. Three have had delayed progress.
Planning /Planned	12	2	Includes five follow up reviews. Three have had delayed progress.
Not started	1	1	-
Defer	3	-	-
Total	35	4	-

- 2.2 A summary of the position of the reports finalised since the last Committee, including a summary of number of recommendations, is provided in Table 2 below.

Table 2: Summary of finalised reports

Assignments	High	Medium	Total	Assurance rating
Operational response to critical incident	2	4	6	Reasonable
Clinical coding	1	1	2	Reasonable
Discharge planning	3	8	11	Limited

Assignments	High	Medium	Total	Assurance rating
Stroke Services	-	3	3	Reasonable
Asbestos management	-	2	2	Reasonable

3 Performance reporting

- 3.1 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.
- 3.2 Our agreed performance indicators, as at the time of this progress report, are set out in table 3 below:

Table 3 – Performance Indicators 2025/26 (ex. JCC)

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100% (9/9)	95%	v>20%	10%<v ≤20%	v≤10 %
Report turnaround: time taken for management response to draft report [15 days per Internal Audit Charter]	Red	29% (2/7)	80%	v>20%	10%<v ≤20%	v≤10 %
Report turnaround: time from management response to issue of final report [10 days]	Green	100% (7/7)	95%	v>20%	10%<v ≤20%	v≤10 %

4 Other activity

Joint Commissioning Committee (JCC)

- 4.1 We have agreed a programme of work for 2025/26 with officers of the JCC, this is for a total of four reviews (Appendix A – Table 6). We have one review in draft and have held planning meetings for a further two reviews.

Meetings

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

Appendix A – Programme of work**Table 4: Core programme of work**

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
30	Follow up - Decarbonisation	N/A	Q2	Aug	Final	Y	Y	-
29	Follow up – Vaccination policy implementation	N/A	Q2	Nov	Final	Y	Y	-
N/A	Discharge planning	Limited	Q1	~~Aug~~ Feb	Final	Y	N	-
9	Clinical coding	Reasonable	Q1	~~Aug~~ Feb	Final	Y	N	-
4	Operational response to critical incident	Reasonable	Q1	~~Aug~~ Feb	Final	Y	N	-
16	Stroke	Reasonable	Q2	~~Nov~~ Feb	Final	Y	N	-
20	Estates assurance – Asbestos Management	Reasonable	Q2	~~Nov~~ Feb	Final	Y	N	-
15	Long term strategy	Reasonable	Q4	Feb	Draft	Y	-	Draft report issued 15.01.26.

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
19	PoW roof replacement	Substantial	Q3	~~Nov~~ May	Draft	Y	-	Delay getting information from external contractor. Draft report issued 21.01.26.
18	Savings	-	Q2	~~Nov~~ May	WIP	-	-	Taken time to agree the brief. Fieldwork completed and file under review.
1	Individually commissioned packages of care	-	Q1	~~Nov~~ May	WIP	-	-	Fieldwork started November. Auditor capacity.
7	Risk management	-	Q3	~~Feb~~ May	WIP	-	-	Fieldwork started in November. Delay due to Auditor absence.
5	Medical sickness records (Advisory)	-	Q2	~~Nov~~ May	WIP	-	-	Delays getting data.
22	Re-audit - Gastro-Intestinal demand management	-	Q3	~~Feb~~ May	WIP	-	-	Delays getting data.
13	Falls management	-	Q3	~~Feb~~ May	WIP	-	-	Delayed in getting meetings booked with managers before Christmas.

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
24	Re-audit – Additional medical pay	-	Q3	Feb May	Planned	-	-	Delayed start due to change of service from Retinue to Locum Nest.
10	Cyber security	-	Q3	May	WIP	-	-	Fieldwork started in December.
11	Digital – Bridgend disaggregation	-	Q3	May	WIP	-	-	Fieldwork started in January.
6	Speaking up safely	-	Q4	May	Planning	-	-	Revised draft brief issued 12.01.26
17	Financial systems	-	Q4	May	Planning	-	-	Draft brief issued 12.01.26.
2	Outpatient booking process	-	Q3	May	Planning	-	-	Detailed scoping meeting cancelled by CTM. Rescheduled for 26.01.26
3	Medical annual leave and rostering	-	Q4	May	Planning	-	-	Held scoping meeting on 08.01.26. May not take forward as may be duplication with Ref.5.
12	Welsh risk pool	-	Q4	May	Planning	-	-	-
14	Ward audits	-	Q4	May	Planning	-	-	Drafting brief

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
23	Medical job planning - re-audit	-	Q4	May	Planned	-	-	-
25	Interventions not normally used (INNU) re-audit	-	Q4	May	Planning	-	-	Scoping meeting 08.01.26
26	Capital systems – follow up	-	Q4	May	Planning	-	-	As at November AC the agree actions were open so unable to follow up.
27	Estates assurance - follow up	-	Q4	May	Planning	-	-	As at November AC the agree actions were open so unable to follow up.
08	Establishment of new committee structure	-	Q4	-	Defer	-	-	Audit Wales have considered as part of their structured assessment. Remove to avoid duplication.
21	End of life care management re-audit	-	Q4	-	Defer	-	-	Agreed actions not due until 2026/27. So defer until actions complete.
28	Digital benefits realisation – follow up	-	Q4	-	Defer	-	-	Agreed actions not due until 2026/27. So defer until actions complete.

Table 5: PCH programme of work for 2025/26

Plan Ref.	Review	Rating	Review period	AC	Status	Draft report issued < 10 working days	Management response received <15 working days	Notes
1	Section 7 – Development of target cost	-	Q3	May	WIP	-	-	Fieldwork started in October, delays getting information from cost advisor.
2	Assessment of community benefits	-	Q4	May	-	-	-	-
3	Deep dive into the final account	-	Q4	May	Planned	-	-	Brief agreed
4	Annual assessment	-	Q4	May	Planned	-	-	Brief agreed

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)	Substantial	Final	-
3	Strategic planning	-	Planning	Work planned for Q4. We have had initial planning meeting.
4	Budget management	-	-	Work planned for Q4.

Clinical Coding

Final Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

CTM-2526-09

July – September 2025

23 December 2025

3 February 2026

Stuart Morris, Director of Digital & Data

Paul Dalton, Head of Internal Audit

Martyn Lewis, IT Audit Manager



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

To consider the Cwm Taf Morgannwg University Health Board’s (the ‘Health Board’) process and plan for timely and accurate clinical coding.

Overview

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

- A significant number of coding staff are towards the upper end of the employment age and approaching retirement. Although this risk to department sustainability has been raised internally, it has not been formally recorded within the risk register.
- There is very little resilience within the coding team establishment. The time demand on coding staff means that any sickness, training or unforeseen events will impact on the organisation’s ability to meet coding targets. We also note that the use and development of the autocoder has fallen behind due to lack of development staff resource.

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	The clinical coding improvement plan is being implemented appropriately and is improving coding timeliness, and the automatic coding of records enabling improved accuracy and a reduction in errors.		-	Substantial
2	The resources required for clinical coding have been assessed and appropriate resourcing is in place.		1, 2	Reasonable

Management Actions



High Priority



Medium Priority

Themes



■ Resourcing

Risk Types

Legal & Regulatory Non-Compliance
Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The clinical coding improvement plan is being implemented appropriately and is improving coding timeliness, and the automatic coding of records enabling improved accuracy and a reduction in errors.	Substantial

Overview / Summary of Observations

In 2021, the Health Board recognised that there were issues with being able to meet Welsh Government (WG) coding targets on a sustainable basis, so developed and enacted a clinical coding improvement plan. The plan had two strands; increasing activity by staff by recruitment and training; and developing digital coding processes.

An update on the impact of the coding plan was provided to committee in 2024, which noted improved productivity and coding completeness, along with the successful development of the auto coder.

The actions defined within the clinical coding improvement plan have been delivered, which has enabled the Health Board to meet WG coding targets and improved the sustainability of the service. The key actions undertaken were: revision of the staffing grades to maintain retention, along with recruitment and improved training; the increased use of e-forms, together with the introduction of fast healthcare interoperability resources (FHIR) to enable coding at source; and the development of the autocoder.

Oversight on clinical coding was originally by the Digital & Data Committee, but digital items are now reported to the newly established Operational Delivery Committee. We confirmed the governance reporting and note clinical coding is reported to committee on coding in terms of the WG targets, risks and overall improvements.

Internal reporting is in place, with a Power Bi dashboard showing both quality and productivity information, which is used for ongoing monitoring to identify areas falling behind and to target clinical coding work.

We reviewed the dashboard and note that information shows coding rate by week, day of week, month, member of staff, the backlog of coding identified by site and speciality, the timeliness, and the location of uncoded notes. As such, there is a good set of reports to track productivity and performance. Furthermore, DHCW reporting on the All Wales clinical coding position for rate and accuracy shows that the Health Board is on target and has the fewest errors and a faster error correction rate than other health boards.

A key strand in the improvement plan was the development of the autocoder, which uses AI / machine learning to code patients records without the need for clinical coding staff. The autocoder comprises of a number of modules, developed in open source, which together pull the information, analyses it and uses natural language processing (NLP) to assign clinical codes to health episodes. We note that there is clarity over how the autocoder was developed and its operation.

There are data quality and error checks as part of the process, and the output is also reviewed by clinical coding staff, with a feedback process to enable improvements

The accuracy of the autocoder is monitored, with the developer assessing key metrics (F1, AUC) to assess performance and improve, and we note that the metrics show the autocoder is good to excellent.

The coder has saved enabled clinical coding to maintain its level of activity and reporting shows that a total of 46k episodes have been coded by the autocoder.

Overview / Summary of Observations

The Clinical Coding improvement plan resulted in investment into the Clinical Coding department which included an increased staffing capacity. The Clinical Coding Department is responsible for coding all finished consultant episodes (FCEs) for the organisation, which since April 2019 has included the Princess of Wales Hospital. There are offices in each of the main sites with approximately 16.5 WTE coders in place plus a manager and administrators at each site. Coders predominately code episodes for the site at which they are based, however the sites do support each other if needed.

Staff skill mix is varied, with some trainees in place: it takes 3 to 4 years training to attain clinical coding accreditation and to an advanced level of coding to enable full capacity. A significant number of coding staff are towards the upper end of the employment age and approaching retirement, with one experienced coder retiring in April 2025 and a further 3 reducing their hours. Although this risk to department sustainability has been raised by management internally, it has not been formally recorded within the risk register.

There has been recent approval to recruit a further three trainee clinical coders as currently there is very little resilience within the coding team establishment, however we note difficulties in recruitment. Coding approximately 140k FCE annually requires each coder to meet the set average rate with little allowance for sickness or training. As such, sickness or unforeseen events will affect the organisation’s ability to meet coding targets.

To support staff, there is Clinical Coding policy which sets out the aims, standards to follow, and the targets. There are also a number of local policies for specific clinal areas. The training requirements are clearly set out for trainees and for all staff, as such processes are in place to enable the resource to be used efficiently.

Coding is monitored to identify issues with patient’s notes which cause errors, following this, resource is in place to work with medical staff to clarify terminology used to efficiently code records.

The target for coding is 95% in month, and June of each year for completion of coding relating to the previous year. We note that the Health Board met targets and achieved 98% coding for 2024/25. The targets are demanding and require a high work rate from each coding member of staff, if a backlog builds up then the autocoder is run to assist.

The use and development of the autocoder has fallen behind due to lack of developer staff resource. It was originally run on a weekly basis, but due to resource constraints it is now only run on request. Furthermore, the ability of the autocoder to code notes has reduced due to changes in the Theatres system database.

The development of the autocoder is the responsibility of a single member of staff within the Digital team, as such, although there is a will and aim to develop further, this has not happened. The Clinical Coding improvement plan identified skills to be added to the department to support the development of the autocoder, however this has not happened, and there is insufficient resource to enable release of staff to assist in the autocoder development. As such, although the autocoder offers the opportunity to resolve staffing constraints the lack of development resource means this is not being progressed.

Key Findings	Risk & Impact	Agreed Management Action

1	Staffing Risk A significant number of coding staff are towards the upper end of the employment age and approaching retirement. Although this risk to department sustainability has been raised, it has not been formally recorded within the risk register.	The organisation may not be able to meet WG coding targets in the future	Agreed Action: The Health Board has entered into a period of consultation with the non-certified members of the coding team, to ascertain interest in their development as qualified coders. Funding has been identified to train 3 as certified clinical coders which will start in April 2026. This step, together with the advancement of AI and digitisation, should go a fair way to minimising the overall risk described in this audit finding.
			Expected Evidence of Implementation: 3 trainee coders commencing their training position in April 2026.
		Medium Priority	Officer: Head of Clinical Coding Target Implementation Date: Commenced
	Theme: Resourcing	Control Operation	
2	Coding Team Resilience There is very little resilience within the coding team establishment. With approximately 140k FCE to code annually, this requires every coder to meet the set average rate and has very little allowance for sickness or training. As such, any sickness or unforeseen events can affect the Health Board's ability to meet coding targets. We also note that the use and development of the autocoder has fallen behind due to lack of resource, and that the ability of the autocoder to code notes has reduced due to a lack of access to Theatres information. As such, although the autocoder offers the opportunity to resolve staffing constraints the lack of development resource means this is not being progressed.	The organisation may not be able to meet WG coding targets in the future	Agreed Action: The Health Board has entered into a period of consultation with the non-certified members of the coding team, to ascertain interest in their development as qualified coders. Funding has been identified to train 3 as certified clinical coders which will start in April 2026. This step, together with the advancement of AI and digitisation should go a fair way to minimising the overall risk described in this audit finding. The Health Board continues to use overtime to maintain compliance with the coding targets. A proposal is being made to ensure that there is sufficient resource within the data and coding teams to maintain and develop the autocoder system. This is likely to require an additional python data scientist.
			Expected Evidence of Implementation: Autocoding support identified in the IMTP prioritisation process.
		High Priority	Officer: Assistant Director for Data Intelligence, Compliance & Design Target Implementation Date: March 2026
	Theme: Resourcing	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.

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

Disclaimer

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

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

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Asbestos Management

Final Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Head of Internal Audit

CTMUHB-SSU-2526-20

July - September 2025

19th January 2026

3rd February 2026

Sally May, Director of Finance,
Procurement, Capital & Estates

Huw Richards, Head of Internal
Audit

Paul Stocker, Audit Manager

Executive Summary

Purpose

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the University Health Board (UHB), taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. The audit forms a part of the internal audit plan for 2025/26 agreed by the Audit Committee.

The overall objective was to ensure that the UHB’s overarching asbestos management procedures are robust and sufficiently comprehensive to manage asbestos based risks.

Of relevance, was the Control of Asbestos Regulations 2012 (CAR 2012), which established the legal framework for the identification, management, and safe handling of asbestos. These regulations place specific duties on duty holders to assess the presence of asbestos prior to any refurbishment or work likely to disturb building materials, and to ensure that appropriate information, instruction, and training are provided to staff.

A broad sample of UHB sites was selected to form part of the testing for this review, in order to represent the estate portfolio. The only exception was Prince Charles Hospital, which was excluded due to ongoing major capital works involving the large-scale removal of asbestos-containing materials from the site.

Overview

Asbestos-containing materials (ACMs) were used for a wide range of construction purposes in new and refurbished buildings until 1999 when almost all use of asbestos was banned. Buildings constructed after year 2000 can normally be regarded as being asbestos-free.

The ACMs are managed by the Compliance team in line with the Health Board’s Asbestos Management Plan/Policy and the Control of Asbestos Regulations 2012. Asbestos management actions include the labelling of higher risk materials, the encapsulation or enclosing of materials to prevent damage, and the periodic re-inspection of their condition. The UHB employ specialist facilities and property management software (MICAD to support the management of the estate).

We have concluded **reasonable assurance** on this area i.e. some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved. The matters requiring management attention are:

- Levels of attendance at asbestos refresher training requires improving; and
- Inconsistent historical Use of ‘Authority to Proceed’ Documentation.

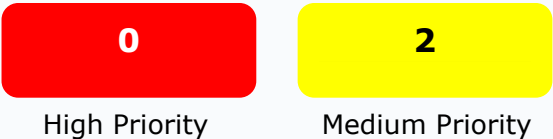
Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

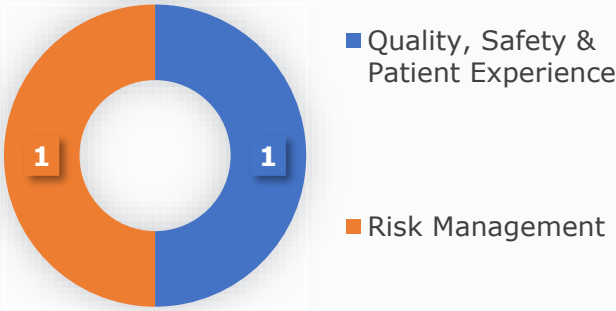
Objectives		Related Findings	Assurance
1	Governance - Assurance that an approved AMP/Policy was in place, verify that there was appropriate and demonstrable executive ownership, that day-to-day management of asbestos has been assigned to a suitably qualified and competent individual and further that monitoring and audit arrangements were operating effectively.		Substantial
2	Identification- Appropriate surveys had been undertaken to identify the presence of asbestos and the potential exposure risk to staff/ public.		Substantial

3	Records – To ensure that the UHB held a fully comprehensive asbestos register to identify the locations of ACMs on all sites.		Substantial
4	Risk Management – To confirm all high-risk ACMs had been identified and escalated to the UHB’s corporate risk register – including proposed action.		Substantial
5	Action Plans - The UHB had an Asbestos Risk Register that identifies all asbestos across the estate, and an AMP that determines how the ACMs are managed in each premises.		Substantial
6	Operational Delivery - That Compliance with Control of Asbestos Regulations 2012 was demonstrated through operational activities including -. Plans of Work, Information, Instruction and Training, Use and Maintenance of Control Measures etc.	1,2	Reasonable

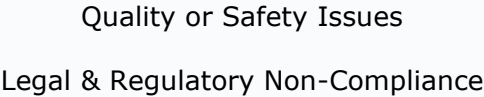
Management Actions



Themes



Risk Types



Findings & Agreed Action Plan

Objective 1: Governance Arrangements	Substantial
Overview / Summary of Observations Key roles and responsibilities for overseeing asbestos management within the UHB were clearly defined, including the Chief Executive, Board Secretary, Head of Assets, Governance and Technical Services, and the Asbestos Manager (Compliance Officer). An AMP was in place, which also functioned as a policy and procedure. The document had been regularly reviewed, with the most recent version approved by the Quality and Safety Committee on 25th March 2025. It addressed the key requirements of CAR 2012, referencing relevant sections. An established Asbestos Advisory Group met quarterly, chaired by the Asbestos Manager. Review of meeting minutes confirmed a wide-ranging agenda, including training provision, survey updates, and ongoing projects. UHB Estates based staff benefited from hour-long Toolbox Talks delivered via Microsoft Teams, these provided comprehensive content, referencing the UHB's Asbestos Policy and Asbestos Register accessed via the MICAD portal, these sessions served to reinforce responsibilities. Attendance rates were strong, supported by robust follow-up for non-attendees.	

Overview / Summary of Observations

The UHB had demonstrated a strong and proactive approach to asbestos risk management through the systematic commissioning of appropriate asbestos surveys across its estate. Over several years, a programme of asbestos surveys had been undertaken, resulting in the successful identification and subsequent removal of all known high-risk (high-level) ACMs, significantly reducing the residual risk across the organisation's property portfolio.

Following these initial efforts, ongoing asbestos management surveys—conducted by UKAS-accredited external consultants—had continued to monitor and assess the condition of any remaining ACMs. These management-level surveys were non-invasive by design and focused on materials that were readily accessible and visible. This was in line with industry best practice and reflected a consistent commitment to compliance with CAR 2012. This work had been supplemented by a regime of cyclical inspection by the UHB's Asbestos Manager based on the risk that each occurrence of asbestos presented.

For any intrusive works, such as refurbishment or demolition, the UHB had clear protocols in place requiring enhanced, invasive surveys. These refurbishment/demolition (R&D) surveys were conducted to identify any hidden asbestos materials that may have been embedded within the fabric of the building.

The use of UKAS-accredited surveyors further supported confidence in the quality and reliability of the UHB's asbestos surveying programme, which was both comprehensive, and responsive to the changing nature of the built environment.

Overview / Summary of Observations

The UHB had implemented a robust and centralised system for managing asbestos across its estate via the MICAD platform. The system in place aligned with the UHB’s AMP, providing comprehensive, accessible, and auditable records of all identified ACMs.

Our reconciliation of property data confirmed that all relevant sites, including those transferred from Swansea Bay University Health Board, were incorporated within the asbestos register. Sample testing of selected properties demonstrated that key information—such as survey reports, risk ratings, photographs, and CAD drawings were consistently captured and up to date.

The UHB’s use of a comprehensive MICAD database to manage asbestos-related information reflected a mature and structured approach to compliance with the Control of Asbestos Regulations 2012. The system appeared to be well maintained and widely used as the primary reference point for asbestos risk management.

Overall, the UHB’s asbestos management arrangements were well-structured and supported effective risk control, compliance monitoring, and informed decision-making across the estate.

Overview / Summary of Observations

Asbestos was not recorded as a specific entry on the UHB’s Corporate Risk Register. This reflected the progress made over recent years in removing all ACMs assessed as medium/high, high or extreme risk. The remaining low/medium-risk ACMs being subject to regular monitoring, inspection, and appropriate management controls.

The UHB advised that the MICAD asbestos database served as the operational risk register for asbestos management. This system contained comprehensive records of all confirmed and presumed ACMs across the estate; each assigned a risk rating based on condition and potential for disturbance.

MICAD was actively used to support the risk assessment of any planned maintenance, refurbishment, or demolition work in the vicinity of ACMs. It also informed decision-making regarding the prioritisation and safe removal of remaining materials, where this was feasible and cost-effective. These matters were regularly reviewed through the Asbestos Advisory Group, which oversaw ongoing asbestos management.

Overview / Summary of Observations

The MICAD portal, functions as the central risk register for all identified ACMs within the UHB estate. This includes all UHB-owned properties, as well as leased premises where the UHB holds management or maintenance responsibilities in accordance with relevant accountability criteria and as such acts as an overarching Management plan for the UHB's remaining asbestos.

ACMs were managed by the Compliance Team in accordance with the UHB's Asbestos Policy and the requirements of the Control of Asbestos Regulations 2012. Management measures include clear labelling of higher-risk materials, the encapsulation or enclosure of ACMs to prevent deterioration or accidental disturbance, and the periodic re-inspection of their condition to ensure ongoing safety.

Asbestos removal is generally considered a last resort, undertaken only when other management options are unsuitable, reflecting the inherent risks associated with removal, as well as the potential cost and disruption to healthcare services. However, where ACMs obstruct essential maintenance or refurbishment works, removal is carried out by licensed specialist contractors in a controlled and compliant manner.

Evidencing this the UHB provided a copy of a programme of potential statutory asbestos related works for 2025/26 prepared by the Senior Capital Project Manager in July 2025 and for discussion at the Asbestos Advisory Group Meeting.

Within MICAD—the UHB's Asbestos Risk Register and central repository—records are maintained for all identified asbestos-containing materials (ACMs). We reviewed a sample of nine UHB sites, assessing two ACM instances at each site. For all items in the sample, we confirmed that risk assessments had been completed and reinspection intervals set in line with Appendix E of the UHB's Asbestos Management Plan. In addition, the MICAD Portal and/or MICAD IPR contained supporting evidence, including photographs, survey reports, and CAD drawings showing the exact location of each material.

Overview / Summary of Observations

The UHB had implemented robust controls to ensure that ACMs were managed safely and in full compliance with regulatory requirements. UHB staff were not permitted to undertake any direct work involving the remediation or removal of ACMs.

Where work was required in the vicinity of known or presumed ACMs, the Asbestos Compliance Manager was engaged to assess the risk and determine appropriate control measures. The review noted in respect of authority to proceed documentation there had been an inconsistent use of the required forms, key finding 1 provides further detail in this regard.

In instances where planned work may impact existing ACMs, only licensed specialist asbestos contractors were commissioned to carry out the activity. This follows the completion of an Authority to Proceed (ATP) by the Asbestos Compliance Manager to ensure full risk assessment and scope definition. All such work is conducted under controlled conditions, with third-party oversight and assurance provided by the UHB’s appointed licensed asbestos surveyors. These surveyors were responsible for undertaking any required post-remediation air monitoring to confirm the area is safe for reoccupation.

The UHB’s AMP set out clearly defined procedures to be followed in the event of an accidental or suspected disturbance of ACMs. The AMP included detailed flowcharts to support timely and consistent responses, with further guidance outlined in Sections 5 and 6. Emergency contact details were readily available in Appendix C, ensuring staff had immediate access to key information in the event of an incident.

Annual classroom-based refresher training was delivered by the UHB’s appointed asbestos consultants, attendance at this has been below par and the UHB have recognised this with further detail in key finding 2 as set out below.

Key Findings		Risk & Impact	Agreed Management Action
1	Inconsistent historical use of ‘Authority to Proceed’ documentation The UHB’s AMP included an appendix titled ‘<i>Authority to Proceed</i>’, which was to be completed for all works affecting the fabric of a building where asbestos is present but where removal or encapsulation is not required. This form serves as a formal record of asbestos risk consideration in accordance with the CAR 2012. During the audit, the UHB was able to provide completed forms for recent projects, demonstrating current compliance with this requirement. It was noted however that there had been inconsistent application of these forms over the past 12 months.	Non-compliance with UHB and regulatory requirements	Agreed Action Actioned - This has been acknowledged and since the appointment of a new Asbestos Compliance Officer in October 2025, ATP forms will be formally completed.

	In mitigation, in many cases, the Asbestos Manager attended site personally to assess and advise on proposed works, which, while effective at the time, did not leave a formalised audit trail. Although the prior practice provided operational assurance, the lack of documented records may present a gap in evidencing compliance with regulatory requirements. The UHB acknowledged this and confirmed that steps were being taken to ensure consistent and routine completion of the 'Authority to Proceed' forms going forward, in line with both internal policy and legislative expectations.		Expected Evidence of Implementation: ATP forms consistently completed, and copies held on file.
		Medium Priority	Officer: Head of Assets, Governance and Technical Services • Capital and Estates
	Theme: Risk Management	Control Operation	Target Implementation Date: Actioned
2	Asbestos Awareness The UHB delivered annual asbestos awareness refresher training for Capital and Operational Estates staff. However, attendance had been impacted by operational pressures, staff sickness, and other resourcing constraints. As of 15th August 2025, completion rates for the current year stood at 62%, as per data provided by the UHB. This issue had previously been discussed at the Asbestos Advisory Group meeting held in April 2025, where potential improvements, including the adoption of online training modules, were explored to increase accessibility and uptake.	Failure to ensure all relevant staff are adequately trained may lead to unintentional disturbance of ACMs, posing significant health risks and potential breaches of the Control of Asbestos Regulations 2012.	Agreed Action: The 2025 Asbestos Awareness Training to CAR2012 will be conducted via e-learning to ensure staff that previously struggled to attend classroom-based training sessions such as shift workers will be able to attend.
		Medium Priority	Expected Evidence of Implementation: Regular reporting of compliance demonstrating ongoing monitoring
		Medium Priority	Officer: Head of Assets, Governance and Technical Services • Capital and Estates
	Theme: Quality, Safety & Patient Experience	Control Operation	Target Implementation Date: 31/01/2026

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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Operational Response to Critical Incident

Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board



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Review Reference

CTM-2526-04

Fieldwork

July - October 2025

Executive Sign Off

28 November 2025

Audit Committee

3 February 2026

Executive Lead

Gethin Hughes, Chief Operating Officer
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

Our review of the Cwm Taf Morgannwg University Health Board's (the 'Health Board') operational response to the critical incident has been undertaken in line with the 2025/26 internal audit plan.

The Health Board's business continuity management guidance document refers to a critical incident as any event that cannot be managed within routine service arrangements. Each event requires the implementation of special procedures and may involve one or more of the emergency services, the wider NHS or the local authority.

A critical incident was declared on 9 October 2024 at the Princess of Wales (PoW) hospital following the discovery of serious damage to the hospital's roof. The decision was made to move a significant proportion of the services located on the first floor at PoW, including six operating theatres, the intensive care unit, endoscopy facilities and eight wards, to other locations.

Our review seeks to provide assurance that appropriate action was taken at that time to manage the incident in line with agreed protocols, and that consideration has been given to lessons that may have been learnt from the incident management process.

Overview

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

- Reviews and updates are required in respect of the Health Board's Business Continuity & Emergency Preparedness Response & Recovery (EPRR) policy and its 'Guidance for Business Continuity Emergency Preparedness Response & Recovery Planning' documents.
- A framework is yet to be established for the production and approval of local business continuity plans throughout the Health Board, and plans have therefore not been produced. The role of the Health Board's civil contingency resources in supporting the business continuity planning (BCP) process has not been clearly defined.
- Site-specific major incident procedures require updating and approval.
- Business continuity leads have not been nominated, a training programme has not been produced, and a repository for business continuity documentation is yet to be established.
- Reports to the Board, including an annual report which is also provided to NHS Wales Performance and Improvement, have not explicitly stated that there is an absence of local business continuity plans within the Health Board.
- The command structure detailed in the Major Incident Plan requires updating to incorporate lessons learnt from the critical incident, the role of the civil contingencies manager or the Health Board's EPRR resources in directly supporting the response to a critical / major incident, has not been clearly defined.

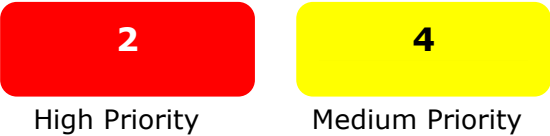
Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The four-stage 'Business Continuity Lifecycle' outlined in the BC guidance does not reinforce learning from events to a sufficient degree, and it does not clearly show how that learning should feed back into the planning and business impact assessment process.
- As the Health Board's business continuity processes are yet to be developed, there was insufficient evidence to demonstrate that measures have been implemented to ensure that plans interrelate.

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	Guidance is in place setting out the expectations for business continuity / significant incident plans at Health Board, hospital sites and care groups levels.	1, 2	Reasonable
2	Plans are in place at the relevant levels within the Health Board and have been refreshed to reflect any lessons learnt following the recent critical incident.	3, 4, 5	Limited
3	A suitable command structure was instigated to oversee the recent incident, with clear lines of responsibility, accountability established including external partners such as the Local Authority.	6	Reasonable
4	Decision making and actions in relation to the critical incident took place in line with the command structure and the Health Board's scheme of delegation, with suitable systems in place to capture and log decisions and information.	-	Substantial
5	Reporting arrangements and communications plans ensured that the Board, patients, patient families, staff and members of the public were provided with timely updates.	-	Substantial

Management Actions



Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Guidance is in place setting out the expectations for business continuity / significant incident plans at Health Board, hospital sites and care groups levels.

Reasonable

In October 2022 the Health Board approved a Business Continuity & Emergency Preparedness Response & Recovery policy. Whilst the policy was not due for review until October 2025, there have been no interim updates in response to the critical incident. The EPRR team’s work programme for 2025/26 does not include a review of the policy.

The policy is supported by a 2023 document: '*Guidance for Business Continuity Emergency Preparedness Response & Recovery Planning*'. While this contains key information in relation to the Health Board's business continuity processes, it does not appear to have gone through an approval process. Elements of the guidance need updating such as job titles and its references to the Health Board’s previous structure.

The guidance requires the development of business continuity plans following the completion of business impact assessments. However, it is not explicit in stating the need for plans at hospital site, care group and directorate level, or how they inter-relate.

Most roles and responsibilities relating to the support of the business continuity planning process are clearly defined in the policy and guidance documents, however, information in relation to the role of the Health Board's EPRR team has not been documented.

Key Findings		Risk & Impact	Agreed Management Action
1	Business Continuity Policy and Guidance reviews The Health Board's 'Business Continuity & Emergency Preparedness Response & Recovery policy' should have been reviewed in October 2025, but at the time of our fieldwork it appears this was not in progress. We have not seen evidence of an interim review or update in response to the critical incident of October 2024. The Health Board's 2023 'Guidance for Business Continuity Emergency Preparedness Response & Recovery Planning' document seems to be draft as it does not appear to have gone through an approval process. Like the policy, no reviews or updates have taken place in response to the critical incident of October 2024.	Lack of a defined process for dealing with major incidents resulting in a lack of accountability.	Agreed Action The Health Board's Business Continuity & Emergency Preparedness Response & Recovery policy will be spilt into the Health Board’s 'Business Continuity Guidance and Framework' and the Health Board’s 'Major Incident Plan'. The two documents will be reviewed with particular emphasis placed on the incorporation of lessons learnt from the response to the critical incident of October 2024. Resources within the EPRR team will increase capacity and training implementation, through an appropriately phased workplan. A review was conducted following the critical incident with key colleagues engaged. The review identified lessons and learning which has supported the development of the health boards plans.
			Expected Evidence of Implementation The Health Board’s 'business continuity guidance and framework' and the Health Board’s 'major incident plan'. is updated and available.

			Approval at EPRR strategy group meeting. Updated guidance document showing review schedule.
		Medium Priority	Officer: Claire Thompson, Executive Director of Strategy and Transformation
	Theme: Policies & Procedures	Control Operation	Operational lead: Sarah James, Deputy COO & Mel Jones, Civil Contingency Manager Target Implementation Date: March 2026
2	Business Continuity guidance gaps There is no Health Board wide framework for producing and approving local business continuity plans. The business continuity guidance states that 'Service Managers / Service Leads will be responsible for the actual business impact analysis and subsequent development of their plans'. However, the guidance does not explicitly set out the levels at which plans should be produced, such as department, directorate, care group and site. Business impact assessments have not been undertaken, and as such plans have not been developed. The role of the Health Board's civil contingency / EPRR team in supporting the business continuity planning process has not been clearly defined.	Lack of a defined process for dealing with major incidents resulting in a lack of accountability.	Agreed Action The Health Board's 'Business Continuity Guidance and Framework' will be updated to include: • An operational framework to ensure business continuity plans can be produced throughout the Health Board. • A section which specifically details the responsibilities of the Health Board's Civil Contingency / EPRR team in supporting the business continuity planning process within the Health Board. – This has been aligned to the job plan for strategy, led by Melanie Jones, Civil Contingency Manager and supported by Sarah James, Deput Chief Operating Officer for an operational oversight.
		Medium Priority	Expected Evidence of Implementation Updated Guidance for Business Continuity including details of the framework. Approval of framework at EPRR strategy group meeting Evidence of business continuity plans for priority areas and a route to track compliance.
	Theme: Planning, Delivery & Deadline Management	Control Design	Officer: Claire Thompson, Executive Director of Strategy and Transformation Operational lead: Sarah James, Deputy COO & Mel Jones, Civil Contingency Manager Target Implementation Date: March 2026

The Health Board has an 'Overarching Major Incident and Critical Business Continuity Procedural Guidance' ('Major Incident Plan'), setting out the process to be followed if a major incident occurs. In March 2025, the Board approved a revised version of the Major Incident Plan subject to completion of site specific plans, although at the time of our fieldwork these site specific plans were still in draft.

Our enquiries with senior staff indicated that responsibilities in relation to the undertaking of business impact assessments and the production of local operational business continuity plans had not been communicated to service managers and service leads. While we note that there are business continuity plans for certain events such as cyber-attacks, we did not see evidence of local operational business continuity plans during our fieldwork. As part of its duties under the Civil Contingencies Act, the Health Board submits an emergency planning annual report, approved by the Board, to NHS Wales Performance and Improvement. It is a source of assurance in relation to the adequacy of business continuity and emergency preparedness across health organisations. The most recent return did not appear to fully reflect the organisation's current position with regards to local operational business continuity plans, although it did include an acknowledgement that work in relation to business continuity plans was outstanding, and the supporting report stated that the site-specific major incident plans had not yet been finalised.

A training programme is an essential component of an organisation's business continuity planning processes and should be designed to ensure that individuals responsible for the undertaking of business impact assessments and the production of business continuity plans are provided with the appropriate information and support to carry out these functions effectively. A training programme is yet to be developed within the Health Board, although we acknowledge that the 2025/26 work plan for the EPRR team includes training.

The storage, retention and dissemination of local operational business continuity plans and associated documentation are also important considerations within a robust business continuity management framework. However, at the time of our fieldwork there was no central storage resource, such as a SharePoint site. Furthermore, there is no mechanism to ensure that the contents of business continuity plans are considered when planning contingency measures. For example, to ensure that wards do not plan to evacuate to the same limited space.

Key Findings		Risk & Impact	Agreed Management Action
3	Procedure approvals A Major Incident Plan was approved by the Board in March 2025 subject to the completion of site-specific plans. It is our understanding that the site-specific plans remain in draft and as such there have been no further updates to the Board.	Lack of a defined process for dealing with major incidents resulting in a lack of accountability. Inability to maintain critical services during an incident leading to service disruption and patient safety issues.	Agreed Action The Health Board's site-specific major incident plans will be finalised and submitted to the Operational Management Board and Emergency Planning Response and Resilience Strategic Group for approval. A report will then be issued to the Board to confirm that this has taken place.
			Expected Evidence of Implementation

			Site specific Major Incident procedures agreed at EPRR strategic group & OMB.
		Medium Priority	Officer: Gethin Hughes, Chief Operating Officer Operational lead: Sarah James, Deputy COO & Mel Jones, Civil Contingency Manager Target Implementation Date: March 2026
	Theme: Approvals	Control Operation	
4	Business continuity plans and supporting systems and processes Business continuity leads have not been nominated, training activities have not taken place, plan owners have not been assigned, and review and approval processes have not been defined. As such, it appears that operational business continuity plans have not been developed. A system to facilitate the storage and access of the Health Board's business continuity plans by appropriate individuals is yet to be developed. Whilst some action cards have been produced, they have not been adapted for use alongside business continuity plans.	Lack of a defined process for dealing with major incidents resulting in a lack of accountability. Inability to maintain critical services during an incident leading to service disruption and patient safety issues.	Agreed Action: To facilitate the establishment of an appropriate business continuity planning framework, business continuity leads for Care Groups and individual services will be nominated, a training programme for business continuity leads will be instituted, and review / approval processes will be maintained. An appropriate, centralised system, such as within SharePoint, for the storage and dissemination of relevant information relating to business continuity and major / critical incidents will be implemented. Action cards will be produced to provide guidance in a broader range of circumstances, the production and adaptation of action cards at a local level will be incorporated into the business continuity planning processes.
			Expected Evidence of Implementation: List of nominated business continuity leads. List of plan owners. Details of training programme(s). Details of the storage system. Action cards, including those produced alongside business continuity plans and major incident plans. Approval at EPRR strategy group meeting
		High Priority	Officer: Gethin Hughes, Chief Operating Officer Operational lead: Sarah James, Deputy COO & Mel Jones, Civil Contingency Manager Target Implementation Date: March 2026 – with leads identified and training starting in January 2026.
	Theme: Training & Development	Control Operation	

5	Future emergency planning annual reports Responses to a self-assessment questionnaire, which informs part of the Health Board's emergency planning annual report to NHS Wales Performance and Improvement did not appear to fully reflect the Health Board's progress in relation to the implementation of appropriate business continuity arrangements.	Lack of a defined process for dealing with major incidents resulting in a lack of accountability. Inability to maintain critical services during an incident leading to service disruption and patient safety issues	Agreed Action Future Emergency Planning Annual Reports will be subject to increased scrutiny by The Health Board. Evidence will be submitted alongside the reports, and enhanced information with respect to the Health Board's progress in relation to the finalisation of site-specific major incident plans and the implementation of appropriate business continuity arrangements will be included.
	Theme: Reporting	Control Operation	Expected Evidence of Implementation Emergency Planning Annual Report – 2026. Board papers. Officer: Claire Thompson, Executive Director of Strategy and Transformation Operational lead: Mel Jones, Civil Contingency Manager Target Implementation Date: June 2026 with evidence of approval of the new format from the Emergency Planning Response and Resilience Strategic Group in quarter 4 2025/26 meeting.

A command structure of a format specified in the Health Board's Major Incident Plan was established immediately following the declaration of the critical incident. It was composed of senior executives and managers throughout the Health Board.

The guidance in the Major Incident Plan provides a high-level overview of a potential command structure involving external parties, but does not provide details in relation to the establishment of a command structure in response to a critical incident that is internal to the Health Board.

Although the Health Board's EPRR resources contributed to the Health Board's response to the critical incident, the responsibilities of the EPRR resources and the management of critical incidents are not clearly documented in the policy or guidance documents. The parameters by which the Civil Contingencies Manager should contribute to the direct management of incidents have not been defined.

With respect to collaborative working with external agencies, provisions have been included in the Health Board's BC Planning guidance. The 'partnerships' silver cell was established as part of the response to the critical incident. The local authorities were cited as key stakeholders and attended the partnership cell meetings. Updates have been received from the Local Partnership Forum via the Chief Executive of the Health Board.

Key Findings		Risk & Impact	Agreed Management Action
6	Command structure The Major Incident Plan contained some guidance with respect to the establishment of a command structure, but it contained some provisions which were not applicable to the critical incident of October 2024. Whilst it is not possible to produce guidance to directly address all potential incidents, the command structure within the plan is intended to support the Health Board’s response to a major incident involving external agencies such as police, and does not provide sufficient guidance with respect to the establishment of a command structure in relation to a business continuity event, or similar incident which is primarily managed within the Health Board. The Major Incident Plan does not clearly define the role of the Civil Contingencies Manager or the Health Board's EPRR resources in directly supporting the response to critical / major incidents as they occur.	Lack of a defined process for dealing with major incidents resulting in a lack of accountability. Inability to maintain critical services during an incident leading to service disruption and patient safety issues.	Agreed Action Some aspects of the command structure guidance will be generalised to ensure the guidance is applicable to a broader range of incidents. Separate provisions will be listed to address the specific exigencies of major incidents which may involve a broader, multi-agency approach, and critical incidents such as that which occurred in October 2024, the effects of which relate to the Health Board's areas of responsibility only and are largely managed within the Health Board. The Major Incident Plan will be updated to include details of the Civil Contingencies Manager's and EPRR Team's responsibilities in relation to the real-time management of critical / major incidents and business continuity events. Expected Evidence of Implementation Updated Major Incident Plan - command structure guidance and roles and responsibilities. Approval at EPRR strategy group meeting.

		Medium Priority	Officer: Claire Thompson, Executive Director of Strategy and Transformation Operational lead: Mel Jones, Civil Contingency Manager Target Implementation Date: January 2026
	Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 4: Decision making and actions in relation to the critical incident took place in line with the command structure and the Health Board's scheme of delegation, with suitable systems in place to capture and log decisions and information.

Substantial

Decisions in relation to the critical incident were effectively captured and logged by several means. Reporting undertaken within the command structure by various cells contained information in relation to the decision-making processes which were in place, detailed reports were made to the Board.

A central record of decisions was maintained setting out their nature, where the decision was discussed (gold or silver command), the outcome of the decision and the action owner. We saw evidence of challenge and scrutiny of decisions, in that some required additional information before a decision could be made and not all were approved.

We did not identify any deviations to the Health Board's scheme of delegation or other policy documents were.

Objective 5: Reporting arrangements and communications plans ensured that the Board, patients, patient families, staff and members of the public were provided with timely updates.

Substantial

Extensive information in relation to the critical incident was reported to the Board promptly during the initial response and throughout the subsequent ongoing efforts.

Various impacts of the incident were reported to and considered by the Board, and some matters were escalated to the organisation's strategic risk register.

Information in relation to the response to the incident was contained in a range of regular and *ad hoc* reports from across the Health Board. Issues addressed ranged from medical staffing levels to financial implications. Staff and service user wellbeing were recurring themes in several reports.

Engaging with staff and ensuring their welfare was a prominent consideration throughout the response to the critical incident.

Communications to service users and the public were co-ordinated at senior levels within the command structure. The gold and silver command groups and the various individual cells were supported by a communications cell which was led by the Head of Communications. The communications issued appeared to contain an appropriate level of detail, were issued promptly following the incident and regularly updated.

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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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 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.



Stroke Services

Final Internal Audit Report

2025/26

Cwm Taf Morgannwg University Health Board



Reasonable Assurance

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Review Reference

CTM-2526-16

Fieldwork

August – September 2025

Executive Sign Off

January 2026

Audit Committee

February 2026

Executive Lead

Lauren Edwards, Executive Director of AHPs and Health Science

Audit Team

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

Our audit review of stroke services has been undertaken in line with the 2025/26 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or CTM).

As reported by the Welsh Government, 'stroke is the fourth leading cause of death in Wales and can have a significant long-term impact on survivors of stroke. There are currently around 70,000 stroke survivors living in Wales, and an estimated 7,400 people experience a stroke each year'.

In 2023 Health Inspectorate Wales (HIW) published their 'National Review of Patient Flow – a journey through the stroke pathway'. The report included 50 recommendations for improving stroke services. The recommendations were aimed at health boards, Welsh Government, WAST and local authorities. The Health Board also participates in the King's College London's Sentinel Stroke National Audit Programme (SSNAP), a major national healthcare quality improvement programme which measures '...how well stroke care is being delivered in the NHS in England, Wales and Northern Ireland'. A set of six national Quality Improvement Measures (QIMs) are in place, which are part of a suite of improvement measures for improving the SSNAP score.

Over the past year, stroke services in CTM have been subject to significant changes, with services moved from the Princess of Wales Hospital to the Royal Glamorgan Hospital following a critical incident relating to the hospital roof. Issues surrounding the recruitment of medical staff, specifically consultants, have resulted in the stroke services at Prince Charles Hospital also being moved. As such, stroke services have been consolidated in a 50-bed unit within the Royal Glamorgan Hospital.

Overview

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

- The inclusion of target dates and more consistent recording of status change dates within the Stroke Services Improvement Action Plan (IAP).
- Clarification with the Quality, Safety and Experience Committee with respect to the amalgamation of previous stroke action plans into the IAP.
- The closure of longer-term actions relating to the 2023 HIW review, along with those which have been substantively complete.

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:

- The Stroke Improvement update reports contain summarised details in relation to the improvement action plan, whereas it may be more appropriate to include the latest version of the entire plan in each update.

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 an approved action plan in place to improve stroke performance, which reflects the lessons learnt and recommendations from external reviews and reports.	1 & 2	Reasonable
2	There are appropriate governance arrangements and mechanisms in place for oversight of the action plan and to monitor progress.		Substantial
3	There are appropriate performance measures in place for monitoring of outcomes to evidence that actions have impact. Remedial action is taken where implementation is off track.	1	Reasonable
4	Periodic reports on the progress against the action plan and stroke performance are produced and submitted to appropriate management and health board committees for review.	3	Reasonable

Management Actions

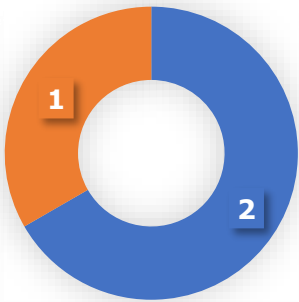


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Reporting

Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: There is an approved action plan in place to improve stroke performance, which reflects the lessons learnt and recommendations from external reviews and reports.	Reasonable
In recent years the stroke service has been subject to external and internal reviews resulting in various action plans. The 2023 HIW 'National review of patient flow – a journey through the stroke pathway' report included 50 recommendations, although not all were for health boards to implement. In March 2025, the Health Board's senior nursing team undertook a ward assurance visit at the stroke ward at Royal Glamorgan Hospital, which resulted in a 'red rating' report, meaning that several significant issues had been identified. The stroke service produced an 'Improvement Action Plan' to address the issues raised in the report. We note that a follow up visit in July 2025 identified that improvements had been made. In addition, the Health Board's Stroke Programme Board, Stroke Operational Group and Stroke Strategy Group each had their own action plans linked to service delivery improvements. In May 2025 the Service Director for Unscheduled Care requested that an amalgamated action plan be put in place, bringing all existing improvement and action plans into one document. We have seen that the Improvement Action plan that was produced following the ward visit was later updated to also incorporate actions from other plans, however, the actions from the HIW report remain separate. We saw that updates on the previous action plans of the stroke groups had regularly been presented at the Health Board's Quality, Safety and Experience (QSE) Committee. However, we have been unable to confirm if the committee is aware of the process of amalgamating previous actions into one plan, and of the closure of recommendations as part of this process. Our review of the amalgamated improvement action plan confirmed that it is regularly reviewed and updated. However, dates have not always been recorded when status changes or updates have taken place, and target dates for when actions should be implemented have not been specified.	

Key Findings		Risk & Impact	Agreed Management Action
1	Improvement action plan format Our review of the Health Board's amalgamated action plan identified: - The plan does not contain target dates for the completion of actions. - Narrative updates appear to show a number of actions as complete, but these actions were still marked as 'Amber' (incomplete). - The actions do not reference the original inspection report. - The outstanding HIW actions are on a separate action plan. - Where relevant actions do not include reference to the quality improvement measures that they relate to.	Appropriate actions are not identified to improve stroke performance. Potential significant harm to patients.	Agreed Action: Dates will be recorded against all status changes recorded on the IAP, and target dates will be added to all actions. Timescales will be approved by the Stroke Operational Group and Stroke Strategy Group as appropriate.
			Expected Evidence of Implementation: Updated IAP. This will be reported through Stroke Operational Group and Stroke Performance Board (in place of Stroke Strategy Group which is no longer in operation).
	Theme: Information, Data Quality & Data Accuracy	Medium Priority Control Operation	Officer: Kate Graham, Directorate Manager Target Implementation Date: 01/04/26
2	Legacy plans Although the actions from previous plans have been incorporated into the improvement action plan, or have been encompassed within actions arising from the HIW review, this has not been explicitly reported to the QSE committee. As such, the actions from the previous plans may appear unresolved.	Work to improve stroke services is not undertaken in a co-ordinated way if multiple action plans are in place from various reviews / reports.	Agreed Action: The next Stroke Services update report will include an explanation with respect to the amalgamation of action plans into the improvement action plan.
			Expected Evidence of Implementation: Stroke Services Update Report.
	Theme: Reporting	Medium Priority Control Operation	Officer: Deborah Matthews, Nurse Director, USC Target Implementation Date: March 2026

Objective 2: There are appropriate governance arrangements and mechanisms in place for oversight of the action plan and to monitor progress.

Substantial

At a service level there are two key groups that have oversight of stroke services: the Stroke Operational Programme Board (SOPB) and the Stroke Operational Group. Previously, each monitored its own action plan.

Two further groups exist as part of the broader governance structure, the CTM Stroke Strategy Group, which also maintained an action plan, and the Southeast Wales Stroke Network Programme Board; both groups are specified within the SOPB terms of reference as being linked with the SOPB.

The terms of reference for the SOPB were issued in July 2025 and updated in September. The stated purpose of the Board is 'to ensure oversight of the overall Stroke Pathway to ensure that it's delivering high quality and timely services to improve health outcomes and quality of life for stroke patients treated by the Health Board'. Membership is comprised of senior representatives from a range of services relevant to the stroke pathway, in addition to the Quality and Performance Manager from NHS Wales Executive (now NHS Wales Performance and Improvement). Meetings are programmed to take place monthly, and it is specified that the SOPB is directly accountable to the Improving Care Board.

Terms of reference for the Stroke Operational Group were issued in June 2025. The stated purpose of the group is 'to ensure an operational structure is in place and being reviewed of the overall Stroke Pathway to ensure that it's delivering high quality and timely services to improve health outcomes and quality of life for stroke patients treated by the Health Board', and it reports to the SOPB. Membership is comprised of the Clinical Director for Stroke, the Service Directors for Unscheduled and Primary Care, and key senior members of the medical and nursing staff from stroke services. The first monthly meeting of the group is recorded as having taken place in September 2023.

The Improvement Action Plan is monitored by the Stroke Operational Group and the SOPB. Summary details are included in the Unscheduled Care Group operational management board reports.

Responsibility for stroke services has been assigned to the Health Board's QSE committee. Overall progress against the action plan is reported as part of the stroke progress reports and updates, which are regularly submitted to the QSE committee.

Recommendations from HIW inspections are recorded on the Health Board's Audit Management and Tracking (AMaT) system. At each QSE meeting updates are provided on outstanding HIW actions including those relating to stroke services.

Objective 3: There are appropriate performance measures in place for monitoring of outcomes to evidence that actions have impact. Remedial action is taken where implementation is off track.

Reasonable

Actions which require ongoing monitoring are included in action plans and have been periodically updated. This has enabled the effectiveness of actions to be monitored as part of the action plan reporting process. Where outcomes have not been satisfactory, remedial actions are shown to have been implemented. This was particularly evident with respect to the response to the critical incident at the Princess of Wales Hospital, which required some actions to be amended or suspended.

The key quality improvement measure for stroke services is reported as part of the Health Board’s integrated performance dashboard and internally within the stroke team. The outcomes of some actions relate directly to stroke services' quality improvement measures. We saw that the previous action plan monitored by the Stroke Operational Group included a matrix where their actions were mapped against the quality improvement measures for stroke services. However, since the amalgamation of actions into the Improvement Action Plan, there do not appear to be clear links to relevant performance measures. Although we have not raised a finding specifically for this issue, there is a link with Key Finding 1 and the completeness of the action plan. As such, we have attributed reasonable assurance to this objective.

Objective 4: Periodic reports on the progress against the action plan and stroke performance are produced and submitted to appropriate management and health board committees for review.

Reasonable

Progress reports against the stroke action plans and general performance monitoring reports are produced at regular intervals. Historically, reports relating to the various stroke groups referenced individual stroke action plans, with updates on each provided to the QSE committee. Since May 2025, reporting within the groups has focussed on the amalgamated Improvement Action Plan (IAP) and the HIW inspection report, which is a separate action plan.

The SOPB provides oversight of the stroke pathway within the Health Board and is accountable to the Improving Care Board (ICB). The SOPB terms of reference state that 'The Board will report formally, regularly and on a timely basis to the Improving Care Board'. The monthly programme update provided to the ICB July 2025 contained the latest IAP. We also saw evidence of stroke service reporting to the executive leadership group.

The Directorate Manager for Integrated Medicine reported that fortnightly 'touchpoint' meetings take place and are attended by the Chief Operating Officer and Executive Stroke Lead. Reports to these meetings include the IAP along with monitoring and performance information.

The QSE Committee has overall responsibility for overseeing stroke services and receives highlight reports from the Unscheduled Care Group's own QSE Committee which regularly include content relating to stroke services. In addition, in July 2025 a full stroke service update report was provided. The Health Board's 'HIW Inspections Recommendation Actions Tracker' is included in the papers of each QSE Committee meeting.

The HIW actions have been transferred to AMaT. While many of these actions had been completed, and update notes made against those which remain outstanding, these updates were not always reflected in the progress status of each action. In addition, some actions were recorded on AMaT as 'overdue' despite narrative updates suggesting they have been implemented. We also note some actions that could be 'business as usual' activities, and as such could remain open on AMaT indefinitely. Furthermore, some recommendations have been identified by management as not being achievable within the foreseeable future so could remain open on the action plan for an extended period.

Extensive information in relation to stroke services has been reported at Board level, and stroke provisions are referenced in several strategic risks which form part of the Board Assurance Framework. Data in relation to the stroke quality improvement measures are presented to Board meetings as part of the Integrated Performance Dashboard. We saw evidence of stroke service updates in the minutes of Board meetings which indicates that stroke services are afforded a substantial degree of attention by the Board.

Key Findings		Risk & Impact	Agreed Management Action
3	Updating HIW actions recorded on AMaT Our review of the narrative updates against the outstanding HIW actions indicates that a significant proportion have been implemented. However, on the AMaT system, some of these are recorded as 'overdue'. As such, data within AMaT may need to be updated to ensure that reported information shows the correct position. Several actions have become 'business as usual' but remain on AMaT as open items. A small number of the recommendations had actions that do not meet SMART criteria and may not be reasonably achievable by the Health Board.	Appropriate actions are not identified to improve stroke performance. Work to improve stroke services is not undertaken in a co-ordinated way if multiple action plans are in place from various reviews / reports.	Agreed Action: Actions which can be confirmed as being substantively complete will be closed and the matters to which they relate will be monitored by alternative means.
		Medium Priority	Expected Evidence of Implementation: Updated action plans. Updated action plans, closure details, and information with respect to alternative monitoring processes.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Kate Graham, Directorate Manager Joanne Thomas, Lead Nurse Target Implementation Date: 01/02/26

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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Discharge Planning

Final Internal Audit Report

2025/26

CTM University Health Board



Limited Assurance

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Review Reference

CTM-2526-31

Fieldwork

July - September 2025

Executive Sign Off

December 2025

Audit Committee

February 2026

Executive Lead

Gethin Hughes – Chief Operating Officer

Julie Denley, Deputy Chief Operating Officer – Mental Health, Primary Care and Community Services.

Audit Team

Paul Dalton, Head of Internal Audit

Emma Samways, Deputy Head of Internal Audit



Executive Summary

Purpose

Our audit of Discharge Planning was completed as part of our 2025/26 Internal Audit programme of work for Cwm Taf Morgannwg University Health Board (the 'Health Board'). The review follows on from our previous audit of the Electronic White Boards (EWB) system implementation. The information captured in EWBs is essential for the day-to-day management of patients and planning their timely discharge.

Appropriate, timely and safe discharge of patients from hospital settings is fundamental to the provision of effective healthcare and enhances the patient's and family/carer's experience. For most patients, discharge from hospital is simple, but for some, their needs are more complex. Regardless of the discharge type, the Health Board need to ensure each patient's discharge is well-planned and there is a smooth transition from one stage of care to the next.

The discharge process needs to be managed seven days a week and should involve patients, family, carers as well as health and social care teams. Poor discharge planning can have substantial implications for the use of health and social care resources as well as for the voluntary sector and other support services. It can lead to the inefficient use of beds, increases in waiting lists, higher re-admission rates, patient safety issues, patient and carer distress, as well as increased workloads for hospital and community staff.

Overview

Following completion of our work, we have concluded limited assurance on this area. The key matters requiring management attention are listed below, though as an overarching action it should be ensured that the Deputy Chief Operating Officer for Primary and Community Care maintains an oversight of the discharge process as a whole, including the longest waits, working closely with the Deputy Chief Operating Officer for the acute sites. This will help ensure an appropriate level of oversight and support an integrated, whole-system approach.

- The Integrated Discharge Policy has not been updated following revised guidance issued by Welsh Government. The policy is also unclear on a number of aspects of the process including the reason and delay codes that need to be captured for patients and the use of 'bridging codes'.
- The Health Board does not communicate with families regarding the discharge process in line with the process set out in the Integrated Discharge Policy.
- The incorrect and inaccurate use of reason codes to describe a patient's criteria to reside, despite them being recorded as clinically optimised for discharge.
- Several patients occupying acute beds where the Electronic Transfer of Care (EToC) or Supported Discharge Notification (SDN) process had not been initiated in the required timescale.
- The use of in-house developed software (Transfer Portal), where the original developer is no longer employed by the Health Board, and there is inability to amend access to the system.
- Differences in the operational approach to the Patient Flow teams across the three sites.
- Weekly validation or long length of stay meetings differ in structure, attendance and coverage across the three sites, which affects efforts to reduce discharge delays.
- There is a lack of resources or adequately trained personnel to carry out the quarterly audits described in the Integrated Discharge Policy.
- The recent update to the Integrated Discharge Delivery Board (IDDB) action log does not include outstanding actions from the previous version.

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:

- The IDDB terms of reference is in draft, with no review date or assigned lead. Once agreed, the Health Board needs to ensure that it is disseminated to the appropriate people.
- Not all actions captured in the Pathways of Care Delay action plan have target dates recoded against them.

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 up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government’s Hospital Discharge Guidance and the Discharge to Recover and Assess (D2RA) Pathways Guidance.	1	Reasonable
2	Processes and resources are in place to support timely discharge of patients, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	2, 3, 4 & 5	Limited
3	Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance. Actions are taken to address areas of poor performance and low/non-compliance.	6, 7, & 8	Reasonable
4	Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective coordination with local authorities and the third sector.	9, 10, & 11	Limited



Findings & Agreed Action Plan

Objective 1: There are up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government’s Hospital Discharge Guidance and the Discharge to Recover and Assess (D2RA) Pathways Guidance.

Reasonable

Overview

The Health Board’s Integrated Discharge Policy was approved in May 2024. The policy sets out the minimum standards for discharge and the roles and responsibilities of all parties, including partner organisations. Additionally, it provides supporting guidance and information for staff, ensuring a comprehensive approach to the hospital discharge process. The policy has a number of appendices, including one with links to numerous other information sources such as Age UK and local authority websites. However, we note that the Welsh Government (WG) discharge guidance is not linked within the policy.

The policy aligns with the D2RA Pathways Guidance, and we confirmed that key points from the September 2024 Welsh Government Hospital Discharge Guidance are incorporated in the policy, although some minor changes are needed. The policy was due for review in May 2025 but has been delayed so that discussions with the local authorities can take place to agree minor changes.

Due to the level of detail contained within the policy and its appendices, separate procedures have not been developed. However, whilst we acknowledge the level of information within the policy, our testing has identified some areas where application of the policy is not clear, for example in the use of internal and external delay codes, bridging reasons and the audit process.

Key Findings		Risk & Impact	Agreed Management Action
1	Integrated Discharge Policy The policy was approved in May 2024. Our review of the policy and testing undertaken in later objectives identified: • The policy has a review date of May 2025, but this review has not taken place. • The WG Hospital Discharge Guidance was published after the policy was approved. Whilst the policy is mostly in line with the guidance, management have identified some updates. • The policy is not clear in relation to when the internal delay codes listed are to be used, or the difference between external delay codes and bridging codes. • The audit process set out in the policy is not clear on the responsibilities for the process, which may be contributing to why audits are not undertaken.	Inaccurate or unclear guidance for staff to follow resulting in differences in approach being adopted and delayed discharges	Agreed Action: The Integrated Discharge Policy will be reviewed to ensure it meets the requirements of Welsh Government guidance and clearly sets out the requirements of all relevant parties to aid timely discharge processes.
		Medium Priority	Expected Evidence of Implementation: Newly approved discharge policy and guidance
	Theme: Policies & Procedures		Control Design

Overview

The Integrated Discharge Policy sets out the process to be followed to aid the timely discharge of patients. It includes patients in acute beds who may need support in order to be discharged home, or require discharge / transfer to a community bed, it also covers community patients being discharged to a care home setting or back to their own home. The policy includes information on how patients and their families or carers should be communicated with. It also sets out the information and data to be captured about patients to plan their timely discharge.

The policy requires a consistent consideration of the cultural and communication needs of individuals and their families or carers. It includes template WG approved letters, that explain the discharge process to patients and families, though acknowledges that communications must be tailored to meet each person’s specific requirements. However, written communication with patients and families is limited, and in some cases has led to misunderstandings about the discharge process.

Within the EWB system, all patients should have an allocated D2RA pathway, and a recorded EDD which should be reviewed daily. Patients should also be reviewed each day to assess the rationale for their ongoing hospitalisation. Patients should either have a ‘criteria to reside’ reason code recorded in EWB or should be recorded as clinically optimised for discharge. Those patients that are clinically optimised should be discharged within 48 hours. Where the timeframes are not met, delay codes should be recorded and those awaiting beds in a community hospital should have a ‘bridging’ code applied.

We analysed the information captured in the EWB system for the 1,078 patients in a hospital bed on a date in July 2025. We looked to ensure key data and information needed to aid the discharge process was in place. We found:

- Patients who were not ‘clinically optimised’ for discharge but had no ‘criteria to reside’ reason recorded and conversely patients who were ‘clinically optimised’ yet had a ‘criteria to reside’ code recorded
- Patients whose ‘criteria to reside’ code stated ‘clinically optimised for discharge’, which is a contradiction and may mean either the wrong criteria to reside code has been applied, or their clinically optimised status has not been correctly updated.
- The same ‘criteria to reside’ codes used for both patients who were not ‘clinically optimised’ for discharge and for patients who were ‘clinically optimised’ for discharge. Again, a contradiction as if a patient is clinically optimised for discharge, there is no criteria to reside.
- Patients with missing EDD information and Patients whose EDD was within 48 hours, yet no Electronic Transfer of Care form had been submitted.
- Patients with missing external delay codes including those that should have been recorded as a ‘bridging criteria to reside’.

The correct application of the process set out in the Integrated Discharge Policy ensures the capturing of information to allow monitoring and analysis to be undertaken to identify problems and blocks in the discharge process. However, our testing identified inaccuracies and gaps in the information recorded, meaning the Health Board may not have an accurate understating of the reasons why a patient remains in a hospital bed and the action needing to be taken. Many of our findings relate to the codes that must be recorded. Whilst the policy lists them (there are over 60 internal delay codes and nearly 100 external delay codes), it is unclear which type of code should be used. Furthermore, the system allows codes to be used that appear to contradict the status of the patient.

Key Findings		Risk & Impact	Agreed Management Action
2	Communication with patients and families Communication with patients and families is mostly verbal: there is limited written communication. There is a <i>Patient Discharge Planning</i>	Patients families do not understand the	Agreed Action: We will conduct a review of the communication processes with patients and families to determine how the information

<i>Letter</i> appended to the Integrated Discharge Policy, but it is not used. We understand that poor communication has led to misunderstandings by patient's families, leading to delays in the discharge process. A digital handbook and QR code that will provide information about what happens when a patient is admitted to a community hospital and the discharge process is being developed. We have not been able to confirm if there is a plan to develop something similar for the acute hospitals. Currently, there is no dedicated discharge team or support for the discharge model, which limits the ability to provide proper communication and resources to families.	discharge process causing delays in the discharge process.	contained in the <i>Patient Discharge Planning Letter</i> can be better disseminated across all hospital settings. The development and implementation of the digital handbook and QR codes providing generic discharge information will continue for community settings. However, consideration will also be given to non-digital communication formats to ensure inclusivity for all families.
Theme: Communication & Engagement	High Priority Control Operation	Expected Evidence of Implementation: Audit to ensure Patient Discharge Planning letters being sent to patients and families. Production of a digital handbook and other non-digital communications. Officer: Julia Wilkinson, Directorate Manager Community Services Target Implementation Date: 05/26
3 Missing and inaccurate criteria to reside & clinically optimised status data 759/1,078 patients in hospital beds on our test date were not clinically optimised for discharge (COFD), therefore should have had a 'criteria to reside' reason recorded. We identified: 118/759 patients had no 'criteria to reside' code recorded. Twelve patients were admitted on the same day, so a code may not yet have been applied. The remaining 106 patients were admitted up to 23 days before, suggesting the review of a patient's reason for remaining in a hospital bed is either not taking place on a daily basis in line with the policy, or daily reviews are not being recorded. 22/759 patients had a 'criteria to reside' code of '<i>clinically optimised (no criteria to reside)</i>'. This code should not be used in these circumstances, but the system does not prevent it. The remaining 319/1,078 patients were recorded as 'clinically optimised for discharge', meaning they did not meet the 'criteria to reside'. However, within this population we identified 108 patients who have been assigned a 'criteria to reside' reason. We understand that some of these patients may have clinically deteriorated since	Inaccurate and incomplete data meaning an inability to properly understand the Health Board's bed situation. The Health Board is unable to demonstrate compliance with internal policy and WG guidance.	Agreed Action: Users of the EWB system will be provided with guidance and reminded of the importance of recording daily the correct 'criteria to reside' reason for all patients. To prevent codes being incorrectly used, we will look at the descriptions available for all codes to ensure they are clear and set out any situations when codes should / should not be used. We will also provide better guidance within the Integrated Discharge Policy on when internal delay codes are to be used. Analysis will be undertaken to identify any trends with wards / departments not capturing criteria to reside data and additional support and training will be offered. Responsibility will be assigned to teams within care groups and reviewed/monitored and scrutinised through performance meetings to ensure appropriate actions are being taken. In the discharge App, we will include a report in relation to missing 'criteria to reside' data. We will undertake regular monitoring at established meetings to ensure that patients without a code ('blank') have one assigned.

	being designated as COFD and were no longer considered clinically optimised; however, the COFD date remained in the EWB record. We noted that for the majority of the 108 clinically optimised patients the criteria to reside reason code used was '<i>community – reablement / rehabilitation assessment</i>'. However, the same code can be used for patients who are not clinically optimised. There is a lack of clarity in the policy, and this could potentially lead to confusion when patient data is being analysed. Furthermore, the policy lists over 60 'pre COFD internal delay codes' but it is not clear when these codes are to be used.		We will review codes and amendments as part of the weekly validation meeting and provide feedback to staff about the correct code and rationale. Expected Evidence of Implementation: Updated Integrated Discharge Policy. EWB user guidance and reminders to staff. Monitoring information used to allow targeted support/training/feedback to specific staff and ward areas. IDDB (Integrated Discharge Delivery Board) Performance meeting minutes / action logs Additional reports available in the Discharge App. Criteria to reside and clinically optimised data populated in the EWB system for all relevant patients.
	Theme: Information, Data Quality & Data Accuracy	High Priority Control Operation	Officer: Lead Julia Wilkinson - Directorate Manager Community Services with Hospital General Managers Target Implementation Date: 07/26
4	Missing Electronic Transfer of Care (EToC) assessments & Supported Discharge Notifications (SDN) An EDD should be set within 24 hours of admission and reviewed daily. Those patients in an acute hospital whose EDD is within the next 48 hours should have an EToC assessment form completed, which enables the community provider (including community hospital) to be aware of the care required when the patient transfers to them. Data from our test date showed: 64 patients across all sites, had no EDD recorded in the EWB system, so staff were unable to monitor when the EToC form was due. 131/164 patients in an acute bed where the EDD date had already passed, or was in the next 48 hours, had no EToC in place. 23/134 patients in an acute bed and clinically optimised for discharge for more than 48 hours, had no EToC in place.	Patients are unable to move through the discharge pathway in a timely manner resulting in lengthier hospital stays. The Health Board is unable to demonstrate compliance with internal policy and WG guidance.	Agreed Action: Staff will be reminded of the importance of maintaining accurate records in the EWB system, specifically regarding Estimated Date of Discharge (EDD). They will also be reminded of the importance in completing timely Electronic Transfer of Care (EToC) and Supported Discharge Notifications (SDN) forms. Analysis will be undertaken to identify any trend with wards / departments not recording EDD data and not completing timely EToC and SDN forms and additional support and training will be offered. We will include in the Discharge App reports in relation to missing EDD data and missing / due EToCs and SDN forms. Regular monitoring at established meetings will be conducted to ensure that missing information is highlighted and captured. We will liaise with Bridgend and Merthyr Tydfil local authorities to understand why they are unable to use the

	Missing EToCs can contribute to delays in the transfer of patients out of acute settings. In addition, whilst EToCs are completed by ward staff, for patient's resident in the Bridgend and Merthyr Tydfil local authority areas, additional assessments are completed. This creates an extra step in the process and we understand can lead to delays in transferring or discharging patients. SDN are to be completed when a patient's pathway is complex and additional support is needed in the discharge process from a professional that is not routinely involved in patient care on a ward. Data from our test date identified 42/175 patients, who were on a D2RA Pathway 3 (complex), were clinically optimised for discharge, yet had no SDN in place.		EToC form as is used by other local authorities. If the current additional assessments are required, we will work to establish if these can be conducted without lengthening the discharge process. Expected Evidence of Implementation: EWB user guidance and reminders to staff. Monitoring information used to allow targeted support/training/feedback to specific staff and ward areas. IDDB (Integrated Discharge Delivery Board) Performance meeting minutes / action logs Additional reports available in the Discharge App. Work to deliver straight to service in Bridgend and Merthyr. EToC and SDN assessments completed and data captured in EWB for all relevant patients.
		Medium Priority	Officer: Julia Wilkinson - Directorate Manager Community Services Target Implementation Date: 06/26
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
5	Delay and bridging codes Patients that are not discharged within 48 hours of becoming clinically optimised should be assigned an 'external delay' code. Monthly delay data is reported to WG via the 'Pathways of Care Delays' report. There are nearly 100 delay codes that can be used. Our analysis identified 21/258 patients without a delay code, who had not been discharged within 48 hours of being clinically optimised. Five patients had been COFD for more than 30 days, suggesting gaps in the weekly delay code verification work. The Integrated Discharge Policy provides information on 'bridging care for patients who are not discharged within 48 hours of becoming clinically optimised and in an acute bed, where the delay is due to a lack of capacity in a community setting. A bridging code sets out the level of bridging care required while the patient waits for community provision. The policy implies that a bridging code is in addition to a delay code, as bridging codes are not listed withing the 100 delay code reasons. However, we have been informed that bridging codes	Patients are not discharged on a timely basis, resulting in poor patient experience, delays in patient flow and lack of bed availability.	Agreed Action: We will provide additional training to staff on the correct use of external delay and bridging codes, and Patient Flow Teams will conduct regular audits to ensure compliance. We will review and update the Integrated Discharge Policy to include clear guidelines on the use of the various code types, with a documented step-by-step process for staff. Expected Evidence of Implementation: Training notes /records

are a type of external code, but this is not clear from reading the policy. 126/258 patients who were on a bridging pathway of care required a 'bridging code', but 92 of these had codes which did not appear to be an external delay code in line with guidance.		Updated Integrated Discharge Policy. Audit to ensure complete and accurate delay codes populated in EWB for all relevant patients.
	Medium Priority	Officer: Julia Wilkison, Directorate Manager Community Services Target Implementation Date: 03/26
Theme: Information, Data Quality & Data Accuracy	Control Operation	

Overview

A 'Discharge App' has been developed that allows the data collected through the EWB system to be analysed and used for monitoring and aid the discharge management process. The Discharge App is used by the Discharge Hub community team, and the Patient Flow teams at the three main hospital sites.

The Discharge Hub facilitates coordination of patient discharge between acute and community care settings by monitoring daily discharge status through tools including the Discharge App and use of the 'Transfer Portal' for allocating beds. We understand that management have concerns regarding which staff have access to the portal.

We saw evidence of the Discharge Hub team using the app to maintain a tracker containing information of the EToCs they receive and those returned to wards due to insufficient information. The team has used this to identify trends in errors and training needs. As a result, in July 2025, a revised EToC form was launched to ensure fewer errors, a more robust flow of information, and to reduce processing delays. The roll out of the new form was supported by on-line training sessions and an updated user guide.

The Discharge Hub is responsible for producing weekly 'Pathways of Care Delay' (PoCD) reports which are sent to each site for validation. Inaccuracies identified in the reports are fed back to the Discharge Hub for amending. On a monthly basis a validated PoCD report is submitted to Welsh Government.

The Patient Flow teams use the Discharge App to help discharge planning at each site. We met with staff from all three teams and note that there are common themes and efforts to achieve consistency across the three sites. However, there are differences in team structures, staffing levels, roles and processes including use of the Discharge App and the approach to their patient flow meetings.

We have seen evidence that the collated data is reviewed and analysed to aid the discharge management process, but different approaches were taken to using the data. In addition, the Discharge App is not used at a ward level which could further aid the discharge process and allow ward staff to see the inaccurate and incomplete data. Whilst we encourage use of the app, our testing undertaken as part of objective 2 identified that there is work to be done regarding the quality and completeness of its data.

Key Findings		Risk & Impact	Agreed Management Action
6	Transfer Portal access The 'Transfer Portal' is used to allocate community beds to patients transferring from an acute hospital bed. While updates to the portal should be undertaken by the Discharge Hub, all staff members have access to the system. This means transfers and changes can be input without the knowledge of the Discharge Hub team. It is our understanding that system creator is no longer employed by the Health Board and as such, access permissions cannot be adjusted.	Inappropriate changes or information is input impacting on the ability to obtain accurate information and delays in patient flow.	Agreed Action: A review of the Transfer Portal will be undertaken with a view to determine if its functions could be effectively managed through an alternative system, such as EWB or Power BI. If it is deemed the portal is required, the risks inherent with the system will be captured and mitigating controls developed. Expected Evidence of Implementation: Decommissioning of the transfer portal or risk and mitigation plan

		Medium Priority	Officer: Julia Wilkinson, Directorate Manager Community Services Target Implementation Date: 02/26
	Theme: Information, Data Quality & Data Accuracy	Control Design	
7	Patient Flow teams While work is underway to develop a unified approach to using data on the Discharge App among the three sites, there remain operational differences between the sites. Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) have structured teams with specific roles, currently the Princess of Wales (PoW) hospital does not have a permanent Head of Patient Flow. RGH and PCH have regular meetings to review patient pathways and discharge status, but PoW is working on improving meeting structures and attendance. All sites use the EWB and Discharge App, but there are inconsistencies in usage often linked to training. While there are plans to roll out access to the Discharge App to ward managers and staff, this has not yet happened. Use of the App by ward staff may in turn promote better engagement with the EWB system as staff can see the output and the gaps / inaccuracies in the data.	Inconsistent approaches to teams across sites impacting on patient flow and timely discharges.	Agreed Action: We will review the structure, establishment and roles within the Patient Flow teams with a view to addressing any variations or issues identified in order to have a more consistent approach across sites. We will ensure that all sites use digital tools like the E-Whiteboards and Discharge App consistently. 'Optimise' training will be provided to key staff in the first instance to improve the usage and effectiveness of these tools, with a plan to roll this out to ward level. We will expand the use of the Discharge App for discharge planning to all sites and provide training to ward managers to improve data management and decision-making. We are working towards making BI app available to use by social care leads to ensure timely review of performance and discharge data and timely actions put in place.
		Medium Priority	Expected Evidence of Implementation: Records of review of patient flow team structures. Optimise training records Greater use of the Discharge App (periodic audits to monitor the use) Access for social care leads to an app relevant for their needs.
	Theme: Resourcing	Control Operation	Officer: Hospital General Managers & Julia Wilkinson, Directorate Manager Community Services Target Implementation Date: 03/26
8	Long length of stay data Data on a patient's length of stay is calculated based on the length of time on their current ward plus time spent on previous wards.	Inconsistent approach and treatment to the	Agreed Action: We will remind staff of the correct procedure to follow when moving patients between wards in order for accurate length

However, if patients move between wards and are 'discharged' from their previous ward, as opposed to being 'transferred', the length of stay data is reset. Of the 1,078 patients in hospital beds on our test date, we identified 150 whose length of stay data based on current and previous ward days was different to their actual length of stay based of the date of their admission. This variation in approach when patients move between wards may mean when patients with the longest length of stay are reviewed, some patients are being missed. <table><tr><th>Length of Stay range (days)</th><th># of patient based on admission date</th><th># of patient based on EWB data</th><th>Difference</th></tr><tr><td><30</td><td>776</td><td>791</td><td>-15</td></tr><tr><td>31-49</td><td>122</td><td>124</td><td>-2</td></tr><tr><td>50-99</td><td>125</td><td>113</td><td>12</td></tr><tr><td>100 -149</td><td>29</td><td>27</td><td>2</td></tr><tr><td>150 - 199</td><td>10</td><td>8</td><td>2</td></tr><tr><td>200 - 300</td><td>13</td><td>12</td><td>1</td></tr><tr><td>> 300</td><td>3</td><td>3</td><td>0</td></tr><tr><td>Grand Total</td><td>1078</td><td>1078</td><td>0</td></tr></table>	Length of Stay range (days)	# of patient based on admission date	# of patient based on EWB data	Difference	<30	776	791	-15	31-49	122	124	-2	50-99	125	113	12	100 -149	29	27	2	150 - 199	10	8	2	200 - 300	13	12	1	> 300	3	3	0	Grand Total	1078	1078	0	discharging of patients, causing inefficiencies and delays.	of stay information to be calculated and used for monitoring purposes.
Length of Stay range (days)	# of patient based on admission date	# of patient based on EWB data	Difference																																			
<30	776	791	-15																																			
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150 - 199	10	8	2																																			
200 - 300	13	12	1																																			
> 300	3	3	0																																			
Grand Total	1078	1078	0																																			
		Expected Evidence of Implementation: Updated guidance and reminders issued to staff. Accurate length of stay data captured.																																				
	Medium Priority	Officer: Hospital General Managers & Julia Wilkinson, Directorate Manager Community Services Target Implementation Date:12/25																																				
Theme: Information, Data Quality & Data Accuracy	Control Operation																																					

Overview

The Health Board's Integrated Discharge Policy outlines a structured governance and reporting framework involving key groups such as the Integrated Discharge Delivery Board (IDDB) and Operational Discharge Group. Operational co-ordination is managed by the Discharge Hub and ward multi-disciplinary teams. Oversight and delivery is supported by daily, weekly, monthly, and quarterly reporting cycles and an escalation framework to aid effective discharge coordination and management of delays.

Our review of IDDB meeting papers for the period March to June 2025 identified two of the four meetings did not take place due to poor attendance. In July 2025 a revised approach to meetings was adopted with a refreshed terms of reference and membership arrangements. The revised approach will mean a greater focus on the design and delivery of discharge processes to improve discharge performance, reducing delays and embed best practice. Action logs are generated following each meeting capturing actions, decisions and timeframes. While these action logs were in place prior to July 2025, previous outstanding actions do not appear to have been considered by the revised IDDB.

Pathways of Care Delay (PoCD) discharges data is submitted to Welsh Government and is included in the Integrated Performance Dashboard which is received by the Health Board's Operational Delivery Committee. WG also require the Health Board to prepare a PoCD action plan. We confirmed that this is monitored by the IDDB, although there appeared to be actions with no timeframes for completion.

In 2024, in response to the critical incident at the Princess of Wales (PoW) hospital, a 'super stranded' command panel was established to review patients who had been occupying a hospital bed for over 100 days. It is our understanding that the format of this meeting was to become 'business as usual' and rolled out across all sites. Weekly 'super stranded' meetings to take place at PoW, and meetings occur across all other sites to discuss patients with extended lengths of stay. However, we note that these meetings vary significantly in structure, attendance, approach and areas being covered, with some meetings poorly attended. Of 18 attendees, 10 had not attended the previous four meetings.

The Integrated Discharge Policy sets out the requirement for quarterly audits to be undertaken at each site to identify key areas for improvement, with outcomes to be reported to the IDDB. However, we note that only one audit has been completed. This was undertaken in April 2024 and covered four wards at PoW. There have been no further audits, and the policy is not clear who is responsible for the audits.

Key Findings		Risk & Impact	Agreed Management Action						
9	Long length of stay / `super stranded` meetings On our test date, 258 patients had been categorised as clinically optimised for discharge for more than 48 hours yet remained in hospital. Our analysis of their length of stay up to our test date, after becoming clinically optimised is: <table><tr><th>Duration of Stay since COFD</th><th>Number of Patients</th></tr><tr><td>Up to 30 days</td><td>154</td></tr><tr><td>31 to 60 days</td><td>62</td></tr></table>	Duration of Stay since COFD	Number of Patients	Up to 30 days	154	31 to 60 days	62	Areas of poor performance are not identified or addressed. Inconsistent approach and treatment to the discharging of patients, causing inefficiencies and delays.	Agreed Action: We will restructure site-based meetings to ensure the function and membership is an enabling tool to improve quality of data and discharge planning process. A review of the meetings where long length of stay / super stranded patients are discussed will take place to determine the different approaches being taken across sites. Best practice will be identified and a decision made on a more standardised format including topics to be covered (i.e. just long length of stay or wider matters such as EDDs, COFDs), attendees, method for updating EWB and approach to
Duration of Stay since COFD	Number of Patients								
Up to 30 days	154								
31 to 60 days	62								

	61 to 90 days	19	
	95 days and over	23	
	Longer than 200 days	3	
	Longest stay	275 days	
All sites hold meeting where prolonged hospital stays and discharge barriers are discussed, but there is no consistency in approach. We established: - PoW hold weekly 'super stranded' panel meetings to focus on patients who have occupied a bed for more than 100 days. Attendance at the meetings was poor, especially from local authority representatives, increasing the follow up workload for the meeting chair. 10/18 of the invited attendees had failed to attend the previous four super stranded meetings - Royal Glamorgan Hospital holds weekly 'length of stay' meetings, although at the time of our visit the weekly meeting was stood down due to other priorities. - Prince Charles Hospital and Ysbyty Cwm Cynon also held weekly meetings that incorporate length of stay reviews. These meetings were well organised, although we found the areas of coverage, attendees and approach (e.g. real time updates of the EWB system) to the meetings varied between the sites.			recording actions. The use of checklist will be considered to ensure consistency. We will also review and produce terms of reference for all site-based meetings relating to flow and discharge to ensure clarity of functions and expected outcomes We will issue clear communication to meeting invitees, including external stakeholders, to set out expectations in relation to attendance and the implications on patient flow when meetings cannot take place. We will identify deputy chair's / leads for meetings to ensure they can continue in the absence of the chair / lead.
			Expected Evidence of Implementation: Revised long length of stay / super stranded meeting structure with up to date terms of reference giving clarity on meeting purpose, expectations and consistency across sites.
		High Priority	Officer: Julia Wilkinson, Directorate Manager Community Services & Hospital General Managers Target Implementation Date: 01/26
Theme: Quality, Safety & Patient Experience		Control Operation	
10	Quarterly Audits The Integrated Discharge Policy sets out the requirement for quarterly discharge audits on each site to identify key themes for improvement. Detailed information in the policy sets out the audit process to be followed, including that the audits should be undertaken by a multi-agency team. However, the policy is not clear on who at each site is responsible for overseeing the audit arrangement. Although initial audits of four wards at Princess of Wales Hospital were completed in April 2024, subsequent audits have been postponed due to competing priorities, staffing transitions and a shortage of trained staff.	Areas of poor performance are not identified or addressed.	Agreed Action: We will undertake a review of the audit process set out in the Integrated Discharge Policy to ensure it is clear and comprehensive, especially in relation to responsibility for undertaking the audit. We will engage with stakeholders, including department heads and senior management, to obtain their views on the audit process and to identify any training that may be needed to strengthen competencies and expertise required for conducting audits. We will develop and maintain audit schedules to ensure that audits are conducted regularly and on time and implement

			continuous monitoring of the audit process to identify and address any issues promptly.
			Expected Evidence of Implementation: Updated Integrated Discharge Policy reflecting revised audit process. Records of audit schedules and outcomes.
	Theme: Quality, Safety & Patient Experience	Medium Priority	Officer: Julia Wilkinson, Directorate Manager Community Services Target Implementation Date: 6/26
11	Integrated Discharge Delivery Board Action Log The approach to the IDDB meeting was refreshed in July 2025. This included appointing a new chair, reviewing terms of reference, and formalising data reporting and action plans to track progress on discharge priorities. It is unclear if actions recorded on the action log prior to the IDDB refresh have been actioned or remain open and beyond their due date.	Control Operation Key issues previously identified are not or address resolved.	Agreed Action: We will ensure that a review of all actions identified in pre-July 2025 IDDB meetings action logs is carried out. A decision will be made whether to close actions that have been implemented or that are no longer relevant. Or if still outstanding, they will be incorporated into the current IDDB action log. Expected Evidence of Implementation: Action and decision log IDDB
	Theme: Performance Monitoring	Medium Priority	Officer: Julia Wilkinson and Sian Nowell (Co – chair of IDDB) Target Implementation Date: 12/2025

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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

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

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

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

Date issued: February 2026



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Introduction

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. We presented our most recent Audit Plan to the committee in May 2025.

We also provide additional information on:

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

Accounts audit update

Audit of the Health Board's Charity's 2024-25 Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's Charity's 2024-25 Annual Report and Accounts
- **Status:** Due to be certified on 29 January 2026.
- **Expected committee date:** The Charitable Funds Committee considered the accounts and our report on 21 January; and the Board is due to consider them on 29 January with the aim of approving and signing the accounts and the letter of representation to the Audit General.

Audit of the 2025-26 Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Planning has commenced.
- **Expected committee date:** various, culminating in our final reporting in late June, to enable audit certification by the Welsh Government's deadline of 30 June 2026.

Performance audit update

Review of Unscheduled Care (Part 2)

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work assessed progress made by the Health Board in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.
- **Status:** Complete – final report in today's papers.
- **Expected committee date:** February 2026

Review of Eye Care Services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work assessed the Health Board's eye care services including plans to meet current and future population needs, regional working and arrangements to improve service efficiency. The review also considered how the Health Board is supporting patients to minimise the risk of harm occurring as a result of delays in access.
- **Status:** Complete – final report in today's papers.
- **Expected committee date:** February 2026

Structured assessment 2025 – core

- **Executive Lead:** Director of Governance / Board Secretary
- **Focus of the work:** Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review:
 - Board and committee cohesion and effectiveness;
 - Corporate systems of assurance;
 - Corporate planning arrangements; and
 - Corporate financial planning and management arrangements.
- **Status:** Draft Report issued for external clearance
- **Expected committee Date:** May 2026

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Report being drafted
- **Expected committee date:** May 2026

Review of Unscheduled Care (Part 1)

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** 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.
- **Status:** Report being drafted
- **Expected committee date:** May 2026

Review of Follow-Up Outpatients (Local Work)

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will examine whether the Health Board is taking appropriate action to strengthen its management of follow-up outpatient appointments. In doing so, we will assess whether it has fully addressed the audit recommendations from our follow-up outpatient reviews in 2015 and 2017.
- **Status:** Fieldwork
- **Expected committee date:** TBC

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how it is prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Planning
- **Expected committee date:** TBC

Review of Cancer Services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will follow on from the review of national leadership arrangements for cancer services. This work will evaluate whether the Health Board is taking effective action to ensure timely and equitable access to cancer treatment in line with national targets and quality standards.
- **Status:** Planning
- **Expected committee date:** TBC

Other relevant publications

Since the last committee update, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

<u>Checking the patients. Results from a pilot data matching exercise on GP patient lists</u>	January 2026
<u>Positive action on fraud and error in community pharmacy but more analysis could reap rewards</u>	December 2025
<u>Biodiversity and Resilience of Ecosystems Duty Report for 2023-2025 and Plan for 2026-2028</u>	December 2025
<u>Facing the Future – Auditor General for Wales Podcast – Episode 4</u>	November 2025
<u>Opportunities for Change – Auditor General for Wales Podcast – Episode 3</u>	November 2025
<u>Under Pressure – Auditor General for Wales Podcast – Episode 2</u>	November 2025
<u>A Unique Perspective – Auditor General for Wales Podcast – Episode 1</u>	November 2025

NHS Wales Finances Data Tool

September 2025

Since the last committee update, Audit Wales has not published any corporate documents.

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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Eye Care Review – Cwm Taf Morgannwg University Health Board

Audit year: 2024

Date issued: November 2025

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Summary report

About this report

- 1 Eye care services are becoming more important as the UK population ages. An ageing population means there are more incidences of age-related eye conditions, such as cataracts, age-related macular degeneration and glaucoma. Many, if caught early, can often be managed effectively with existing treatments and medicines. But delays can also result in increased risk of harm and irreversible sight loss. As a result of the increased risk of harm, in 2019 NHS Wales introduced the 'Eye Care Measure' which is an approach for prioritising and measuring waiting times based on clinical condition and risk of harm. Ophthalmology waits also continue to be recorded and reported as part of the wider referral to treatment time metrics.
- 2 In March 2021, Welsh Government published [NHS Wales Eye Health Care - Future Approach for Optometry Services](#). The plan forecasts a long-term growth in the prevalence of major eye conditions over the next 20 years including:
 - 47% increase in the numbers of people with age-related macular degeneration;
 - 50% increase in the numbers of people having cataracts; and
 - 44% increase in the numbers of people living with glaucoma.
- 3 At the end of May 2025, across Wales, 32,683 ophthalmology patient pathways had waited over a year for treatment and 1,730 over two years, and 20,283 over a year for their first outpatient appointment¹. The three health boards with the most challenging position in respect of ophthalmology waits are Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University health boards.
- 4 Given these challenges Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards committed to work in partnership and launched the 2022-2025 South East Wales Regional Ophthalmology Strategy (the regional strategy). Aneurin Bevan University Health Board is the lead organisation for the regional ophthalmology programme. The Auditor General has included a review of eye care services within his local audit plans for all three health boards.
- 5 This report sets out the findings of our work at Cwm Taf Morgannwg University Health Board (the Health Board). We reviewed local and regional plans to improve eye care services, leadership arrangements to drive improvements and address barriers to progress; and whether the Health Board is actively managing the harms resulting from long ophthalmology waits.
- 6 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

¹ Data source: Referral to treatment times, Welsh Government.

INTOSAI² audit standards. **Appendices 1 and 2** provide more information about our work.

Key messages

Overall conclusion

- 7 The Health Board has reduced the longest ophthalmology waits but is not yet meeting planned-care recovery targets. Performance against the 'eye care measure' is poor which increases the risk of avoidable harm.
- 8 In the context of these challenges, there is a need to strengthen local planning of eye care services, broaden the scope of regional working and secure further productivity and efficiency gains.

Key issues

Regional partnership working

- Delivery of the regional eye-care approach sets out a positive direction of travel. However, it was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity for cataract procedures.
- The regional cataract approach is targeting long waits, but it is not making a marked difference on overall numbers of patients waiting for treatment.
- Governance arrangements to oversee regional strategy delivery are in place, but the process for decision making on business cases can be slow and cumbersome involving multiple groups across the three health boards.

Health Board plans for eye care services

- The Health Board is acting on short-term pressures but needs a long-term plan to help ensure that eye care services meet both current and growing future need. While the Health Board is taking steps to improve the efficiency of its eye care services, it still needs to improve surgical productivity and reduce outpatient inefficiencies.

² International Organisation of Supreme Audit Institutions

Leadership and governance

- There are good executive, clinical and operational structures and leadership to drive improvements in acute eye care services. Operational eye care service risks are generally well managed and there is reasonable Board and committee oversight of eye care services. However, there is scope to improve how committees oversee ophthalmology services including its spotlight report and progress updates on the ophthalmology GIRFT review.

Ophthalmology performance

- While the Health Board has significantly reduced its longest ‘two-year’ waits, it still has a large number of eye care patients waiting a long time. It has also consistently failed to meet Welsh Government’s eye-care measure target, falling substantially short of the 95% target.

Managing the risk of harm

- Despite the Health Board taking steps to proactively manage the risk of harm resulting from ophthalmology waiting list delays, there is evidence that some patients are experiencing avoidable harm.

Recommendations

- 9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board’s response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations	
Regional ophthalmology strategy	
R1	To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases. (see paragraph 17)
R2	Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy. (see paragraph 18)
R3	Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy. (see paragraph 18)

Recommendations

Developing a sustainable eye care plan

- R4 The Health Board should urgently develop an eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is:
- based on current and projected future demand for services;
 - includes capacity plans based on realistically ambitious levels of productivity;
 - costed, at a minimum, for the medium term (3-5 year);
 - supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models;
 - supported by clear delivery actions and milestones; and
 - approved by the Board. (**see paragraph 28**)

Ophthalmology deep-dive report

- R5 Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spotlight' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include (**see paragraph 39**):
- comprehensive overview of current ophthalmology waiting times;
 - information on avoidable harm suffered by patients as a result of waiting for treatment;
 - mitigating actions in place; and
 - outline of longer-term plans for eye care services.

Ophthalmology GIRFT recommendations, Board level updates

- R6 The Health Board should provide routine updates to an appropriate committee on its progress with implementing the ophthalmology GIRFT recommendations. (**see paragraph 40**)

Detailed report

Regional partnership working

- 10 We considered whether the regional ophthalmology strategy supports the delivery of sustainable ophthalmology services, and whether there are appropriate governance arrangements in place to support its implementation.
- 11 We found that **while now progressing, delivery of the regional eye-care approach was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity.**
- 12 In 2022, Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevan University Health Boards launched the 2022-2025 Regional Ophthalmology Strategy (the regional strategy). It responds to key issues from the 2021 Pyott Review³, including rising demand, limited specialist capacity, and reliance on English providers.
- 13 The strategy sets out a clear vision for sustainable, high-quality services. It aims to establish a Regional Centre of Excellence and deliver complex eye care regionally, while less complex care is provided closer to patient's homes.
- 14 The regional strategy identifies key clinical risks, including sight loss from long waits, rising demand, and workforce shortages. It sets high-level targets for 2023–2025, including expanded cataract and emergency services, a regional vitreoretinal service, workforce development, and plans for a Regional Centre of Excellence.
- 15 Aneurin Bevan University Health Board is the regional lead for the new partnership approach, with involvement and engagement from its regional partners. The programme is split into three phases with annual milestones, these are:
 - by 2023: Regional expansion in capacity for cataracts will be fully utilised, Regional Vitreo Retinal Service will be operational, Regional Eye Casualty and Out of Hours Care will be in place (**Phase 1**).
 - by 2024: Research, Innovation and Development will be well established, Workforce Development Programme will be in place (**Phase 2**).
 - by 2025: Regional Centre of Excellence network funding will be agreed (**Phase 3**).
- 16 While governance arrangements to oversee regional strategy delivery are clear, there is a risk that the structure is too complex, causing delays. The Regional Ophthalmology Programme Board meets monthly and is supported by the Delivery and Development Group. Both have clear objectives, effective management, and strong clinical engagement from each health board. The Programme Board reports to the Regional Portfolio Oversight Board, which oversees all regional programmes. In April 2025, the Cabinet Secretary for Health and Social Care instructed the south-east region to further establish a joint regional committee during 2025–26.

³ External Review of Eye Care Services in Wales (rcophth.ac.uk) undertaken by Andrew Pyott

- 17 While decisions are being made through the established governance groups, they are also being taken separately by each health board. For example, the business case for regional cataract services required approval at ten different meetings, resulting in delay. The creation of the joint regional committee presents an opportunity to also consider how delegated authority and decision-making processes are streamlined (**Recommendation 1**).
- 18 Phase 1 of the strategy aimed to expand key regional services by 2023, but overall progress has been slower than planned. The focus on creating regional cataract service capacity was pragmatic because of the waiting list backlog, but slow to progress. Other elements of the regional strategy have also been slower to deliver particularly those set out in phases 2 and 3 above relating to a specialist centre of excellence and research. There are many factors constraining progress. This includes the focus on short-term planning detracting attention from the longer-term priorities, and operational and clinical workforce challenges (**Recommendation 2**). To help better monitor strategy delivery, there needs to be clearer reporting against the original strategy commitments, setting out clear delivery timescales (**Recommendation 3**).
- 19 It is clear that the new regional arrangements are creating new service activity in addition to the core activity provided by each Health Board. In July 2023, Welsh Government agreed £7 million recurrent funding to deliver the Regional Cataracts Business Case. From a slow start, particularly because of recruitment challenges in the Nevill Hall north hub, the levels of cataract procedures have now increased (**Exhibit 2**).

Exhibit 2: Profiled and actual delivery of cataract procedures facilitated by recurrent Welsh Government funding, by delivery hub

Financial year	Provider	Profiled	Actual
2023-24	South hub	2905	2764
	North hub	39	26
	Regionally outsourced	750	676
	Total	3694	3466
2024-25	South hub	2049	1930
	North hub	950	846
	Regionally outsourced	1308	1308
	Total	4307	4084

Source: Aneurin Bevan University Health Board

- 20 While the regional cataract approach is targeting long waits, it is not making a marked difference on overall numbers of patients waiting across the region. The funding used for regional working is being used to treat patients waiting a long time for cataracts services. However, there are more people on the referral to treatment ophthalmology waiting list now than there was in March 2023. In March 2023, there were 45,930 patients waiting across the region and this increased to 54,977 by 2025. For cataracts, in March 2023 there were 18,998 patients waiting across the region, this increased to 23,289 by March 2025. Without the regional investments, the position would have been worse, but the regional arrangements are not yet significantly resulting in reduced overall level of ophthalmology waits.
- 21 In October 2024, Welsh Government awarded the region a further £7.5 million non-recurrent funding to help reduce the long waits, particularly those waiting more than 2 years. Following Ministerial Advisory Group recommendations, and supported by £19.5 million non-recurrent funding, the region may further increase its use of the independent sector during 2025-26.
- 22 To support equitable access to treatment, regional capacity has not been distributed equally across the three health boards. Instead, it has been focused on patients who have been waiting the longest. Because the proportion of very long waits are not the same across the health boards, the Welsh Government has provided more regional funding to Cwm Taf Morgannwg University Health Board than the others. This targeted allocation aims to reduce waiting lists in a way that promotes fairness across the region. While this may not appear a 'fair share', it reflects a practical and equitable approach to addressing variation in access across the region. This approach is also supported by a regional booking team, helping to ensure more consistent access to treatment.

Health Board plans for eye care services

- 23 To ensure patients receive timely eye care in an appropriate setting, and prevent avoidable, irreversible harm, it is essential that the Health Board has a clear plan to improve its current, community and hospital-based eye care services and develop a sustainable model of care for the future. We considered whether there are realistic plans to improve eyecare services at a local level, considering whether:
- the Health Board has an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges; and
 - the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services.
- 24 We found that **despite signs of improvement, local eye care service planning remains short-term focused, and efforts to improve productivity and efficiency have delivered mixed results.**

Local eye care plans

The Health Board is acting on short-term pressures but needs a long-term plan to help ensure that eye care services meet both current and growing future need.

- 25 The Health Board is taking action to address the barriers to improving eye care services. These include rising demand, not enough staff and an ageing workforce, workplace culture issues, and poor digital systems and estates. More recently, unsafe roofing at the Princess of Wales Hospital, where eye services are based, created an urgent problem.
- 26 The Health Board's current plans mainly focus on short-term actions to deal with immediate problems and reduce long waiting lists. These include installing a SurgiCube to increase theatre capacity and outsourcing oculoplastic, medical retina and cataract procedures. There are also targeted plans to cut long waits and support regional cataract work. These, along with other actions to improve service activity and capacity, are realistic and achievable.
- 27 At present, however, the Health Board does not have an overarching eye care plan to guide long-term service improvement and address these challenges. Instead, it has a fragmented approach with eye care priorities incorporated within other plans or documents. These include its Integrated Medium-Term Plan (IMTP), its planned care Productivity, Improvement and Transformation programme, actions to implement the Wales General Ophthalmic Services 'WGOS' pathways⁴, and recommendations from Getting It Right First Time (GIRFT) and Health Inspectorate Wales (HIW) reviews of ophthalmology services.
- 28 In January 2025, the Operational Delivery Committee received an update that set out some ideas for a more sustainable approach. These included centralising cataract services at the Princess of Wales Hospital, introducing a one-stop cataract model, expanding virtual clinics, creating a glaucoma hub, and implementing WGOS pathways. While these actions could help improve services in the long term, there is still no single eye care plan. This makes it hard to see the Health Board's long-term vision, whether the changes are affordable, and when they will be delivered. Our recent [planned care review](#) also identified the need to strengthen longer-term demand and capacity planning, to support the development of sustainable eye care services. Given ongoing pressures, the Health Board should urgently develop a Board-approved eye care plan to guide long-term, sustainable improvements (**Recommendation 4**).

⁴ The WGOS ([Wales General Ophthalmic Services](#)) pathway is a structured framework designed to enhance eye care services in Wales.

Plans for improving service efficiency

While the Health Board is taking steps to improve the efficiency of its eye care services, it still needs to improve surgical productivity and reduce outpatient inefficiencies.

- 29 The Health Board's 2025-28 Integrated Medium-Term Plan focuses on making services more efficient, tracking performance and highlights specific improvement for eye care productivity. This work to take these actions forward forms part of the Productivity, Improvement and Transformation Programme. The Service Improvement Group oversees the efficiency approach, which is based on GIRFT recommendations. The main priorities are:
- improving waiting list management;
 - modernising outpatient and pre-assessment services; and
 - making the best use of theatre capacity.
- 30 Evidence indicates a strengthened focus on service efficiency, which is starting to see improvement in some areas, although not meeting targets. Between April and October 2025⁵:
- Did Not Attend rate for new ophthalmology outpatients improved from 9% to 7%, although still missing 5% or less target;
 - theatre utilisation rates decreased slightly from 77% to 75%, the targets is 85%; and
 - average operating theatre late starts reduced (improved) from 57% to 32%, and early finishes from 40% to 33%, although the targets is 10% or less target.
- 31 The Ministerial Advisory Group on NHS Wales Performance and Productivity has recommended reducing unnecessary differences in waiting times and using best practice in theatre management. One key recommendation is to set up Local Theatre Optimisation Boards to improve how theatres are used. This includes following best practice for the number of cases per theatre session. For eye surgery, the standard is:
- 10 cataract operations in a 4-hour session, or
 - 8 operations if it is a training session.
- 32 The Health Board recognises it needs to improve surgical productivity. Its 2025-28 IMTP states that it is achieving around 4–5 cataract operations on an average surgical list. It has set a target for 7 cataract procedures on 90% of lists by September 2025. To support this, the Board is also streamlining referrals so that all new cataract cases are listed directly for treatment by September 2025.

⁵ Productivity, Improvement and Transformation Programme - Ophthalmology Service Improvement Group, October 2025.

Leadership and governance arrangements

- 33 Clear leadership and governance arrangements are key to supporting well managed service improvement. We considered whether the Health Board has:
- clear and effective executive, operational and clinical accountability;
 - appropriate Board and committee level oversight and scrutiny; and
 - appropriate arrangements to capture, manage and oversee operational and corporate risks.
- 34 We found that **the Health Board has clear operational and clinical leadership and good Board-level oversight of short-term acute eye care services and associated risks.**

Operational and clinical leadership

There is clear executive, clinical and operational structures and leadership to drive improvements in acute eye care services.

- 35 The Health Board has clear leadership for eye care services. The Chief Operating Officer, supported by two deputies, is responsible for both hospital and primary care. Ophthalmology sits within the specialist surgery directorate under the planned care group. The service is led by a team made up of a service manager, a clinical director and a senior nurse, who also leads harm reviews. In primary care, the community optometry lead is rolling out the Welsh General Ophthalmic Services schemes, overseen by the Ophthalmology Clinical Director. The Health Board reports that it has good working relationships with community optometrists.
- 36 We found good executive and operational oversight of ophthalmology performance. Performance is reviewed regularly through the Chief Operating Officer's directorate performance reviews, weekly waiting list meetings and service level meetings. As noted earlier, Ophthalmology is also one of the workstreams of the Productivity, Improvement and Transformation Programme, which also has a clear governance and reporting structure.
- 37 Management oversight is focussed on improving waiting times and service efficiency, while valid they focus on the short-term and hospital services. This highlights the importance of developing an overarching eye care plan, allowing longer-term service improvements across acute and community pathways. The new Eye Care Collaborative Group should provide the structure to oversee the plans development and delivery.

Board and committee oversight

While Board and committee oversight of eye care services is reasonable, there is scope to improve how committees oversee ophthalmology services including its spotlight report and progress updates on the ophthalmology GIRFT review.

- 38 We found that the Board and its committees provide reasonable oversight of ophthalmology services. The Operational Delivery Committee (ODC) receives routine updates through the integrated performance dashboard, which breaks down ophthalmology performance, as well as quarterly IMTP reports and updates on planned care, primary care and community services. The committee also receives regular updates on the implementation of WGOS pathways through quarterly IMTP progress reports, enabling oversight of moving appropriate eye care services to the community. The Quality, Safety and Experience (QSE) Committee also receives regular ophthalmology report, through its care group highlight reports, the HIW ophthalmology improvement tracker, and the quality dashboard. Both committees oversee eye care services risks.
- 39 While there is regular reporting on performance, risk and quality the updates are high-level. In September 2023, the Quality, Safety and Experience Committee received a spotlight or deep-dive report on the ophthalmology backlog. Given the continued level of risk associated with long ophthalmology waits, the Quality, Safety and Experience Committee and/or the Operational Delivery Committee should receive an updated spotlight report (**Recommendation 5**).
- 40 HIW's [national Ophthalmology Service Review](#) was published in 2017, alongside a specific [action plan](#) for the Health Board. Routine updates on this review are still being shared with the Quality, Safety and Experience Committee, suggesting progress in response to recommendations has been slow. In contrast, there are few updates on the progress of the GIRFT ophthalmology review, although we understand actions are monitored through the Ophthalmology Service Improvement Group (**Recommendation 6**).

Risk management arrangements

Operational eye care service risks are generally well managed.

- 41 The Health Board's ophthalmology risk register reflects the main operational issues affecting eye care services. These include limited service capacity, patients being referred for specialist retina monitoring services that are not yet in place, and a shortage of glaucoma consultants. There is regular oversight, clear accountability and update of service risks. However, some of these risks have been on the register for many years, suggesting the mitigating actions are not fully addressing the issues.
- 42 Until recently, ophthalmology was classed as a high-risk service on the Health Board's organisational risk register because of limited capacity and risk of harm to glaucoma patients. It has since taken steps to reduce this risk, including stabilising clinical staffing, reducing staff absences, securing extra funding for follow-up appointments, and outsourcing services. As a result, the risk was downgraded in

March 2025. However, ophthalmology still appears in the Board Assurance Framework under wider concerns about the Health Board's ability to meet demand for planned care, although the risk rating has improved following successful actions.

Ophthalmology performance

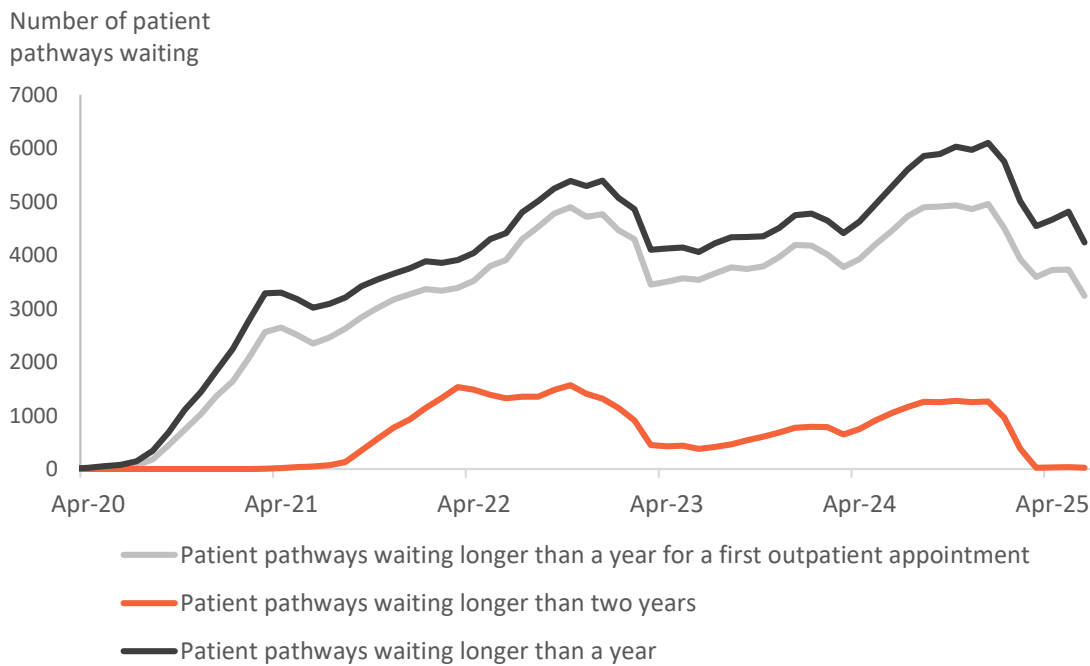
- 43 We analysed ophthalmology waiting list performance and trends to determine whether the Health Board is meeting Ministerial priorities and Welsh Government national targets related to reducing long waiting lists. The targets are as follows:
- no one waiting longer than a year for their first outpatient appointment by the end of 2022 (target date revised to December 2023);
 - eliminate the number of people waiting longer than two years in most specialities by March 2023 (target date revised to March 2026); and
 - eliminate the number of people waiting longer than one year in most specialities by Spring 2025.
- 44 In addition, ophthalmology services are measured using the eye-care measure. This measures the extent of delay for those patients at most risk of harm because of a delay in treatment. This approach is explained in **Exhibit 4**.
- 45 We found that **while long waits over two years for ophthalmology have significantly reduced, the Health Board continues to fall short of Welsh Government's targets for the eye-care measure and patients waiting over one year.**

Performance against Welsh Government planned care targets

While the Health Board has significantly reduced its longest 'two-year' waits, it still has a large number of eye care patients waiting a long time.

- 46 **Exhibit 3** shows the Health Board's performance against Welsh Government planned care waiting list targets. In June 2025, the Health Board had:
- 4,243 patients waiting longer than a year on the ophthalmology waiting list;
 - 3,239 patients waiting longer than one year for their first ophthalmology outpatient appointment; and
 - 24 patients waiting longer than two years on the ophthalmology waiting list.
- 47 Performance across all three measures has worsened since the pandemic. There has been some improvement from January 2025 onwards, especially in relation to reducing waits over two-years. The improvements coincide with further additional Welsh Government non-recurrent funding to address long cataract waits. Over the past two years, the number of patients waiting for treatment has risen from around 13,000 to nearly 16,000. This growth alongside the long-term trends identified in **Exhibit 3** suggest that the Health Board needs a sustainable solution to address both long waits, and the overall level of waits.

Exhibit 3: the number of ophthalmology patients waiting longer than two years and one year, Cwm Taf Morgannwg University Health Board



Source: Referral to treatment times, Welsh Government

Eyecare measure waiting list performance

The Health Board has consistently failed to meet Welsh Government’s eye-care measure target, falling substantially short of the 95% target.

48 In addition to the referral to treatment time waiting list, NHS Wales reports patient waits for those who are most at risk of harm because of a delay. **Exhibit 4** provides a basic explanation of this measure.

Exhibit 4: A basic introduction to the eye care measure

The Welsh Government introduced the eye care measure to help prioritise those most at risk of harm as a result of a delay in accessing services.

Ophthalmology patients are risk assessed based on their condition and then given a target date to be seen. If a patient who is categorised as the highest risk (R1)⁶ waits 25% longer than the clinically assessed target date, then it counts as a breach.

⁶ The highest risk is known as Risk Factor 1 or R1. R1 category is for patients that have been assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed.

Example: Mrs Jones has wet AMD and has been clinically assessed as needing to be seen in 4 weeks. Mrs Jones waits just over 6 weeks – therefore the target has been breached. Within 5 weeks, this would not have been a breach.

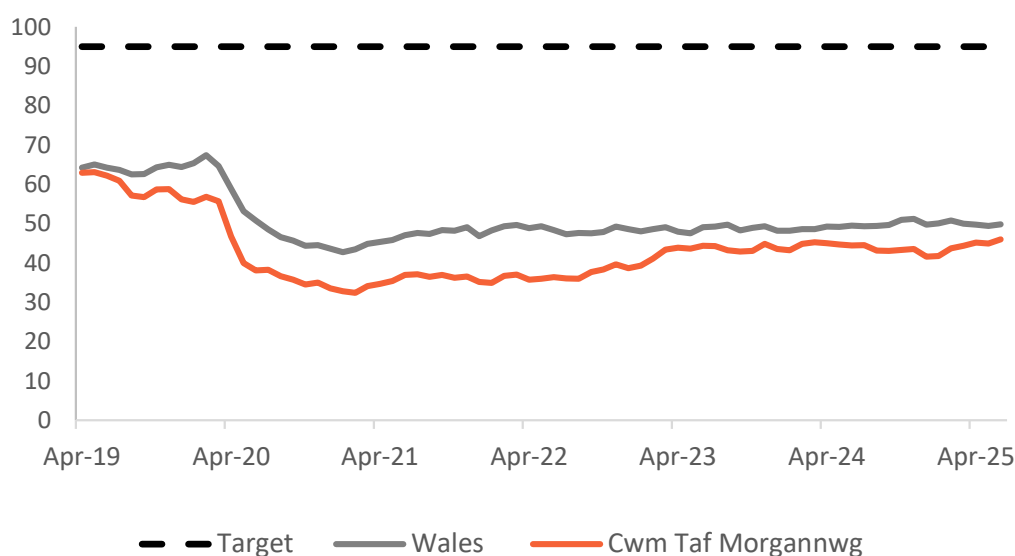
The national target is for 95% of patients on the Eye Care Measure waiting list to be seen by their target date or within 25% beyond their target date.

Source: Audit Wales

- 49 **Exhibit 5** shows performance against the Welsh Government eyecare measure target. The Health Board consistently performs below the Welsh average and has never met the national target of 95%, in June 2025 performance was 46%. Patients identified as Health Risk Factor R1 have an increased potential risk of harm and permanent sight loss. The Health Board's performance against the eye care measure remains a significant concern and means that there is a real and continued risk of patients coming to avoidable harm and suffering irreversible sight loss.

Exhibit 5: Percentage of eye care patients seen by their target date or within 25% beyond their target date, Cwm Taf Morgannwg University Health Board

Percentage within target date



Source: Eye Care Measure performance, Welsh Government

Managing the risk of harm

- 50 Until the Health Board can sustainably manage its ophthalmology waiting lists, referral to treatment and eye care measure performance remains a significant concern. This will likely continue placing some patients at greater risk of avoidable harm and irreversible sight loss. Patients' eye conditions may deteriorate while waiting, causing pain, anxiety, affect their quality of life and ability to work or care for others. It is important that the Health Board actively manages harms associated with long waiting list delays. We considered whether the Health Board:
- has effective processes to record and report on incidence of harm that results from eye care waiting list delays; and
 - is taking appropriate action to manage the risk of patient harm, particularly sight loss.
- 51 We found that **while the Health Board is proactively managing the risk of harm resulting from ophthalmology waiting list delays, there is evidence that some patients are experiencing avoidable harm.**
- 52 The Health Board has introduced processes to help manage the risk of harm to patients which include early escalation procedures by booking staff. It has also developed a Standard Operating Procedure for detecting ophthalmology harms, which includes grading the extent of eye harms when undertaking diagnostic testing. To further support this work, the Health Board is planning to appoint a 'Fail-Safe Officer' who will help booking staff manage higher-risk glaucoma patients more effectively.
- 53 The Health Board has appropriate processes in place for managing harms related to ophthalmology, these are managed at executive, care group and Patient Safety Team level. The service has several ways to identify and review harm, including a dedicated Governance Lead who reviews both current and past harms recorded on the DATIX system. Moderate and serious harms are escalated to the Ophthalmology Harm Review Panel, and severe harm is also reported to the Welsh Government. Some cases may trigger Duty of Candour or Welsh Government's serious incidents process. These cases often involve multidisciplinary meetings and 'safety huddles' to ensure thorough review and learning.
- 54 The Health Board reported that between April and September 2025 it reported five ophthalmology related serious incidents, identified seven incidents involving actual harm and received 15 concerns. We have seen evidence of the Quality, Safety and Experience Committee receiving high level updates on ophthalmology harm, specifically nationally reported incidents (NRI). For example, at the November 2024 committee nine ophthalmology related NIRs were reported, and two at the January 2025 committee. These are mainly reported through the planned care group highlight report. While the Health Board is using lessons learned to improve care, long waiting times still pose a significant risk to some patients.

Appendix 1

Audit methods

Exhibit 6 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • 2024-27 and 2025-28 Integrated Medium-Term Plans • Delivery/implementation plans and progress reports • Quality and Safety Committee papers • Operational Delivery Committee papers • Ophthalmology Harms Standard Operating Procedure • Health Board GIRFT review • Steering and programme board agendas and terms of reference • Risk register and SBAR reporting • Documentation on the use of Welsh Government funding • Regional Ophthalmology Strategy, associated programme management documentation and progress reports • Regional ophthalmology financial plans • Regional cataracts plan • Regional Demand and Capacity planning
Interviews	We interviewed the following: • Chief Operating Officer • Executive Medical Director • Executive Director of Nursing & Deputy CEO • Ophthalmology Consultant & Ophthalmology Clinical Director • Directorate Manager, Ophthalmology & Dermatology Service Manager, and Ophthalmology Lead waiting list Manager • Head of Planning for Planned Care • Ophthalmology Senior Nurse and Lead for Ophthalmology harms reviews

Element of audit methods	Description
	• Chair of Quality & Safety Committee • Director of Operations • Clinical Optometrist • Consultant Ophthalmologist for Macular and Diabetic Eye Disease
Observations	We observed the South East Wales Regional Ophthalmology Programme Board
Data analysis	We analysed key ophthalmology service data on: • waiting list performance • referrals • medical workforce • outpatient and inpatient activity and efficiency • surgical cancellations • inpatient and day case admissions

Appendix 2

Audit criteria

Exhibit 7: Main audit question - Does the Health Board have effective arrangements to improve eye care services?

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
Does the Health Board have realistic plans to improve eyecare services at a regional and local level?	Does the Health Board have an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges?	- The Health Board has a clear eye care plan, which has been approved at Board level which: - seeks to address current and future challenges with a view to developing sustainable eye care services; and - supports delivery of the Health Board’s strategic objectives/priorities and aligns with the ambitions set out in national strategies/plans and legislation. - The eye care plan appropriately reflects regional plans, which the Health Board is invested in, which aim to deliver sustainable ophthalmology services on a regional basis.
	Is the Health Board’s eye care plan realistically deliverable?	- The eye plan is supported by/includes a clear delivery plan with clear actions and milestones. - The eye care plan is based on current and projected future demand for services. - Capacity plans are based on realistically ambitious levels of productivity. - The plan is costed, at a minimum, for the medium term (3-5 year). - The plan is deliverable within the resources available to the Health Board.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
	Do the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services?	- The Health Board is proactively targeting and improving eye care service efficiency in a range of areas such as reducing DNAs and cancellations in outpatients and surgical settings, improving surgical productivity (particularly cataracts), maximising eye-care theatre list utilisation, and utilising see on symptom and patient initiated follow-ups. - Plans include national and local performance and efficiency measures and draw upon the work of GIRFT reviews where relevant. - The Health Board is working with others effectively to drive wider efficiency improvements. - The Health Board is making use of digital systems to improve service efficiency. - Use of outsourcing has been considered / implemented as a mechanism to help reduce waiting list backlogs, supported by the necessary considerations of value for money and service safety.
Does the Health Board have appropriate leadership arrangements to drive improvements in eye care services and address the barriers that might inhibit progress?	Are there appropriate governance and leadership structures to drive forward the necessary improvements?	- There is clear Executive and Senior Management accountability for the delivery of eye care improvement plans. - There is clear clinical leadership for the delivery of eye care improvement plans. - There is evidence of operational oversight of the delivery of eye care improvement plans. - There is evidence of oversight and scrutiny of the delivery of eye care plans at the appropriate Committee and at Board. - Risks are appropriately captured within operational and corporate risk registers. - There are escalation mechanisms in place in the event of services failing to meet required standards / targets / milestones.
	Is the Health Board identifying and addressing the barriers to improving its eye care services?	- The Health Board has a clear understanding of the barriers that might prevent it delivering its eye care improvements/improvement plans and intentions. - The Health Board can demonstrate that it is putting in place arrangements to tackle the barriers that could impede delivery of the improvement plans.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
	Is the Health Board effectively delivering its improvement plans for eye care services?	The Health Board can demonstrate that it is making good overall progress implementing eye care plans and initiatives, and the achievement of milestones, targets and outcome measures identified within its plans.
Is the Health Board actively managing the risk of harm resulting from ophthalmology waiting list delays?	Does the Health Board have effective approaches to record and report on incidence of harm that results from eye care waiting list delays?	- The Health Board has appropriate arrangements to identify, capture, and report on harm associated with long waits for eye care treatment: - There is a clear process for identifying and capturing patient harm caused by delays to eye care treatment. - The Health Board is reporting on actual harm caused by delays to eye care treatment to its Quality and Safety Committee. - The Quality and Safety Committee receives assurances that the Health Board is learning from incidence of harm to prevent it in the future.
	Is the Health Board taking appropriate action to manage the risk of patient harm, particularly sight loss?	- The Health Board has an appropriate system to assess patients on the eye care waiting list to ensure those most at risk of sight loss are treated first. - The eye care waiting list is frequently reviewed by a clinician to ensure clinical risks are up to date and correctly prioritised. - The Health Board is managing potential health inequalities in access to eye care services. - The Health Board is applying the principles of Welsh Government's promote, prevent, and prepare policy to help patients on eye care waiting lists.

Appendix 3

Management response

Exhibit 8 below sets out the Health Board's response to our recommendations.

Recommendation	Management response	Completion date	Responsible officer
R1 To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes	December 2025	Chair of Regional Ophthalmology Programme Board
R2 Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality.	March 2026	Chair of Regional Ophthalmology Programme Board
R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of	The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result the Regional Strategy will be reviewed as part of the programme plan in 25/26,	March 2026	Chair of Regional Ophthalmology

Recommendation	Management response	Completion date	Responsible officer
the South East Wales Regional Ophthalmology Strategy.	with appropriate phasing and timeframes assigned to programme priorities		Programme Board
R4 The Health Board should urgently develop an eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: - based on current and projected future demand for services; - includes capacity plans based on realistically ambitious levels of productivity; - costed, at a minimum, for the medium term (3-5 year); - supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; - supported by clear delivery actions and milestones; and approved by the Board.	Finalise and implement the Eye Care Plan based on demand and capacity analysis.	December 2025	Directorate Manager
	Complete demand and capacity reviews for stages 1, 3, and 4 and address gaps by subspecialty.	September 2025	PCR Manager /Directorate Manager
	Review and update job plans and clinic templates to increase activity and ensure sustainability.	January 2026	Directorate Manager
	Centralise cataract surgery to POWH (from 1 Sept 2025) and deliver higher volumes through HVLC lists.	September 2025	Directorate Manager
	Implement Straight to Listing from Sept 2025 to increase outpatient capacity.	September 2025	Service Manager
	Continue virtual clinics for medical retina and macular patients to expand outpatient access.	Ongoing	Directorate Manager
	Reduce cataract waiting times to 86 weeks stage 1 cataracts by end of Sept 25.	September 2025	Directorate Manager
	Continue bilateral cataract surgeries using the Surgicube at POWH.	September 2025	Service manager

Recommendation	Management response	Completion date	Responsible officer
	Increased virtual clinics for medical retina and macular patients – again increasing outpatient capacity.	February 2026	Service manager
	Redesign waiting list cards for better list planning and high-risk case identification.	September 2025	Service manager
	Implement Medical Comorbidities SOP.	September 2025	Clinical Director
	Implementation of Service Improvement Group with focus on theatre utilisation, PIFU / SOS and DNA rate.	September 2025	Directorate Manager
R5 Due to ongoing risks from long ophthalmology waits, an updated ophthalmology 'spotlight' report should be provided to the Quality, Safety and Experience Committee and/or the Operational Delivery Committee to support continued oversight and action. The report should include: - comprehensive overview of current ophthalmology waiting times; - information on avoidable harm suffered by patients as a result of waiting for treatment;	Produce a Planned Care Report for the Quality, Safety & Experience Committee, covering waiting times, harm, mitigation, and long-term plans.	October 2025	Directorate Manager / Lead Nurse
	Continue regular updates to IQPD meetings with Welsh Government.	October 2025	Directorate Manager
	Maintain reporting of harm and incidents through the Harm Review Panel, ensuring RCA and Duty of Candour processes are followed.	October 2025	Directorate Manager
	Full implementation of WGOS pathways (Glaucoma, MR, Independent Prescribing, HCQ) and monitor performance.	March 2026	Directorate Manager / Clinical Director

Recommendation	Management response	Completion date	Responsible officer
- mitigating actions in place; and - outline of longer-term plans for eye care services.	Recruited into band 3 admin post to support WGOS pathway implementation.	August 2025	Service Manager
	Appointment of clinical lead in Optometry and Orthoptist in to lead on implementation of WGOS pathways.	May 2025	Directorate Manager
	Launch HCQ pathway and ensure transfer of identified patients to primary care.	November 2025	Directorate Manager / Clinical Director
	Implement Glaucoma pathway and manage referrals to optometry practices.	October 2025	Directorate Manager
	Develop and finalise SOP for Medical Retina pathway and commence filtering once approved.	January 2025	Clinical Director
	Continue weekly internal RTT review meetings to monitor high-risk subspecialties and maintain 104-week targets.	Ongoing	Service Director
	Validation of list as high numbers of cataracts patients are inappropriately categorised as R1. Internally agreed vetting prioritisation to mitigate against this risk.	December 2025	Service Manager
	Update risk register as Risk to patients due to volume, waiting list and service demand is captured on the HB's generic Risk Register.	November 2025	Directorate Manager
	Ensure Planned Care Group provides incident overviews and NRIs to the Quality, Safety & Experience Committee.	October 2025	Nurse Director

Recommendation	Management response	Completion date	Responsible officer
R6 The Health Board should provide routine updates to an appropriate committee on its progress with implementing the ophthalmology GIRFT recommendations.	Provide regular progress updates on GIRFT implementation at Quality, Safety & Experience and Operational Delivery Committees. Continue to track actions via the Operational Management Group, ensuring alignment with IMTP progress.	October 2025 November 2025	Directorate Manager / Service Director Directorate Manager / Service Director



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Urgent and Emergency Care: Arrangements for Managing Demand – Cwm Taf Morgannwg University Health Board

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 review of the arrangements for managing demand for urgent and emergency care at Cwm Taf Morgannwg University Health Board (the Health Board). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, is reported separately.
- 2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system operates effectively and efficiently. The Welsh Government's Six Goals for Urgent and Emergency Care Programme (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our work, the urgent and emergency care system in Wales continued to be under significant pressure.
- 3 Our work has examined the Health Board's arrangements for managing the demand for urgent and emergency care to reduce unnecessary pressure on the system. It has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to ensure the efficient, effective, and economic use of its resources.
- 4 We undertook our work during the 2024-25 financial year. The audit methods and criteria we used to deliver our work are summarised in **Appendix 1 and 2**.

Key facts and figures

Primary Care Services	
824	Number of GP urgent and acute appointments ¹ available per day per 100,000 head of GP population in March 2025 compared with the all-Wales average of 751. This is a reduction of 16.1% since April 2023.
898	Number of GP out-of-hours contacts per month per 100,000 head of GP population in July 2024 compared with an all-Wales average of 973.
53 ²	Number of contacts at an Urgent Primary Care Centre, compared with an all-Wales average of 433 per 100,000 head of GP population in March 2025.

Ambulance Services	
177%	Increase in Category A (red) ambulance calls between April 2019 and March 2025 compared with an all-Wales average of 127%.
53%	Category A (red) ambulance calls responded to within eight minutes in February 2025, compared with the all-Wales average of 50% and a national target of 65%. This is a reduction of 18% from April 2019.
20%	Patients handed over from ambulance crews to the emergency department within 15 minutes of arrival in March 2025, compared with the all-Wales average of 14% and a national target of 100%. This is a reduction of 53% from April 2019.

¹ Urgent and acute appointments are defined as appointments for urgent or acute conditions which have occurred over the short term.

² This low number is due to the fact the region operated only one urgent treatment centre at Prince Charles Hospital at the time of our audit, which had been in place since November 2024.

Hospital Services

2.6%	Decrease in the number of attendances at the Health Board's Emergency Departments between April 2019 and March 2025, compared with an all-Wales average decrease of 8%.
1691	Number of people waiting more than 12 hours in the Health Board's Emergency Departments in March 2025. This is an increase of 80% since April 2019.
05:33	Average time spent in the Health Board's Emergency Departments in March 2025, compared with the all-Wales average of 5 hours, 27 minutes. This is an increase of 1 hour 30 minutes since April 2019.
343	Number of attendances to the Same Day Emergency Care units per 100,000 head of GP population in March 2025 compared with an all-Wales average of 278.

Funding

£63m	Additional monies allocated to the Health Board for the period 2022-25 to recover planned and urgent and emergency care over and above the Health Board's core funding.
£5.7m	Additional in-year monies received by the Health Board in 2023-24, and 2024-25 to support delivery of the ambitions of the Six Goals Programme.

Key messages

Overall conclusion

- 5 Overall, we found that **urgent and emergency care service performance continues to be challenging. Whilst plans and new services, including the Navigation Hub, are having a positive impact on managing demand, further action is needed to improve access, patient and staff engagement and clarify resource requirements.**

Key findings

Planning arrangements

- 6 The Health Board has reasonable plans to set out how it will implement the Six Goals Programme to better manage urgent and emergency care. Plans align with the requirements of the Six Goals Programme and set out key actions which include activities such as developing the Navigation Hub³.
- 7 The Health Board shows a clear commitment to implementing these plans. However, plans do not set out the required staffing and lack clarity on how new models will be funded in the medium to longer term.

Accessing services

- 8 The Health Board does not have a communications plan for its interaction with the public, staff, and stakeholders on urgent and emergency care. The Health Board does communicate and provide information to the public through its website and social media platforms, but these are not accessible to all, and the website is difficult to navigate. The Health Board does not currently evaluate the effectiveness of this communication activity, and feedback during our review indicates that there is a need to further strengthen public messaging of the purpose of services and how to access them.
- 9 The Health Board's approach to managing urgent and emergency care demand is evolving, but gaps remain in staff and patient engagement. In the absence of a communications plan, staff reported varied awareness of alternative care pathways. The Strategic Transformation of Acute Medicine Programme (STAMP), launched in July 2024, aims to standardise urgent and emergency care delivery across acute sites. Referral data shows that 999 and 111 services are broadly in line with all-Wales averages, though 111 directs fewer patients to alternative

³ Staffed by a multi-disciplinary team including GPs, clinical directors and care group members, the Navigation Hub acts as a central point for triaging and directing patients within the Health Board region to suitable care options

services. The Navigation Hub, introduced in 2020, has helped avoid admissions in 87% of cases, but staff have raised concerns about infrastructure, retention, and skill mix for this service.

- 10 The Health Board has a strong network of community pharmacies, with the highest rate per GP population in Wales and full participation in the common ailment scheme. The Health Board has established three Same Day Emergency Care (SDEC) units, with plans to expand hours and improve referral pathways. Attendance rates are high, and discharge rates exceed the national average, indicating effective use. However, ambulance referrals to SDEC remain low due to access barriers, and current practice does not align with Welsh Government policy on direct paramedic referrals. The Health Board has also piloted an Urgent Primary Care Centre and continues to evaluate its potential.
- 11 Ambulance demand across the Health Board has risen significantly since the pandemic, with red call volumes more than doubling compared to pre-pandemic levels. Although amber calls have declined, conveyance rates to hospital remain the highest in Wales, with 98.4% of patients taken to major Emergency Departments which is far above the national average. Referrals to alternative units, including Minor Injuries Units and SDECs, are notably low. Ambulance handover delays continue to be a major concern with delays increasing patient risk for those on the ambulance as well as impacting ambulance response times, which remain below national targets for both red and amber calls. Emergency Department attendance rates are significantly higher than the all-Wales average, and while four-hour performance has remained stable, the number of patients waiting over 12 hours has increased sharply.

Scrutiny and monitoring arrangements

- 12 The Health Board is still developing its approach to monitoring alternative clinical pathways. It regularly reviews live data on ambulance and handover delays through urgent and emergency care dashboards. While metrics are in place for services like the Navigation Hub and Emergency Departments, staff noted that current data does not fully show the clinical impact of alternative services, and that there are inconsistencies between Health Board and WAST data. The Health Board collects staff and patient feedback but it is unclear how this informs service changes.
- 13 There is strong operational oversight for urgent and emergency care performance and plan delivery through daily performance reviews and regular reporting structures linked to the Six Goals Programme. The Health Board could strengthen strategic oversight further by ensuring WAST representation on the Six Goals Urgent and Emergency Care Board. Specific developments, such as the Navigation Hub, are regularly reported to the Board and the Health Board is monitoring project investment.

Recommendations

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

Exhibit 1: recommendations

Recommendations	
Resourcing urgent and emergency care plans	
R1	Future Six Goals plans should clarify the use of the entirety of financial allocations (Exhibit 2).
R2	To support the ongoing delivery of Six Goals related initiatives, the Health Board should ensure that its Six Goals plans identify any funding needs beyond the current annual allocation (Exhibit 2).
R3	To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements (Exhibit 2).
Improving information on alternative services	
R4	To ensure that patients can locate relevant information quickly and confidently, the Health Board should improve the visibility and accessibility of urgent and emergency care information on its main website homepage. This could include adding a clearly labelled, prominently positioned link or banner (Paragraph 26).
Monitor compliance with national SDEC referral guidance	
R5	To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee (Paragraph 51).
Data monitoring of alternative services	
R6	To inform decision-making, the Health Board should enhance its data collection to capture the clinical impact of alternative services, such as those accessed via the Navigation Hub (Exhibit 9).

Recommendations

Ensuring data quality to inform plans

- R7 The Health Board should review and regularly validate the data that is currently available for urgent and emergency care, so more assurance can be taken when making decisions based on the data available (**Exhibit 9**).
-

Use of staff and patient feedback

- R8 To ensure the Health Board is building on feedback from staff and patients, plans for urgent and emergency care should demonstrate how they have considered staff and patient feedback (**Exhibit 9**).
-

Oversight and Scrutiny

- R9 To strengthen its ability to join up strategic plans and service changes for its urgent and emergency care services, the Health Board should include WAST as a member of its Six Goals Delivery Board (**Exhibit 10**).

Detailed report

Planning arrangements

- 15
- This section considers whether the Health Board has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:

 - being informed by relevant and up to date information;
 - identifying and seeking to address key risks associated with urgent and emergency care services;
 - aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
 - identifying the current and required levels of resource and staffing to achieve the intended ambitions.
- 16
- We reviewed the Health Board’s Six Goals for Urgent & Emergency Care Delivery Plan (2024-25), along with relevant sections of its Annual Plan (2024-25) and its Integrated Medium-Term Plan (2024-27) focussed on urgent and emergency care services.
- 17
- We found that **plans to manage demand are reasonable and are supported by investment from the Six Goals Programme and other additional funding. However, plans do not set out the required levels of staffing and lack clarity on how new models will be funded in the medium to longer term.**
- 18
- The findings from our review of plans are summarised in **Exhibit 2**.

Exhibit 2: approach to planning urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Are plans informed by relevant and up-to-date information?	Yes	Plans draw upon a range of data, including Navigation Hub activity, and SDEC activity. Plans also reflect key ministerial and local priorities, including strengthening urgent and emergency care service resilience and improving outcomes, with a specific focus on improving frailty services.
Do plans identify and seek to address key risks associated with urgent and	Yes	The Health Board’s urgent and emergency care plans identify key risks and mitigating actions the Health Board intends to take. The Six Goals Plan is supported by a Risk Actions Issues and Decision log. Individual risk areas are given a severity rating, assigned a risk owner and given a mitigating action plan.

Audit question	Yes/ No/ Partially	Findings
emergency care services?		Risks are monitored through the Six Goals Programme Board. Some of the risks listed on the Risk Actions Issues and Decision log are particularly challenging as they relate to workforce and resource challenges. The Organisational Risk Register (ORR) identifies risks in more detail including one relating to the estates issues at Princess of Wales Hospital, the knock-on effect of availability of beds and the resulting impact of extra demand on Royal Glamorgan Hospital capacity. The Health Board has several controls in place and is tracking progress.
Do plans align with the requirements of the <u>Six Goals for Urgent and Emergency Care Programme</u> , and clearly set out how the alternative clinical pathways will work?	Yes	Health Board plans align with the requirements of the Six Goals Programme. The Health Board has consolidated the Six Goals into four main workstreams, the first of which is alternatives to admission. Plans set out details of existing and new initiatives/service models and clinical pathways the Health Board is offering as alternatives to emergency admission. The Navigation Hub is an integral part of workstream one, as well as piloting a local Urgent Primary Care Centre (UPCC) model in the Cynon Cluster. The second workstream focuses on the implementation of Same Day Emergency Care Services (SDEC) and direct access pathways.
Do plans identify the current and required levels of resource and staffing to achieve the intended ambitions?	Partially	The Health Board was allocated £2.96 million in 2024-25 to support its delivery of the Six Goals Programme for Urgent and Emergency Care. The Six Goals Plan provided costings related to how these monies would be allocated between five main areas. The predicted spend was £2.7 million which was within the allocated spend, but it was unclear how the Health Board would utilise the remaining £260,000 of its total allocation (Recommendation 1). Positively, the Six Goals Plan does identify where the Health Board is utilising other funding, including the Regional Integration Fund and Further Faster money. However, the plan did not identify funding needs beyond the 2024-25 financial year (Recommendation 2). Despite the Six Goals Plan noting that recruiting to certain roles would pose a challenge in delivering the plan ambitions, the plan does not specifically identify the required resources needed (Recommendation 3).

Accessing services

- 19 This section considers whether the Health Board has robust arrangements in place to encourage and enable people to access the right care, in the right place, at the right time, and whether these are working. We were specifically looking for evidence of:
- effective signposting of patients to the urgent and emergency care services that best meets their needs;
 - staff having good knowledge of, and information on the range of services available to patients; and
 - changes to service delivery resulting in improvements in access to urgent and emergency care services.
- 20 We found that **whilst there are some arrangements in place to signpost services to the public, they are fragmented and hard to access via the Health Board website and data indicates potential to improve arrangements for ambulance staff to treat patients remotely.**

Signposting of services to the public

- 21 We found that **the Health Board has some arrangements to signpost information on services to the public, but arrangements are not strategic or consistent with feedback suggesting a need to improve public awareness of services.**

Communication plans

- 22 The Health Board does not have a standalone communications plan setting out how it communicates urgent and emergency care messages to the public, its staff, and other agencies.
- 23 The Health Board's position is that signposting should come via national directives, namely campaigns associated with the 111 service, the 111 press 2 for mental health service and the choose well campaign. The Health Board is active on their social media channels, regularly posting about 111 services. However, this is not accessible to those not on social media.
- 24 Whilst it is understandable that the Health Board does not wish to provide information that may confuse the public about various services, it is important that its population is aware of the differences in services available within the Health Board. Furthermore, there are differences in urgent and emergency care services in place across the Health Board's three main hospitals. These differences can make it more difficult for patients and staff to understand how to access services.

Public information

- 25 The first point of call for most patients with an urgent need may be their GP, and our review of available data suggests that, between April 2024 and March 2025, the Health Board's GP practices provided a slightly higher than average level of urgent and acute appointments per day than all-Wales average (801 and 777 appointments per day respectively). This level has decreased from an average rate per day of 896 for 2023-24. Furthermore, these appointments are only available during the day, and in times of high demand and out of hours, patients need to be signposted to alternative services that may be better placed to meet their needs.
- 26 The Health Board's website contains information for those with urgent and emergency care needs such as accessing healthcare out of hours and minor injuries, however this information is not easy to navigate to from the Health Board's main page given that urgent and emergency care needs are not listed under the websites 'patient advice' section. (**Recommendation 4**). If the patient is aware of the 111 service, there is an icon on the front page which takes them to more information on accessing urgent care when the GP practice is closed.
- 27 We also considered information available to the public via GP and dental practices to assess whether there was clear signposting for patients if they have urgent or emergency care needs out of hours. **Exhibit 3** sets out the results of this work, which reviewed the websites and out of hours phone messages of 11 GP practices and 15 dental practices⁴.

⁴ The sample included a mix of NHS and private dental practices.

Exhibit 3: results of the review of GP and dental practice information (October 2024)

Indicator	This Health Board	All-Wales position
% of GP practice websites with clear signposting	73	57
% of GP practice answer phone messages with clear signposting	73	90
% of dental practice websites with clear signposting	40	37
% of dental practice answer phone messages with clear signposting	93	87

Source: Audit Wales

- 28

The Health Board has higher rates of GP and dental practice websites which provide clear signposting compared to the all-Wales position, although performance generally across dental websites is low. Clear signposting on dental answerphone messages is much more prevalent, although there is scope to improve signposting on GP answerphone messages.
- 29

Across Wales, between 450,000 – 500,000 people access the 111 website each month. The Health Board has a lower-than-average rate of 111 calls per head of GP population. In February 2024, the 111 calls made by the Health Board residents accounted for 11.7% of all calls. The top five reasons for calls are set out in **Exhibit 4**.

Exhibit 4: top five reasons for calling 111 (February 2024)⁵

This Health Board	% of all calls	All-Wales position	% of all calls
Abdominal pain	2.7	Dental problems	4.1
Chest pain	2.0	Abdominal pain	2.4
Cough	1.6	Chest pain	1.6
Rash	1.2	Cough	1.4
Fever	1.1	Rash	1.0

Source: Ambulance Services Indicators - February 2024

⁵ Due to ongoing issues with the new 111 system implemented in April 2024, there has been no data on the 111-service reported since February 2024.

- 30 Abdominal pain is the most common reason for contacting 111 in the region, though this rate is broadly in line with the all-Wales position. Of note is the fact that the Health Board is one of only two health board regions where dental problems is not one of the top five reasons for calling 111. This is despite data showing that the Health Board has the lowest number of dental contracts per 100,000 of population compared to the all-Wales figure (12.5 and 16.8 respectively). This is likely due to the Health Board managing urgent and emergency dental calls through its Navigation Hub. Within the Navigation Hub a dental nurse/GP triages each call and addresses emergency or urgent calls accordingly.

Patient awareness

- 31 The Health Board does not currently have mechanisms to evaluate the effectiveness of its public communication to understand whether its activity is reaching the right audience or whether its messages are changing public behaviour in the way they access urgent and emergency care. During our review, staff from the Health Board suggested there is scope to improve the public's awareness and understanding of urgent and emergency care services, with staff noting that the system within the Health Board is complex.
- 32 Feedback from Llais⁶ indicates that they do not receive many complaints about signposting as the Health Board tends to see people wherever they present. Whilst this provides a good experience for patients it does not support the ambitions of the Six Goals Programme to treat people in the right place, first time. Llais are often contacted about concerns relating to the long waits and busy waiting areas, lack of access to refreshments and lack of understanding of openings hours for minor injury units.

Staff awareness and ability to refer

- 33 We found that **the development of a Navigation Hub is supporting referrals for some professionals, but data suggests scope to improve arrangements for ambulance staff to treat patients remotely.**

Promoting staff awareness of services

- 34 In the absence of a communications plan, it was not clear how the Health Board engages its staff on plans to manage demand for urgent and emergency care. Interviews with a range of staff as part of this review indicated that the methods used are inconsistent.

⁶ Llais Wales is a national, independent body set up by the Welsh Government to collect and report the views and experiences of the public to influence decision-makers in the NHS and social care sector

- 35 In our interviews we found that staff had varied knowledge of alternative care pathways. Staff did, however, consistently raise issues with accessing a single Health Board service directory, and noted that there was differing pathways depending on location which is a barrier to their use by partners, such as ambulance staff and GPs). Those we spoke to also mentioned that it is easier to signpost patients to the Emergency Department than an alternative pathway.
- 36 The Health Board established a Strategic Transformation of Acute Medicine Programme (STAMP) in July 2024 to provide a consistent approach in the delivery of Acute Medicine across all three acute sites. Through the programme, the Health Board is reviewing SDEC, pathways and flow models within its urgent and emergency care services. The STAMP is expected to help standardise the Health Board's approach around urgent and emergency care services.

Referring to services

- 37 The rate of patients that call 999 who are dealt with through 'consult and close' over-the-phone advice or signposting within the Health Board is consistently in line with the all-Wales average (14.9% compared with 15.1% in April 2024). Of those calls, the proportion that are directed to alternative services is also in line with the all-Wales average (76.8% compared with 72.9%).
- 38 However, the 111 service directs a lower proportion of patients to alternative services than at an all-Wales level. **Exhibit 5** sets out the extent to which the 111 service has been able to direct patients to other services.

Exhibit 5: referral to other services (February 2024)

Indicator	This Health Board	All-Wales position
% of 111 calls referred to GP out of hours	53.0	41.0
% of 111 calls referred to another health profession	2.8	2.4
% of 111 calls referred to dental services	8.5	9.9

Source: DHCW Urgent and Emergency Care Dashboard, Ambulance Services Indicators

- 39 During 2023-24, the rate at which 111 staff referred patients to GP out of hours and to other health professions has been above the all-Wales level and some of the highest rates in Wales. However, 111 staff have referred lower proportions of calls to urgent dental care than the all-Wales average. This is in line with the data contained in **Exhibit 4** which shows that demand for urgent dental care is lower in the Health Board region compared to the all-Wales position.
- 40 In addition, 4.5% of 999 calls within the Health Board area were transferred to the 111 service during 2023-24. However, 29.3% of these were returned from 111

back to the 999 phoneline to be considered for an ambulance dispatch. This is higher than the all-Wales average, which was 27.6% for the same period. This suggests that, although the triage software has identified that the caller has a less severe urgent care need and therefore does not require a 999-call response, there is an absence of a suitable alternative service for that patient, and they have needed to be diverted back to the emergency 999 service as a result.

- 41 The Health Board introduced the Navigation Hub in 2020. The aim of the Navigation Hub is to provide alternative care options to patients by through advice and support. The Navigation Hub is accessed by health and care professionals on behalf of a patient. Instead of defaulting to emergency admissions, health and care professionals can contact the hub for clinical advice and alternative care pathways. The Navigation Hub takes calls from professionals working in the community and nursing homes, with work also ongoing to enable access to residential homes. Ambulance staff are able to refer patients to the Navigation Hub via a direct phone number, and the Health Board provides training to some Advanced Paramedic Practitioners to support their direct access to the Navigation Hub software.
- 42 The Health Board reports that it received 2,547 calls to the Navigation Hub from care homes and ambulance call staff and clinicians between January 2023 and January 2024. It also reports that, following the work of the Navigation Hub 88% of those care home calls and 79% of those ambulance calls resulted in admission or conveyance avoidance. Whilst these results are positive, the numbers of calls remain small compared to overall demand for urgent and emergency care services at the Health Board. In addition, some of the staff we spoke to from the Hub noted ongoing challenges in managing the service in terms of access to appropriate space and IT equipment as well as staff retention and skill mix.
- 43 Whilst the Navigation Hub is supporting the management of urgent and emergency care needs and avoiding some ambulance calls from resulting in conveyance, the extent to which ambulance crews can 'see and treat' patients at scene within the Health Board area was consistently below the all-Wales average during April 2024 and March 2025. The Health Board had the lowest rate in Wales for March 2025 (8.8% compared with 14.3%). The percentage of patients referred to alternative care services has also been the lowest in Wales (5.5% in March 2025 compared with 11.9%).
- 44 During our interviews we heard of the success of the introduction of Advanced Paramedic Practitioners in diverting patients away from the Emergency Department. Advanced Paramedic Practitioners provide triage services to patients by reviewing the 999 calls awaiting an ambulance dispatch, providing treatment within the community, and referring patients onto appropriate services.

Services to help manage demand

- 45 We found that **data suggests that the Health Board's SDEC services are effectively supporting the management of demand, but there remains scope to increase additional provision of community pharmacy services.**

Community pharmacy services

- 46
- For 2023-24 the Health Board had one of the highest numbers of community pharmacies per head of GP population in Wales, at 23.1 (compared to 20.9 at an all-Wales level). Every one of the Health Board’s community pharmacies had signed up to provide the common ailment scheme in 2023-24. This scheme allows pharmacists to assess and treat a common list of minor ailments⁷. However, should antibiotics be required, then patients would need to be referred to their GP. The number of common ailment consultations per 100,000 head of GP population for 2023-24 was above the all- Wales average (13,598 compared with 10,472). The most common ailments reported were conjunctivitis, sore throat, and hay fever.
- 47
- To supplement the scheme, some community pharmacies have also signed up to provide additional enhanced services, which further increase the ability of community pharmacists to respond to minor ailments. This includes providing the sore throat treat and test service, and the independent prescribing service. Both services enable the community pharmacist to prescribe antibiotics. In addition, community pharmacists can also provide the additional hours service, which allows them to extend their opening hours and provide bank holiday cover. The uptake of these is set out in **Exhibit 6**:

Exhibit 6: uptake of enhanced services in community pharmacies (2023-24)

Indicator	This Health Board	All-Wales position
% of community pharmacies providing the sore throat treat and test service	94	79
% of community pharmacies providing the independent prescribing service	23	28
% of community pharmacies providing additional hours services	8	16

Source: StatsWales

- 48
- The Health Board has a higher number of community pharmacies providing the sore throat treat and test service. The Health Board has a lower rate of pharmacies that provide the independent prescribing service and additional hours services, which suggests there are opportunities for these to improve further. However anecdotal evidence from our work also highlighted that whilst all pharmacies within the Health Board are part of the common ailments scheme they have varying levels of ability to prescribe as not all pharmacists are qualified as independent

⁷ Common ailments scheme, 2021

prescribers, this may undermine patient confidence in the service if they are unable to get the treatment they need.

Same Day Emergency Care and Urgent Primary Care Centres

- 49 In line with the ambitions of the [Six Goals for Urgent and Emergency Care Programme](#), the Health Board has established three SDEC units. It has medical SDEC units at Prince Charles, Princess of Wales and Royal Glamorgan Hospitals which are currently open Monday to Friday, 10am to 6pm. Royal Glamorgan and Prince Charles Hospitals also have a Surgical SDEC unit. The Health Board has plans to increase the operating hours of its SDECs and redesign the pathways into the SDEC unit from the ambulance service, primary care and the Emergency Departments.
- 50 Between April 2024 and March 2025, the Health Board had one of the highest rates of attendance to its SDEC units per 100,000 head of GP population than at an all-Wales level (335.8 compared to 249.0). Although this rate had been decreasing since October 2023.
- 51 Data from WAST indicates that the Health Board has extremely low rates of SDEC referrals from ambulance staff each month. Ambulance staff informed us the only SDEC unit they are able to refer in to is at the Royal Glamorgan Hospital. However, they cannot directly contact SDEC and have to go through the main switchboard. This creates a risk of crews disengaging with the service especially as there has been a history of refusal of admission if crews are out of area. In April 2022, Welsh Government issued an all-Wales policy⁸ to encourage direct paramedic referral to SDEC. The data above along with intelligence gathered through our fieldwork indicates that the Health Board is not currently adhering to this policy (**Recommendation 5**).
- 52 Good practice says that there should be high rates of discharge from SDEC units to ensure that they are used effectively and appropriately. Within the Health Board, the percentage of patients discharged from the SDEC units has been relatively stable, with an average rate of 93% between April 2024 and March 2025. This is higher than the all-Wales average, which was 84% for the same period. This indicates appropriate use of the SDEC.
- 53 The Health Board tested an Urgent Primary Care Centre model in 2021. The evaluation of the pilot concluded that the service would be too costly to roll out further and would destabilise GP practices. It was agreed that the Health Board would implement a Navigation Hub to ensure equity of provision to the community. However, there was a pilot for an Urgent Treatment Centre in Prince Charles Hospital which helped support demand at the front door. Data on UPCC contact rates show that this centre began to accept contacts from November 2024. Small numbers of contacts were seen between November 2024 and March 2025, with

⁸ [Direct paramedic referral to same day emergency care: All Wales policy, April 2022](#)

the region having 53 contacts per 100,000 head of population in March 2025, compared to an average rate of 433 contacts per 100,000 head of population across Wales. Funding for the pilot ended in March 2025 but at the time of our audit an evaluation was taking place to look at opportunity to extend the project.

Impact of service changes on urgent and emergency care performance

- 54 We found that **performance on handover delays compares better to other health boards, but opportunities remain to make better use of minor injuries units and further reduce handover times and Emergency Department waits.**

Ambulance performance

- 55 Since the pandemic, 999 calls to the ambulance service across the Health Board have continued to rise and have now passed the level experienced by the service pre-pandemic with an average of 792 red calls per month between April 2024 and March 2025, compared to an average of 350 calls between April 2019 and March 2020. Whilst continuing to account for most 999 calls, the number of amber calls has decreased since the pandemic with an average of 3,035 calls per month between April 2024 and March 2025, compared to 3,742 between April 2019 and March 2020.
- 56 The rate at which ambulance crews convey patients in the Health Board to hospital has decreased since pre-pandemic levels from 72.9% (April 2019 - March 2020), to 68.4% (April 2024 – March 2025). However, this rate is the highest in Wales (63.3% between April 2024 and March 2025). This suggests there is more work to do to reduce conveyance to hospital through alternative services, such as expanding the Navigation Hub. **Exhibit 7** sets out the destination for all conveyances.

Exhibit 7: conveyance destination as a proportion of total conveyance (April 2024 – March 2025)

Indicator	This Health Board	Trend	All-Wales position
% of patients conveyed to major emergency departments	98.4		88.8
% of patients conveyed to minor injuries units	0.4		6.2
% of patients conveyed to major acute medical admissions unit	0.1		3.1
% of patients conveyed to other unit e.g. mental health or maternity unit	1.2		1.8

Source: Ambulance Services Indicators

- 57

Ambulance crews convey a higher proportion of patients to the Health Board’s major Emergency Departments than the all-Wales average. The rate of conveyance to major acute medical admissions units, including SDECs is one of the lowest in Wales. Whilst paramedics can convey patients to Minor Injuries Units, in practice very few are, with conveyance rates across the Health Board significantly lower than the all-Wales average. The Minor Injury Units are located in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda.
- 58

Data shows that ambulance handover delays across the Health Board continue to be at unacceptably high levels. The percentage of ambulance handovers completed within 15 minutes between April 2024 and March 2025 was just 22.7%, against a national target of 100%. Performance however is the second highest in Wales, compared to an all-Wales position of 15.5%. Except for seasonal fluctuations, handover performance has remained fairly consistent since September 2021. Despite this, handover delays continue to result in a high number of lost hours. The Health Board lost on average 2,412 hours every month between April 2024 and March 2025.
- 59

A clinical review developed by the Association of Ambulance Chief Executives⁹ discovered that the rate at which harm occurs for patients increases when their handovers take over an hour to complete. This review indicated that the likelihood of a patient experiencing severe, or permanent, harm was 7% for handovers taking between an hour and an hour and a half, 10% for handovers taking between two and three hours, and 27% for handovers taking over four hours to complete. Data from June 2025 showed that 16.1% (306) of handovers within the Health Board

⁹ ‘Delayed hospital handovers: Impact assessment of patient harm’ Association of Ambulance Chief Executives, November 2021.

took over one hour to complete, 4% (88) of handovers took between two and three hours to complete, and 1% (32) of handovers took over three hours to complete¹⁰.

- 60 Handover delays inhibit the ability of ambulance staff to respond to other urgent and emergency calls in the community. Ambulance response times continue to be challenging and below performance targets (**Exhibit 8**). The percentage of red calls responded to within eight minutes between April 2024 and March 2025 was below the all-Wales average and significantly below the target of 65%. During the same period, the response time to amber calls was two hours 23 minutes, 31 minutes higher than the all-Wales position. Performance has fluctuated between April 2024 and March 2025.

Exhibit 8: red and amber call response times (April 2024 – March 2025)

Indicator	This Health Board	Trend	All-Wales position
% of red calls responded to within eight minutes	44.9		48.7
Median response to amber calls (minutes)	143		112

Source: Ambulance Service Indicators

Emergency Department performance

- 61 Within the Health Board, the rate of attendance at an Emergency Department per 100,000 head of GP population has increased during the past two years and is considerably higher than the all-Wales average (3,064 and 1,989 respectively). The rates increased significantly in March 2025. Since January 2025, the Health Board has reported business continuity incidents (BCI) at its sites on five separate occasions.
- 62 Waiting times within the Emergency Departments in the Health Board have remained relatively static over the last twelve months, and below the all-Wales average. The percentage of patients spending less than four hours in the Emergency Departments in March 2025 was 65.4%, compared to 66.1% in April 2024. The number of patients spending over 12 hours in the Emergency Department has increased by 80% from 939 patient in April 2019 to 1,691 patients in March 2025. Once assessed, the rate of admission is lower than the all-Wales average, at 18.2% between March 2024 and February 2025, compared to 22.3% across Wales.

¹⁰ The Health Board’s performance reports do not specify the number of handovers taking over four hours.

Scrutiny and monitoring arrangements

- 63 This section considers whether the Health Board is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:
- arrangements for monitoring the impact of alternative clinical pathways; and
 - effective oversight and scrutiny of the delivery of plans for urgent and emergency care.
- 64 We found that **oversight and scrutiny of urgent and emergency care performance and plan delivery is effective, but it is not clear how patient and staff feedback is being used to inform and strengthen plans.**

Monitoring impact

- 65 We found that **arrangements to monitor patient access to services appropriately are still evolving and whilst the Health Board collects staff and patient feedback, it is not clear how it uses this information to inform improvements.**
- 66 The findings that have led us to this conclusion are summarised in **Exhibit 9.**

Exhibit 9: approach to monitoring impact on urgent and emergency care services.

Audit question	Yes/ No/ Partially	Findings
Is the Health Board tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	Partially	The Health Board's arrangements to monitor the effectiveness of alternative clinical pathways are still evolving. We saw evidence of performance data on ambulance response time delays and handover delays being reported and discussed regularly with urgent and emergency care and Emergency Department dashboards providing the Health Board with live data throughout the day. Whilst the Health Board has good metrics for areas such as the Navigation Hub and its Emergency Departments, staff acknowledged that this data needed to be improved as the data in its current format does not provide the Health Board with an insight into the clinical impact of alternative services on patient outcomes. This information would help the Health Board to understand how services are being used and plan further improvements (Recommendation 6). Staff also voiced concerns over the reliability of operational data, citing discrepancies between Health

Audit question	Yes/ No/ Partially	Findings
		Board data and WAST data to ensure a shared and accurate record of demand and capacity (Recommendation 7).
Is regular patient feedback being sought and used to inform and improve plans?	Partially	Regular patient feedback is actively sought for services including the Navigation Hub. Feedback is mainly collected through the CIVICA¹¹ system. Patient feedback is included in regular updates to the Quality, Safety & Experience Committee, and the Board. However, this information is not routinely presented back to the Six Goals Urgent and Emergency Care Board, and it is not clear how this information is used to shape decision making or changes to service delivery. The Health Board recently asked for staff and patient feedback via the STAMP review at Prince Charles Hospital. However, again, it is not clear how services are then improved or changed (Recommendation 8).
Is there regular staff feedback on the impact of changes to services and pilots to identify and apply lessons?	Yes	There are regular consultations with staff. For example, the Health Board initiated a staff engagement ideas process called "Simply do", where staff were encouraged to come up with ideas on how to improve processes and approaches. Over 200 staff responded. The Health Board was analysing the results at the time of the audit. Also, as part of the STAMP programme, views of staff were collected to make improvements to the flow of the SDEC units. Despite this, the Health Board does not clearly indicate within its plans or reporting how it is using this intelligence to make improvements.

Source: Audit Wales

Oversight and scrutiny

- 67 We considered whether there is effective oversight and scrutiny of the delivery of plans for urgent and emergency care services.

¹¹ CIVICA is a software platform designed to measure patient feedback within healthcare organisations.

- 68 We found that **there is regular oversight and scrutiny of urgent and emergency care performance and plan delivery, although this could be strengthened further by ensuring WAST representation in strategic discussions.**
- 69 The findings that have led us to this conclusion are summarised in **Exhibit 11.**

Exhibit 10: approach to oversight and scrutiny of urgent and emergency care services.

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	Partially	The Six Goals Urgent and Emergency Care Board meets every six weeks and provides a framework for reporting to the Health Board's Executive Leadership Group. However, whilst WAST have regular meetings at an operational level, they are not represented at the Six Goals Urgent and Emergency Care Board (Recommendation 9). The Six Goals Urgent and Emergency Care Board also provides reports to the Regional Partnership Board.
Is there effective oversight of urgent and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	Yes	There is effective oversight at both Board and Committee levels. Delivery of the Six Goals for Urgent and Emergency Care is monitored through highlight reports produced by the Six Goals Urgent and Emergency Care Board. These reports are shared with the Operational Delivery Committee (a sub-committee of the Board) via the Executive Leadership Group. Reports typically include information on the Navigation Hub and performance against the Six Goals for Urgent and Emergency Care Plan. The Health Board reports on performance the Board, and the Operational Delivery Committee at each meeting via an Integrated Performance Dashboard. The Integrated Performance Dashboard contains several metrics relating to managing urgent and emergency care demand, including ambulance response times, ED waiting times and GP practices achieving National Access Standards for in-hours.

Audit question	Yes/ No/ Partially	Findings
Are there arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government?	Yes	The Six Goals Urgent and Emergency Care Programme Board monitor spend for their six goals programme via a quarterly progress report which includes spend on SDEC, UPCC/Navigation Hub and related Digital workstreams. The Monthly Monitoring Report for month 12 of 2024-25 shows that the Health Board spent its urgent and emergency care allocation in line with its Six Goals Plan.

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 11 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 11: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Urgent and Emergency Care Plan (including resources required and costings); • Integrated Medium Term Plan and Annual Plan; • Six Goal Programme Plan and progress reports, including submissions to Welsh Government; • Performance reports on urgent and emergency care to Board and committees; • Evaluation reports aimed at initiatives appropriately managing urgent and emergency care demand; • Six Goals Urgent and Emergency Care Board terms of reference, agendas for last year and papers relevant to appropriately managing urgent and emergency care demand; • Results from patient surveys relating to the accessibility of urgent and emergency care services; and • Diagrams which set out the structure of urgent and emergency care.
Interviews	We interviewed the following: • Clinical Director - Acute Medicine, • Clinical Director - Emergency and Acute Medicine • Deputy COO – Acute Care • Deputy COO - Director for Primary Care, Communities and Mental Health • Executive Director of Nursing, Midwifery and Patient Care • Directorate Manager - Emergency and Acute Medicine • Chief Operating Officer • Local Llais Wales Lead • Medical Director -Unscheduled Care

Element of audit approach	Description
	• Head of Performance information USC Dashboard App Developer USC • Service Director - Primary Care and Community • Six Goals Triumvirate Team Clinical Lead • Unscheduled Care Group Director • Urgent and Emergency Care - Programme Manager • WAST Director of Operations for the Health Board
Group discussions	We held group discussions with the following: • GP Out of Hours leads and Urgent and Emergency care representatives from the Health Board and WAST (Clinical and Operational)
Data analysis	We analysed data relating to urgent and emergency care services, using the following sources: • Ambulance Services Indicators; • DHCW Urgent and Emergency Care Dashboard; • StatsWales; • Data provided by Welsh Government in relation to GP out of hours services; and • Monthly Monitoring Returns.
Website and practice reviews	We reviewed the Health Board's website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services. We reviewed a sample of 11 GP practice websites and answerphones and 15 dental websites and answerphones.

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 12 sets out the audit criteria that we used to deliver this work.

Exhibit 12: audit criteria

Audit questions	Audit criteria
Does the Health Board have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the six goals for Urgent and Emergency care?	• Strategies and/or plans relating to urgent and emergency care: – are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients. – identify and seek to address key risks associated with demand for urgent and emergency care services. – align with the requirements of the Welsh Government Six goals for Urgent and Emergency Care for better managing demand. – include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required levels of resource and	• Strategies and/or plans detail the: – resource requirements and identified funding to support any changes to service delivery included within the strategy/plan.

Audit questions	Audit criteria
staffing to achieve the ambitions?	– workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
Are arrangements in place to encourage and enable people to access the right care, in the right place, at the first time, and are these working?	
Is the Health Board effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?	• The Health Board provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, GP/dentist websites and phone lines, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the WG Six goals for Urgent and Emergency Care (Right care, right place, first time) • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs
Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?	• There is engagement between Health Boards and GP clusters / dentists / paramedics / pharmacists about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services are accessible for staff. • Staff can refer directly / divert patients to more appropriate settings for their needs, including Urgent Primary Care Centres (UPCC) and Same Day Emergency Centres (SDEC).
Is there evidence that changes to service delivery are resulting in better demand management?	• Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC. • Calls to 111 are answered quickly and abandonment rates are low.

Audit questions	Audit criteria
	• Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data shows decreasing volumes of patients with low acuity / minor complaints presenting at Emergency Departments. • Data indicates a good range of GP appointment availability. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate with low levels of calls diverted back and low numbers of re-contact rates.
Is the Health Board doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?	
Is the Health Board monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?	• The Health Board tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Health Board can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons
Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency care and alternative clinical pathways?	• There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate. • There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit x sets out the Health Board's management response to the recommendations made because of this audit. [The completed management response will be inserted once considered by the Health Board's [insert name of audit committee]].

Exhibit x: management response

Recommendation	Management response	Completion date	Responsible officer
R1 Future Six Goals plans should clarify the use of the entirety of financial allocations (Exhibit 2).	–		
R2 To support the ongoing delivery of Six Goals related initiatives, the Health Board should ensure that its Six Goals plans identify any funding needs beyond the current annual allocation (Exhibit 2).			
R3 To support achievement of the ambitions of its urgent and emergency			

Recommendation	Management response	Completion date	Responsible officer
care plans, the Health Board should clearly set out the current and future workforce requirements (Exhibit 2).			
R4 To ensure that patients can locate relevant information quickly and confidently, the Health Board should improve the visibility and accessibility of urgent and emergency care information on its main website homepage. This could include adding a clearly labelled, prominently positioned link or banner (Paragraph 26).			
R5 To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee (Paragraph 51).			
R6 To inform decision-making, the Health Board should enhance its data collection to capture the clinical impact of alternative services, such as those accessed via the Navigation Hub (Exhibit 9).			

Recommendation	Management response	Completion date	Responsible officer
R7 The Health Board should review and regularly validate the data that is currently available for urgent and emergency care, so more assurance can be taken when making decisions based on the data available (Exhibit 9).			
R8 To ensure the Health Board is building on feedback from staff and patients, plans for urgent and emergency care should demonstrate how they have considered staff and patient feedback (Exhibit 9).			
R9 To strengthen its ability to join up strategic plans and service changes for its urgent and emergency care services, the Health Board should include WAST as a member of its Six Goals Delivery Board (Exhibit 10).			

Source: Audit Wales



Audit Wales

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Website: www.audit.wales

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

Management response form



Audited body	Cwm Taf Morgannwg University Health Board
Audit name	Urgent and Emergency Care – Managing Demand
Issue date	October 2025

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	Future Six Goals plans should clarify the use of the entirety of financial allocations (Exhibit 2).	Six Goals financial allocation covers various service provision across urgent and emergency care pathway. Detailed plans and financial allocation are produced annually and shared with NHS Performance and Improvement and subsequently with Welsh Government via national Six Goals Programme team. 2025/2026 delivery plans and financial allocation are currently subject to WG review and decision on future planning and delivery of ministerial	December 2025 – January 2026	Gethin Hughes (Chief Operating Officer – Six Goals SRO)

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		priorities. Updated requirements for delivery of urgent and emergency care priorities will be released on 19 th December 2025		
R2	To support the ongoing delivery of Six Goals related initiatives, the Health Board should ensure that its Six Goals plans identify any funding needs beyond the current annual allocation (Exhibit 2) .	Funding needs to support current Six Goals funding to ensure sustainable delivery of transformation across urgent and emergency pathway should be identified and described within care groups' Integrated Medium Term Plans (IMTPs)	31 March 2026	Sarah James – Deputy Chief Operating Officer
R3	To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements (Exhibit 2) .	The Emergency and Acute Medicine Directorate are undertaking a comprehensive assessment of the current workforce capacity with the aim of outlining the additional roles, skills and staffing levels required to meet current and future service needs.	31 March 2026	Lee Collins – Deputy Service Director Ruth Morrissey – Directorate Manager

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		A workforce review for emergency medicine in PCH was undertaken in November 2025, with reviews of POW and RGH expects in quarter 4. Acute medicine workforce requirements are being reviewing as part of the Strategic Transformation of Acute Medicine Programme (STAMP).		Dr Amanda Farrow – Clinical Director Emergency Medicine Dr Les Ala – Clinical Director Acute Medicine
R4	To ensure that patients can locate relevant information quickly and confidently, the Health Board should improve the visibility and accessibility of urgent and emergency care information on its main website homepage. This could include adding a	We will liaise with CTM Communications department to ensure that appropriate and clear information is accessible and visible to the public	January – February 2026	6 Goals Programme Manager Communications Lead

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	clearly labelled, prominently positioned link or banner (Paragraph 26) .			
R5	To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee (Paragraph 51) .	The Health Board will utilise SAMBA platform to conduct SDEC audit across all three district general hospitals. In addition to this, national performance and improvement team conducts separate audits to provide a benchmarking analysis of findings and data. Recent audit was conducted in November 2025, CTM UHB is awaiting outcomes of the review.	February - March 2026	Unscheduled Care and Planned Care Group triumvirates

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6	To inform decision-making, the Health Board should enhance its data collection to capture the clinical impact of alternative services, such as those accessed via the Navigation Hub (Exhibit 9) .	The Health Board regularly (monthly) captures and analyses data from community services such as Navigation Hub to consider further service developments and implementation of new pathways. As a result of such review and analysis, new pathways: Respiratory Pathway and virtual ward for patients with chronic COPD Podiatry Pathway supporting GMS and prescribing in community Falls Response Pathway – clinical assessment of people who fell in community and collaborative approach with local authorities’ mobile responder teams	February 2026	Sarah Bradley

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R7	The Health Board should review and regularly validate the data that is currently available for urgent and emergency care, so more assurance can be taken when making decisions based on the data available (Exhibit 9).	The Health Board regularly reviews and validates urgent and emergency care data collected locally and nationally i.e. SEDIT/GIRFT. As a result of such review and validation, an Urgent Treatment Centre was set up in Prince Charles Hospital, Merthyr Tydfil to support high demand of self-presenting patients with lower acuity who would be suitable to be seen by GP. The service is based in proximity to ED which enables timely see and treat response and reduces number of patients waiting in ED.	Complete	Sarah Follows

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R8	To ensure the Health Board is building on feedback from staff and patients, plans for urgent and emergency care should demonstrate how they have considered staff and patient feedback (Exhibit 9).	Reporting on PREMS is a key priority using QR Codes and an update on the analysis of the results is provided in Unscheduled Care bimonthly Quality, Safety, Risk and Patient Experience. The detail reports on updates from previous findings. The clinical areas include “Appreciation Boards”, and “You said” and “We did”. The above is reported in the quarterly People’s Experience. Reported via the Local partnership meetings with Unscheduled Care describing any improvement work. PALS are based in these areas and provide detailed feedback both positive and any issues that require immediate attention so that there is a proactive response from the MDT. Close working relationship with HIW and LLAIS, where any issues identified are formally responded to with evidence of sustained improvements.	March 2026	Deborah Matthews Nurse Director Unscheduled Care

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Staff Survey is key and Unscheduled Care compliance is the highest it has been over recent years currently at 28%		
R9	To strengthen its ability to join up strategic plans and service changes for its urgent and emergency care services, the Health Board should include WAST as a member of its Six Goals Delivery Board (Exhibit 10).	Six Goals Programme Board and its Terms of Reference produced at the inception of the programme had always taken a collaborative and partnership-based approach to delivery of programme objectives with inclusion of stakeholders external to CTM UHB such as WAST.  Terms of Reference - 6 Goals and UEC C	Completed December 2023	Gethin Hughes (Chief Operating Officer – Six Goals SRO)



Agenda Item

7.5

Audit, Risk & Assurance Committee

CTMUHB CLINICAL AUDIT FORWARD PLAN 2026-27 AND MONITORING

Dyddiad y Cyfarfod / Date of Meeting	03/02/2026
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	David Morgan – Deputy AMD for Clinical Audit and Effectiveness, Mark Townsend – Head of Clinical Audit & Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms

CTMUHB	Cwm Taf Morgannwg University Health Board
NICE	National Institute for Health and Care Excellence
HQIP	Healthcare Quality Improvement Partnership
WG	Welsh Government
NCA&ORP	National Clinical Audit and Outcome Review Plan
CEC	Clinical Effectiveness Committee
NEIAA	National Early Inflammatory Arthritis Audit

NELA	National Emergency Laparotomy Audit

1. Situation /Background

- 1.1 This report provides the Audit & Risk Committee with an annual update on compliance against the CTMUHB Clinical Audit Forward Plan 2025-26 as noted in the 2025-26 compliance and RAG columns of the attached Clinical Audit Forward Plan for 2026-27 at **Appendix 1**.
- 1.2 **The CTMUHB Forward Plan for 2026/27:** Released annually, the plan is aligned with the HQIP directory and will be reviewed/revised on release of the National Clinical Audit and Outcome Review Plan (NCA&ORP) for Wales (due for publication in June/July 2026).
- 1.3 **Governance:** Compliance is monitored via bi-monthly specialty meetings and monthly themed CEC meetings and quarterly reports to the Quality and Safety Committee.
- 1.4 **Monitoring:** The CEC system was co-produced with multi-disciplinary teams to review the findings from national clinical audits, improve accountability, review NICE/HTW compliance, and share learning across senior clinical leadership.
- 1.5 **Recent Activity:** Seven themed CEC meetings were held between July 2024 and October 2025 covering Cancer, Respiratory, Falls/Frailty, Paediatrics, and Cardiology.

2. Specific Matters for Consideration

2.1 Clinical Audit Forward Plan

- 2.1.1 While 95% of national Tier 1 audits are fully compliant for 2025/26, the NEIAA and NELA audits remain Amber. Targeted work is ongoing to clear existing backlogs and meet national reporting deadlines.

2.2 Monitoring

- 2.2.1 While the CEC provides a central forum, individual Care Groups maintain primary responsibility for the scrutiny and governance of National Clinical Audits, HTW and NICE guidance.

2.3 Impact on Patient Quality of Care

2.3.1 Access to Proven Innovations (HTW & NICE)

Evidence-Based Treatment: Compliance with HTW and NICE guidance ensures patients have access to the latest medical technologies and evidence-based treatments that have been proven to be clinically effective and provide value.

Best Practice: Standardising care against national benchmarks ensures that a patient receives the same high-quality treatment regardless of which hospital they visit within the Health Board.

2.3.2 Continuous Quality Improvement (Audits)

Identifying Gaps: Clinical audits allow the Health Board to monitor their own services, identifying exactly where care might be improved based on national standards and implementing action plans to address any identified areas for improvement.

Proven Outcomes: Systematic auditing has been shown to significantly increase adherence to clinical guidelines, which leads to faster recovery times and fewer complications for patients.

2.3.3 Enhanced Patient Safety

Risk Mitigation: The Quality and Safety Committee can utilise the evidence to spot emerging risks before they lead to incidents, lowering the likelihood of preventable errors or harm.

Reduced Adverse Events: Research confirms that organisations who strictly follow NICE guidelines experience lower rates of complications and mortality.

2.3.4 Accountability and Transparency

The outlined clinical effectiveness monitoring and reporting process provides a formal mechanism for senior leadership to hold clinical teams accountable, ensuring that the health board is meeting its statutory Duty of Quality to the people of Wales.

3. Key Risks / Matters for Escalation

No key risks or concerns to note.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Improving Care
	If more than one applies please list below:



Link to CTMUHB Strategic Goal(s)	
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: Data to Knowledge
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective If more than one applies please list below: Efficient and Safe Care
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is not a policy or service review



	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau (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 **Continuous Monitoring:** The Audit & Risk Committee should note the progress against the 2025-26 Forward Plan and the Clinical Audit Forward Plan for 2026-27.

6. Next Steps

- 6.1 To ensure delivery of the Clinical Audit Forward Plan for 2026-27 and monitor progress through the CEC process reporting quarterly to the Quality and Safety committee.



(Agenda Item) 7.4	(03/02/2026)	Audit, Risk & Assurance Committee	CTMUHB CLINICAL AUDIT FORWARD PLAN 2026-27 AND MONITORING

Report Details:		Impact Assessment:	
FOI Status:	Open (Public)	Indicate the Quality / Safety / Patient Experience Implications:	
If closed please indicate reason:		Related Health and Care Standard	Learning, Improvement & Research
Prepared By: <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	David Morgan – Deputy AMD for Clinical Audit and Effectiveness, Mark Townsend – Head of Clinical Audit & Quality Informatics	Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes
Presented By: <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Mark Townsend – Head of Clinical Audit & Quality Informatics	Are there any Legal Implications /Impact.	Yes or No
Approving Executive Sponsor:	Dom Hurford, Executive Medical Director	Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Report Purpose	For Noting	Link to Strategic Goals	Improving Care
Engagement undertaken to date:			

CTMUHB Clinical Audit Annual Forward Plan and Monitoring

Presentation by
Mark Townsend, Head of Clinical Audit and Quality Informatics





Introduction

- CTMUHB Clinical Audit Forward Plan is released in Quarter 4 each year and includes all the tier 1 (national priority) and tier 2 (organisation priority) clinical audits that the organisation must participate in.
- Compliance is monitored through bi-monthly speciality based clinical audit meetings and through an annual programme of themed Clinical Effectiveness Committee (CEC) meetings
- The outcomes / action points from the CEC meetings are reported quarterly to the Quality and Safety Committee



Purpose of the Forward Plan

- Provide data to monitor quality of care across the HB using evidence-based approaches...for measurement and quality improvement
- Large amounts of data; powerful tool to appraise and inform practice
- Provide assurance to the Board that organisation has effective systems to deliver required standards
- Identify areas to progress improvements



Clinical Effectiveness Committee

- Evolved the system in co-production with MD team to improve engagement, action and accountability for Clinical Audit and Effectiveness
- Aim to improve care
- Hold relevant meetings supported by the appropriate level of senior professionals
- Opportunity to review **NICE/HTW** guideline compliance
- Share the learning and feedback through clearly defined channels



Clinical Effectiveness Committee

- Set annual program of monthly meetings
- Meetings are themed - national audits grouped, relevant parties only required
- Representation from the Clinical Audit team along with relevant high level senior clinicians and management



CEC Attendance/Membership

- AMD Clinical Audit – (Chair)
- Head of Clinical Audit & Quality Informatics & Clinical Audit Manager
- Care Group Director of Operations/Service Director or representative
- Care Group Medical Director or representative
- Care Group Nursing Director or representative
- Speciality CD(s)
- National Audit Clinical Leads
- Heads of Quality & Safety
- Quality Improvement representative
- Pharmacy representative
- Therapies representative



Clinical Effectiveness Committee

- Meeting structure allows all responsible for a service to be aware of performance and what areas need focus
- Identify risks, produce and implement action plan
- Opportunity to review NICE/HTW
- Quarterly reports to QSR committee
- Re-visit within relevant department as often as required
- Review local and national data to demonstrate change
- Review meetings held annually to focus on progress and new national report findings



CEC Programme Held

- Jul 2024 - Cancer
- Sep 2024 - Respiratory
- Apr 2025 - Falls, Frailty & Orthopaedics / Trauma
- May 2025 - Children and Young People
- Sep 2025 - Respiratory & Lung Cancer
- Oct 2025 – Cardiology

CEC Programme Deferred Meetings

- Sep 2025 - Diabetic
- Oct 2025 – Cancer (1st CEC review meeting)

Annual CEC Plan for 2026/27
currently being finalised

Please do not delete this slide...

Recommendation

Example:
The Committee are asked to:

- The Audit & Risk Committee should note the progress against the 2025-26 Forward Plan and the Clinical Audit Forward Plan for 2026-27.

Next Steps

Example:
The Committee are asked to:

- To ensure delivery of the Clinical Audit Forward Plan for 2026-27 and monitor progress through the CEC process reporting quarterly to the Quality and Safety committee.



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Cwm Taf Morgannwg
University Health Board

Knowing How Well
We Are Doing

Clinical Audit Forward Plan 2026-27



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

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

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

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

A Welsh Health Circular and Annual Plan is due to be published in June 2026 to clarify the mandatory audit list. The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan has been developed based on the HQIP audit directory released in October 2025, but may need to be updated following HQIP audit directory released in January 2026 and the final release of the Welsh Health Circular by WG in June/July 2026.

Clinical Effectiveness Committees (CEC) were established in 2025/26 to monitor quality of care across CTMUHB using evidence-based approaches, predominantly national audit findings for measurement and quality improvement; Provide assurance to the Board that our organisation has effective systems to deliver required standards, and identify areas to progress improvements in the delivery of patient care.

The CEC comprises of representation from Clinical Audit, Heads of Nursing and Clinical Leads, Allied Health Professionals and Pharmacy, Quality Improvement and Patient Safety. National audit action plans are reviewed and agreed through the CECs and enable the monitoring of compliance against the CTMUHB Clinical Audit Forward Plan.

Compliance Key

RED	Cause for concern. Full compliance not achieved by audit deadline.
AMBER	Tier 1: National audit delayed; backlog exists but plan in place to comply with national audit deadline. Tier 2: Organisation priority audit delayed by one quarter, but plan in place to comply with revised audit deadline.
GREEN	Audit on track at 31/03/2026 or completed, evidence of audit compliance documented on AMaT system.
BLUE	Audit and action plan completed by clinical audit leads and signed off on AMaT system.

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

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/26
Acute						
National Joint Registry (NJR)	operates continuous data capture	February 2026	September 2026	Trauma and Orthopaedics	Organisation wide compliance Action Plan agreed CEC April 2025	BLUE
National Emergency Laparotomy Audit (NELA)	operates continuous data capture	N/A	November 2026	Surgery / Anaesthetics	PCH compliant, working towards compliance in RGH/PWH	AMBER
National Emergency Laparotomy Audit (NELA) – No Lap Audit (Non-laparotomy)	operates continuous data capture	June 2025	TBC	Surgery	PCH compliant, working towards compliance in RGH/PWH	AMBER
Case Mix Programme (CMP) ICNARC	operates continuous data capture	Monthly	March 2026	Anaesthetics	Organisation wide compliance	GREEN
Major Trauma Audit # (NMTR)	operates continuous data capture	Awaiting details at time of reporting	TBC	Emergency Medicine	Organisation wide compliance for quarter 4, 2025/26. Action Plan agreed CEC April 2025	BLUE

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/26
Long Term Conditions						
National Diabetes Audit *						
Note this covers the following areas : National Diabetes Foot Care Audit (NDFCA)	operates continuous data capture	N/A	May 2026 (Continuous dashboard reporting now available)	Therapies	Organisation wide compliance	GREEN
National Pregnancy in Diabetes Audit (NPID)	operates continuous data capture	N/A	TBC	Obstetrics and Gynaecology	Organisation wide compliance	GREEN
National Diabetes Inpatient Audit (NDISA)	operates continuous data capture	TBC	TBC	General medicine	N/A	N/A
National Core Diabetes Audit (NCDA)	Data capture from Primary Care at specific intervals	N/A	N/A	Primary Care / Secondary Care	Organisation data extracted	GREEN
National Diabetes Paediatric Audit (NPDA) * #	operates continuous data capture	N/A	March 2025	Paediatrics	Organisation wide compliance Action Plan agreed CEC June 2025	BLUE
National Diabetes Integrated Specialist Survey	Annual survey	November 2025	Dashboard Reporting	Organisation Wide	Organisation wide compliance	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/26
National Respiratory Audit Programme (NRAP)* # Note this covers the following areas: Adult Asthma Secondary Care	operates continuous data capture	N/A	June 2025	General medicine	Organisation wide compliance Action Plan agreed CEC September 2025	BLUE
COPD Secondary Care	operates continuous data capture	N/A	June 2026	General medicine	Action being taken to improve overall % compliance Action Plan agreed CEC September 2025	BLUE
COPD Primary Care (Wales)	Data capture from Primary Care at specific intervals	N/A	TBC	Primary Care	Organisation wide compliance	GREEN
Paediatric Asthma Secondary Care	operates continuous data capture	N/A	June 2026	Paediatrics	Organisation wide compliance Action Plan agreed CEC June 2025	BLUE
Pulmonary Rehabilitation	operates continuous data capture	N/A	June 2026	Therapies	Organisation wide compliance Action Plan agreed CEC April 2025	BLUE
National Early Inflammatory Arthritis Audit * # (NEIRT)	N/A	May 2026	October 2026	Rheumatology	Action being taken to improve compliance at the PWH/RGH. Fully Compliant PCH	AMBER

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/26
All Wales Audiology Audit #	operates continuous data capture	N/A	TBC	Ears, Nose and Throat	Organisation wide compliance	GREEN
Older People						
Sentinel Stroke National Audit Programme (SSNAP) (SSNAP) *	operates continuous data capture	N/A	November 2025	General medicine / Therapies	Organisation wide compliance	GREEN
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls * (NAIF)	operates continuous data capture	March 2026	TBC	General Medicine / Trauma & Orthopaedics	Organisation wide compliance Action Plan agreed CEC April 2025	BLUE
• National Hip Fracture Database (NHFD)	operates continuous data capture	January 2026	TBC	General Medicine / Trauma & Orthopaedics	Organisation wide compliance Action Plan agreed CEC April 2025	BLUE
• Fracture Liaison Service Database (FLS-DB)	operates continuous data capture	TBC	N/A	General Medicine / Trauma & Orthopaedics	Organisation wide compliance	GREEN
National Dementia Audit * (NDA)	Completed 5 Year cycle	N/A	N/A	Mental Health / Care of the Elderly	Not undertaken for 2025/26	N/A

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/26
End of Life						
National Audit for Care at the End of Life (NACEL) *	TBC	TBC	August 2026	Palliative Care / Medicine	Organisation wide compliance	GREEN
Heart						
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * (NHFA)	operates continuous data capture	June 2025	TBC	Cardiology	Organisation wide compliance Action Plan agreed CEC October 2025	BLUE
• Cardiac Rhythm Management * (CRM)	operates continuous data capture	N/A	TBC	Cardiology	Organisation wide compliance Action Plan agreed CEC October 2025	BLUE
• Myocardial Ischaemia National Audit Project (MINAP) *	operates continuous data capture	June 2025	TBC	Cardiology	Organisation wide compliance Action Plan agreed CEC October 2025	BLUE
Cardiac Rehabilitation Audit (CRA)	operates continuous data capture	N/A	December 2026	Cardiology	Organisation wide compliance Action Plan agreed CEC October 2025	BLUE
Cancer **						
National Bowel Cancer Audit (NOGCA) *	operates continuous data capture	N/A	April 2026	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/26
National Oesophago-Gastric Cancer Audit (NOGCA) *	operates continuous data capture	N/A	April 2026	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Audit of Metastatic Breast Cancer (NAoMe) *	operates continuous data capture	TBC	April 2026	Surgery	Newly added mid year compliance under review. Managed through cancer services.	N/A
National Audit of Primary Breast Cancer (NAoPri) *	operates continuous data capture	TBC	April 2026	Surgery	Newly added mid year compliance under review. Managed through cancer services.	N/A
National Lung Cancer Audit (NLCA) *	operates continuous data capture	N/A	April 2026	Respiratory Medicine	Organisation wide compliance Action Plan agreed CEC September 2025	BLUE
National Prostate Cancer Audit (NPCA) *	operates continuous data capture	N/A	April 2026	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Ovarian Cancer Audit (NOCA)	operates continuous data capture	N/A	TBC	Gynaecology	Newly added mid year compliance under review. Managed through cancer services.	N/A
National Pancreatic Cancer Audit (NPaCA)	operates continuous data capture	N/A	TBC	Gastroenterology	Newly added mid year compliance under review. Managed through cancer services.	N/A

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/26
National Non-Hodgkin Lymphoma Audit (NNHLA)	operates continuous data capture	N/A	TBC		Newly added mid year compliance under review. Managed through cancer services.	N/A
National Kidney Cancer Audit (NKCA)	operates continuous data capture	N/A	TBC		Newly added mid year compliance under review. Managed through cancer services.	N/A
Women's and Children's Health						
National Neonatal Audit Programme Audit * # (NNAPA)	operates continuous data capture	N/A	October 2026	Paediatrics	Organisation wide compliance.	GREEN
National Maternity and Perinatal Audit * # (NMPA)	operates continuous data capture	N/A	May 2026	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
National Perinatal Mortality Review Tool (PMRT)	operates continuous data capture	N/A	The PMRT is available for continuous use	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
Other						
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) * # (NASECYP)	Series of data collection cohorts within the audit	Various deadlines for cohorts	February 2026	Paediatrics	Organisation wide compliance. Action Plan agreed CEC June 2025	BLUE
National Clinical Audit of Psychosis * (NCAP) EIP Audit	operates continuous data capture	N/A	Dashboard Reports being developed	Mental Health	Organisation wide compliance.	GREEN

(* denotes NCAPOP Audits)

(# denotes reports likely to include information on children and / or maternity services)

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

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

Clinical Outcomes Review Programme (2024/25)

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

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2025/26	RAG Status 2025/26
National Confidential Inquiry into Suicide and Safety in Mental Health	operates continuous data capture	N/A	April 2025	Mental Health Programme	Organisation wide compliance.	GREEN
MBRRACE – Perinatal Mortality Surveillance	operates continuous data capture	TBC	October 2025	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	GREEN
MBRRACE – Saving Lives Improving Mothers Care	operates continuous data capture	TBC	October 2025	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	GREEN

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

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2025/26	RAG Status 2025/2026
Case Note Documentation Audits: - Acute Hospital Documentation Audit - Community Hospital Documentation Audit - A&E Documentation Audit	Revised methodology TBC	TBC	TBC	Acute inpatient activity	Audit process currently under review	N/A
				Community hospital inpatient activity	Audit process currently under review	N/A
				Emergency Medicine	Audit process currently under review	N/A
Consent to Treat Audit	TBC	TBC	Quarter 4, 2026/27	Medicine / Surgery	Organisation wide compliance. Action Plan Prepared for Consent Working Group in February 2026	BLUE
National Ophthalmology Audit (Adult Cataract surgery) * (NOD)	operates continuous data capture	N/A	TBC	Ophthalmology	Participation in RGH and PCH only.	GREEN



7.5		3 February 2025	Audit, Risk & Assurance Meeting)	JAG Accreditation Update
Report Details:		Impact Assessment:		
FOI Status:	Open (Public)	Indicate the Quality / Safety / Patient Experience Implications:	Delivery of a quality service.	
If closed please indicate reason:	N/A	Related Health and Care Standard	A Healthier Wales – improved quality of service delivery and reduced waiting times.	
Prepared By:	Tomos Rodrigues - Service Manager, Gastroenterology and Endoscopy	Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Not at this stage. If required at later stages will undertake accordingly alongside Welsh Language Lead and People Directorate Business Partner.	
Presented By:	Gethin Hughes – Chief Operating Officer	Are there any Legal Implications /Impact.	No obvious legal implications at this stage.	
Approving Executive Sponsor:	Gethin Hughes – Chief Operating Officer	Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes, revenue / workforce implications (see recommendation slide).	
Report Purpose	For Noting	Link to Strategic Goals	Improving Care	
Engagement undertaken to date:	Engagement via the usual channels within Planned Care			

Summary of position

- Recent appointment of Dr Joanna Hurley as Deputy CD / Endoscopy Medical Lead that will support with the overall JAG accreditation process.
- Refresh of site based EUG agendas during Q1 of 2026 in line with proposed agenda and guidance circulated by the National Endoscopy Programme (NEP).
- Endoscopy recovery plans have been successful in reducing the 8-week breach position from >1400 at the start of Summer 2025 down to ~500 at the end of December 2025. Clearance of the 8-week breach position is a pre-requisite for JAG.
- Expectation is that the CTM JAG work programme would start with PCH, followed by POW, and then explore how we can ensure best alignment with JAG accepting infrastructure constraints at RGH site.
- Risks and mitigation for surveillance – requirement to have 3 month waiting list the service is currently evaluating options for delivery.
- Llantrisant Health Park, has been designed for JAG compliance and accreditation process will commence for this site once open.

Prince Charles Hospital (PCH)

- New Endoscopy (JAG designed) suite opened.
- GRS (Global Rating Scale) – being progressed, with a renewed focus via working group establishment in Q1 of 2026.
- Step down programme of insourcing in Theatre C with a view to sustainable service delivery using existing establishment from end of Q1 2026.

Anticipated date of initial assessment: **Apr 2027 – Sep 2027**

Anticipate date of achievement of JAG: **Sep 2027 – Mar 2028**

Princess of Wales Hospital (POW)

- Loss of JAG accreditation in 2024, due to non centralisation of Decon
- Majority of evidence in place from previous accreditation submissions but requires updating and alignment to newer JAG standards.
- Welsh Government funding agreed for central decontamination unit at POW – expectation is that this will be in place from late 2026.

Anticipated date of initial assessment: **Apr 2028 – Sep 2028**

Anticipate date of achievement of JAG: **Sep 2028 – Mar 2029**

(to run in sequence, rather than in parallel, with PCH JAG – given overlap of key staff members required)

Royal Glamorgan Hospital (RGH)

- Band 6 position who will take a lead on JAG.
- Internal JAG preparation meetings to be established to work through gap analysis.
- All JAG audits need to be completed, can then be presented during audit day.
- GRS (Global Rating Scale) being progressed, with a working group to be established in Q1 2026.
- LHP design incorporates JAG requirements for accreditation

Anticipated date of alignment with JAG requirements: **Sep 2027 – Mar 2028**

(we understand achievement of JAG will not be possible based on infrastructure constraints)

Recommendation:

The Committee are asked to:

Note the enclosed plan – with reference to risks and resource required to resolve the existing demand-capacity deficit across endoscopy, which if unresolved will prohibit JAG accreditation on any site.

Note that if the plan is to proceed that the resource required will require **significant uplifts to nursing, medical, administrative and managerial establishment** to deliver 7 day working across Endoscopy Services (as per GSGI Directorate IMTP), notably to bridge the gap until Endoscopy Services are available via Llantrisant Health Park (LHP).

This uplift would be required early in the 2026/27 FY if the timelines outlined in this slide pack are to be delivered.

Unapproved Minutes of the CTMUHB Audit, Risk & Assurance Committee

Date and Time of Meeting	Thursday 13 November 2025 at 10:30am
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member (Committee Chair)
	Kathy Mason	Independent Member
	Helen Lentle	Independent Member
In Attendance	Sally May	Executive Director of Finance
	Stuart Morris	Director of Digital
	Owen James	Head of Corporate Finance
	Amanda Legge	All Wales Post Payment Verification Manager (in-part)
	Sara Jeremiah	Post Payment Verification Local Manager (in-part)
	Nathan Couch	Auditor – Audit Wales
	Paul Dalton	Head of Internal Audit - NWSSP Internal Audit
	Emma Samways	Deputy Head of Internal Audit – NWSSP Internal Audit
	Murray Gard	Audit Manager – NWSSP Internal Audit
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Kathrine Davies	Corporate Governance Manager (Meeting Secretariat)
	Emma Walters	Head of Corporate Governance & Board Business
Meeting Observers	Kelly Eddington	Quality, Assurance & Compliance Officer
	Hannah Jones	Auditor - Audit Wales

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 • Dilys Jouvenat – Independent Member • Matthew Evans – Local Counter Fraud Officer
1.3	Declarations of Interest
	No declarations were identified.
2.	CONSENT AGENDA BUSINESS
2.1	The P. Roseblade 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. P. Roseblade advised that with regard to Agenda Item 8.2.1 Outcome of Committee Referral to Quality, Safety & Experience Committee - Concern in relation to increased medical negligence costs, this item was on the Consent Agenda due to the concerns raised being fully discussed at the Quality, Safety & Experience Committee, therefore the Committee had been provided with sufficient assurances that the Committee referral could now be closed. P. Roseblade referenced a proposal within the report to increase the threshold for redress cases to £50k and sought clarity on possible implications for the Health Board. O. James confirmed that he would review this and provide more detail outside of the meeting. P. Roseblade referred to the Forward Plan which was on the Consent Agenda and advised that it would be helpful to have a date on the Plan for a Joint Advisory Group (JAG) Accreditation Update.
Action:	To review the statement in the report regarding increased thresholds for redress cases to £50k outside of the meeting.
Action:	Governance Team to liaise with the Chief Operating Officer regarding a date to receive the JAG accreditation update.
3.	MAIN AGENDA
3.1	Action Log

	G. Watts presented the action log noting that all actions were proposed for closure or being addressed in the current meeting. One item remained open regarding counter fraud mandatory training which was in hand with a discussion due to be held shortly and then reported back to the Committee. S. May expressed caution about increasing mandatory training without considering the cost and time required with her preference being a targeted approach. G. Watts confirmed that this would be considered in the discussions. P. Roseblade advised that the document was difficult to read due to formatting issues and suggested that future Action Logs be in landscape format for clarity. G. Watts advised that the team would look at this.
Resolution:	The Committee DISCUSSED and NOTED the Action Log and APPROVED the actions for closure.
Action:	To reformat the Action Log in a landscape format for future meetings.
3.2	Matters Arising Not Captured on the Action Log
	No further matters were identified.
4.	COMMITTEE GOVERNANCE ARRANGEMENTS / IMPROVING CARE
4.1	Organisational Risk Register
	G. Watts presented the November iteration of the Organisational Risk Register drawing members attention to the detailed updates captured in the Cover Paper and Appendix to the report emphasising that it had taken up significant time to complete and included regular updates on risk management training across the Health Board. G. Watts advised that seven new risks were added, and seven risks had their scores decreased for various reasons with one risk closed. Horizon scanning for emerging risks, especially around planned care, was highlighted. K. Mason referred to the new risk 6372 relating to Microsoft enterprise software Agreement renewal which looked like it a potentially high cost pressure but due to it marked as commercially sensitive there was no detail on this. G. Watts advised that he would request an update outside of the meeting. K. Mason and H. Lentle also questioned the usefulness of the heat map, asking for more context on whether risk levels were improving or worsening over time. G. Watts agreed that narrative context and trend analysis would be helpful and offered to discuss improvements offline. P. Roseblade emphasised the importance of honest risk reporting rather than presenting what people think the Committee wants to see. She also asked about the meaning of "shed" in the mental health risk and compared two risks: one (air handling unit) was reduced due to completed mitigation, while another (cellular pathology) was reduced based on expected, not proven, mitigation and highlighted the need for clear evidence when reducing risk scores.
Resolution:	The Organisational Risk Register was REVIEWED and CONSIDERED .

Action:	To provide an update on 6372 - Cost escalation risk – Microsoft Enterprise Agreement renewal.
Action:	Discussions to be held offline on the usefulness of the heat map, narrative context and trend analysis improvements.
4.2	Amendment to the Standing Orders (Schedule 4.1 – Standing Orders for the NHS Wales Joint Commissioning Committee)
	G. Watts presented the report that outlined amendments to the standing orders. G. Watts advised that the report was self explanatory and referenced correspondence from Welsh Government regarding to the JCC Standing Orders.
Resolution:	The Standing Orders were ENDORSED FOR BOARD APPROVAL
Action:	None identified.
4.3	Data Lapses/Data Losses Report
	S. Morris presented the report and advised that this will be a regular item with trend analysis in future. He assured the Committee that while there had been some service disruptions, none required reporting to NIS-D or the Cyber Resilience Unit. S. Morris highlighted two main issues - National Intelligent Integrated Audit Solution (NIIAS) availability was disrupted due to a master patient index problem, with local mitigations in place and ongoing work with Digital Health and Care Wales to resolve it; and a master patient index incident, which was remedied but requires permanent technical fixes. P. Roseblade referred inappropriate access to records and queried whether disciplinary action was taken. S. Morris confirmed that such cases are traceable and can result in disciplinary action, including staff leaving employment. P. Roseblade also questioned if the master patient index incident led to data breaches, such as appointment letters being sent to the wrong person. S. Morris advised that he did not have full details but believed most issues related to outdated addresses, not entirely erroneous data, and would follow up outside of the meeting. K. Mason referred to the data incidents and asked if S. Morris could expand on Executive oversight and lessons learned from high-impact data incidents. S. Morris, in response, described the internal escalation process, including briefing Executive Leadership Group or Executive Management Board and working closely with the Cyber Resilience Unit, and outlined the process for assessing and escalating incidents to the Information Commissioners Office or the Cyber Resilience Unit.
Resolution	The report was NOTED .
Action	To provide an update on whether the master patient index incident had led to data breaches outside of the meeting.



4.4	Declarations of Interest and Gifts, Hospitality & Sponsorship Report
	G. Watts presented the report that provided detail on the Declarations of Interest, Gifts, Hospitality and Sponsorship activities approved within the Health Board. This report has also been considered by the Executive Leadership Group prior to the Committee. P. Roseblade advised that P. Daniels was listed as an Independent Member and not an Executive Director. G. Watts advised that this error would be corrected.
Resolution	The Committee NOTED the entries on the registers included at Appendix 1 and Appendix 2
Action	To amend the detail listed in relation to P. Daniels.
5.	FINANCIAL GOVERNANCE ACTIVITY
5.1	Losses and Special Payments Report
	S May presented the report. S. May reported an increase in the net cash write-off and net provision of values owed from the Welsh Risk Pool, noting that the amount being paid out is currently higher than the value being recovered. She explained this is largely a timing issue but emphasised the need for timely completion of learning to ensure reimbursements are approved and released by the Welsh Risk Pool. S. May also highlighted the ongoing risk of overspend against the Welsh Risk Pool sharing agreement, which is being treated as a risk pending confirmation of the allocation adjustment from Welsh Government.
Resolution:	The Committee: • NOTED the losses and special payments made for the period 1 July 2025 to 30 September 2025. • NOTED the risk of overspend on the WRP risk sharing agreement of £6.1 - £7.8m. • NOTED the key risks for escalation on the increasing net provision value. • NOTED the number of claims that have been paid out but we are awaiting reimbursement from Welsh Risk Pool has increased significantly to £31.875m at the end of September.
Action:	None identified.
5.2	Procurements and Scheme of Delegation Report
	S. May presented the report and highlighted some key matters for the attention of the Committee: The implementation of a file note process for procurement. This process addresses issues where retrospective approval is needed for spend deviations above £5K, allowing for quarterly reporting to the Committee. S. May advised that the process will improve transparency and helps to identify repeat offenders with procurement awareness training to be required for those breaching more than once.

	P. Roseblade suggested that the awareness training for those repeatedly breaching should be required rather than just available. S. May agreed with the suggestion and confirmed that budget holders should already be aware of their responsibilities but may need refresher training.
Resolution:	The Committee: • NOTED the position on procurement matters for the period 01.07.2025 to 30.09.2025; • NOTED the update regarding Purchase to Pay and achievement of PSPP target up to Month 6 of 2025/26; • APPROVED the updated FCPs
Action:	None identified.
5.3	Post Payment Verification Mid-Year Report
	A Legge and S Jeremiah presented the report which provided an update on post payment verification (PPV) activities, noting a strong start to the financial year, changes to reporting for more detail, and the introduction of duplicate reporting checks, which have prompted discussions on system validation and potential prepayment checks. Other key matters highlighted were: • The number of visits completed and in progress for GMS, ophthalmic, and pharmacy contractors, mentioning delays in dispensing work but ongoing recovery. • Highlighted the expanding scope of PPV, including new checks for COVID, flu, and optometry services, and ongoing collaboration with health boards, working groups, and counter fraud colleagues. • Any concerns identified are shared with Health Boards and counter fraud for further investigation, and that training is offered to contractors after visits. • The management of clinical waste contracts and new initiatives for cost savings. P. Roseblade commented that the report was difficult to read in its current PDF format and suggested re-formatting for future meetings. A. Legge advised that she work with the Corporate Governance team to rectify this.
Resolution:	The report was NOTED .
Action:	To reformat the report for future meetings.
6.	COUNTER FRAUD ACTIVITY
6.1	Local Counter Fraud Report
	The Chair advised that this report was being taken at the (CLOSED) In Committee session due to potentially identifiable information.
6.2	National Fraud Initiatives Progress and Outcomes
	P. Roseblade advised that M. Evans was not able to attend today to present the report which provided detail on tasks and actions undertaken with the four

	strategic counter fraud work areas. P. Roseblade advised that any questions could be addressed via S. May outside of the meeting with M. Evans.
Resolution	The report was NOTED .
Action	None identified.
7.	AUDIT REVIEWS AND ASSURANCE ACTIVITY
7.1	Audit Recommendations Tracker
	G. Watts presented the report and highlighted the following key areas in presenting the newly formatted report and approach: • The ongoing efforts to improve the tracker, noting the historical challenges with outstanding recommendations and the need for data cleansing, especially for older items that may no longer be relevant or deliverable. • Regular meetings were held with Executives to review outstanding recommendations, aiming for a more accurate and meaningful tracker, and that a more substantive update would be provided at a future meeting. • The new Internal Audit Model, which involves agreed actions between auditors and officers, should help reduce issues with undeliverable recommendations in the future. K. Mason asked about the process for recommendations that are agreed but cannot be implemented due to capacity or funding constraints. G. Watts advised that such items often have their implementation dates moved. P. Dalton added that unresolved recommendations would be discussed in the Committee to determine if the associated risk is acceptable to the organisation. P. Roseblade provided background for new Members and advised that the Committee acts as a final line of defence, ensuring that only deliverable recommendations are accepted onto the tracker and described previous data cleansing exercises involved both internal and external audit colleagues. H. Lentle queried the timeline for the cleansing process. G. Watts advised that the meetings with Executives would be completed by the end of January 2026 with an update to be provided at the February 2026 meeting, though full completion might take a little longer. K. Mason asked if the Committee would be briefed on any material items removed during the cleansing process. G. Watts confirmed that any proposed closures or removals would be brought to the Committee for review before final updates to the tracker. P. Roseblade explained the rationale for the tracker's current format, emphasising the focus on high-risk overdue recommendations and the need for clarity amid a large volume of data.

	P. Roseblade also questioned whether the pie charts at the front of the report included the items listed as the 39 recommendations proposed for closure as the numbers were very similar. G. Watts agreed to check with the team outside of the meeting.
Resolution:	The Committee NOTED the Report and AGREED the assurances provided.
Action:	To check with the team on the numbers listed on the pie chart includes the 39 recommendations proposed for closure.
7.2	NWSSP Internal Audit Progress Report
	P Dalton presented the report and highlighted the following: • Three reports were on the agenda, five reviews were in draft, six were in progress, and several at the planning stage. • The new global internal audit standards were detailed in Section 5 of the report. • A significant number of reports are expected for the February Committee meeting, and internal audit will work with the corporate governance team to ensure pragmatic scheduling and adequate time for review. P Roseblade asked about the revised approach to follow-ups, and specifically whether a criteria would be set for re-auditing limited assurance reports, commenting that she relies on the assurance that these reports are always followed up. P. Roseblade also sought clarification on how the new pragmatic approach would ensure that limited reports continued to receive appropriate follow ups. In response, P. Dalton clarified that limited assurance reports will continue to be followed up, either through a re-audit or a verification exercise against agreed actions. K. Mason sought clarification on the meaning of 'limited assurance'. P. Dalton explained the four levels of assurance ratings as substantial, reasonable, limited and unsatisfactory and offered to meet with K. Mason separately to discuss the audit process in more detail.
Resolution:	The report was NOTED .
7.3	NWSSP Internal Audit Review Reports
7.3.1	IA Review – Prince Charles Hospital Financial and Technical
	M. Gard presented the report noting the 'substantial' assurance rating. M. Guard advised that appropriate processes were in place for reviewing, challenges, and authorising payment submissions and invoice approvals.
Resolution:	The report was NOTED .
Action:	None identified.



7.3.2	IA Review – PCH Redevelopment Programme Integrated Audit Plan 2025/26
	M. Gard presented the report. M. Gard outlined the annual update of the integrated audit plan for the Prince Charles Hospital redevelopment, explaining that it outlines the planned audit coverage for the year. He advised that the target cost review is underway, with other assignments to be scoped, and confirmed that all assignments will be reported to the committee as in previous years.
Resolution:	The report and the proposed audit plan for 2025-26 was NOTED .
Action:	None identified.
7.3.3	IA Review – Vaccination Policy – Follow Up
	E Samways presented the report which was a follow up review focussing on the actions agreed in the original audit report. E. Samways advised that out of the three agreed actions (two high and one medium), two have been implemented and closed while one action remained ongoing.
Resolution:	The report was NOTED .
Action:	No action identified.
7.4	Audit Wales Audit & Risk Committee Update
	Nathan Couch provided the Committee with an update on the current and planned accounts and performance audit work and highlighted the following: • The audit of 2024-25 charitable funds had commenced. • Fieldwork for the 2025 structured assessment and digital transformation reviews was completed, with reports being drafted. • The draft unscheduled care report (front door) was issued, with a back door report to follow soon. The eye care services report was finalised. • Reviews of estates, cancer services, and follow-up outpatients were still in the scoping stage. • The February Committee meeting would be busy with several reports expected and would coordinate with the Corporate Governance Team, on managing the workload. • No new relevant Audit Wales corporate publications were reported, except for the Welsh language report.
Resolution:	The report was NOTED .
Action:	None identified.



7.5	Audit Wales Review – National Fraud Initiative 2024-25 Update for CTMUHB
	N. Couch presented the report and advised that work would focus on governance arrangements and that matches had been referred to the Health Board for counter fraud to progress, aligning with the further report on the agenda from Local Counter Fraud specialists.
Resolution:	The report was NOTED .
Action:	None identified.
8.	CONSENT ITEMS
8.1	FOR APPROVAL
8.1.1	Unconfirmed minutes of the meeting held 14 August 2025
Resolution:	The Unconfirmed minutes of the meeting held on 14 August 2025 were APPROVED .
8.1.2	Unconfirmed minutes of the In Committee meeting held on 14 August 2025
Resolution:	The Unconfirmed minutes of the In-Committee meeting held on 14 August 2025 were APPROVED .
8.2	FOR NOTING
8.2.1	Outcome of Committee Referral to Quality, Safety & Experience Committee - Concern in relation to increased medical negligence costs
Resolution	The Committee NOTED the report and CONFIRMED they were satisfied that the review has provided sufficient assurances and that the Committee Referral can now be closed.
8.2.2	Audit Wales Report – Tackling the Planned Care Challenges
Resolution	The Committee NOTED the Report.
8.2.3	Annual Cycle of Business 2025
Resolution	The Committee Annual Cycle of Business was NOTED .
8.2.4	Committee Forward Work Plan
Resolution	The Committee Forward Plan was NOTED .
9.	CLOSE OF BUSINESS
9.1	Any other Business
	No further items were identified.
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 Corporate Governance Team outside the meeting.
9.3	Committee Highlight Report



	The Committee Chair advised that this would be drafted outside the meeting by the Governance Team.
10.	ITEMS TO BE DISCUSSED IN CLOSED SESSION
10.1	• Organisational Risk Register - Business Sensitive Risks • Financial Control Procedure - Medical Variable pay - Summary of Authorised Breaches – this item has been deferred to the February 2026 meeting. • Local Counter Fraud Update
11.	DATE AND TIME OF THE NEXT MEETING
11.1	The next meeting is scheduled for 3 rd February 2026.



Agenda Item

8.1.2

Unapproved Minutes of the CLOSED CTMUHB Audit, Risk & Assurance In Committee

Date and Time of Meeting	Thursday 13 November 2025 at 12:30pm
Venue	Virtual via Microsoft Teams

Members Present	Patsy Roseblade	Independent Member (Committee Chair)
	Kath Mason	Independent Member
	Helen Lentle	Independent Member
In Attendance	Sally May	Executive Director of Finance
	Paul Dalton	Head of Internal Audit NWSSP
	Nathan Couch	Audit Wales
	Owen James	Head of Corporate Finance
	Gareth Watts	Director of Corporate Governance/Board Secretary
	Kathrine Davies	Corporate Governance Manager
Meeting Observers	Hannah Jones	Audit Wales

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	P. Roseblade, Committee Chair welcomed everyone to the meeting.
1.2	Apologies for Absence
	Apologies were received from: - Dilys Jouvenat, Independent Member (Committee Vice Chair) - Kath Palmer, Vice Chair - Matthew Evans, Local Counter Fraud Officer
1.3	Declarations of Interest
	No declarations were identified.

2. MAIN AGENDA



2.1	Organisational Risk Register – Business Sensitive Risks
	G. Watts presented the business sensitive risks captured on the Organisational Risk Register which had been subject to review with detailed updates provided.
Resolution	The Organisational Risk Register was REVIEWED and DISCUSSED.
Action	No actions identified.
2.2	Local Counter Fraud Report S. May advised that late apologies had been received from M. Evans, Local Counter Fraud Officer and therefore any questions raised could be referred to Local Counter Fraud outside of the meeting. S. May advised that the report was being discussed at the (CLOSED) In Committee session due to the potentially identifiable information contained within the Open Investigation Cases report. Members discussed the content of the report and agreed that for future Audit, Risk and Assurance Committee Meetings the main body of the report would be received in the main meeting and that the Open Investigation Cases would be received at the (CLOSED) In Committee meeting
Resolution	The report was NOTED and DISCUSSED.
Action	To receive the Open Investigation Cases report at future meetings of the (CLOSED) In Committee session.
3.	ANY OTHER BUSINESS
	No further items were identified.
4.	DATE AND TIME OF NEXT MEETING
	3 February 2026 at 12:00 pm
5.	CLOSE

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
January 2026	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Discharge Planning	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	February 2026	This item is on the Agenda for the February 2026 meeting.
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Stroke Services	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	This item is on the Agenda for the February 2026 meeting.
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Estates Assurance Asbestos Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	This item is on the Agenda for the February 2026 meeting.
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Operational response critical incident	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	This item is on the Agenda for the February 2026 meeting.
August 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Clinical Coding	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	Deferred from November 2025	This item is on the Agenda for the February 2026 meeting.
24 October 2025	Email	Audit Wales	Audit Wales – Structured Assessment	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	Deferred from February 2026	This item is on the agenda for the May 2026 meeting.
24 October 2025	Email	Audit Wales	Audit Wales Report – Eye Care	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	Deferred from November 2025	This item is on the Agenda for the February 2026 meeting.
18 January 2026	Email	Audit Wales	Audit Wales Report - Urgent and Emergency Care Arrangements for Managing Demand	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	February 2026	This item is on the Agenda for the February 2026 meeting.
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – PoW Roof Replacement	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – Savings	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026

22 January 2026	Internal Audit Progress Report	Internal Audit	IA Review – Individually Commissioned Packages of Care	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Risk Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Medical Sickness Records (Advisory)	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Re-audit – Gastro Intestinal Demand Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Falls Management	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Re-Audit – Additional Medical pay	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Cyber Security	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – digital – Bridgend Disaggregation	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Speaking up Safely	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Financial Systems	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Outpatient Booking Process	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Medical Annual Leave and Rostering	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026

22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Welsh Risk Pool	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Ward Audits	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Medical Job Planning re-audit	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Interventions not normally used re-audit	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026
22 January 2026	Internal Audit Progress Report	Internal Audit	Internal Audit Review – Estates Assurance – follow up	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	May 2026	This item is on the agenda for May 2026

COMPLETED ITEMS:

November 2025	Audit Risk & Assurance Committee	Internal Audit	IA Review – PCH Redevelopment Programme and Audit Plan	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	November 2025	This item was received at the November 2025 meeting – Closed
November 2025	Internal Audit Progress Report	Internal Audit	IA Review – Follow up - Decarbonisation	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	August 2026	This item was received at the August 2026 meeting - Closed
October 2025	Audit, Risk & Assurance Committee	Internal Audit	IA Review – Follow Up Vaccination Implementation	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	November 2025	This item was received at the November 2025 meeting – Closed
November 2025	Audit Risk & Assurance Committee	Internal Audit	IA Review – PCH Financial and Technical – Final	Internal Audit Progress Report	Internal Audit	Gareth Watts, Director of Governance/Board Secretary	November 2025	This item was received at the November 2025 meeting – Closed
10 October 2025	Email	Audit Wales	Audit Wales Report – Tackling Planned Care - Management Response	Audit Wales Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	November 2025	Received at the November 2025 meeting - Closed
February 2025	Audit, Risk & Assurance Committee	Committee	Outcome of Committee Referral to Quality, Safety &	Committee raised concern in relation to increased medical negligence costs and requested	Head of Corporate Finance	Gareth Watts, Director of Governance/Board Secretary	November 2025	Received at the November 2025 meeting - Closed

			Experience Committee	that the Quality, Safety & Experience Committee review				
28 October 2025	Notification from Welsh Government	Assistant Director of Governance & Risk	Amendments to CTMUHB Standing Orders (Schedule 4.1 – Standing Orders for the NHS Wales Joint Commissioning Committee)	Revised JCC Standing Orders	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	November 2025	Received at the November 2025 meeting - Closed
16 October 2025	Email	Audit Wales	Audit Wales Briefing National Fraud Initiatives 2024-25 CTMUHB Update	Audit Wales Briefing Report	Audit Wales Performance Audit Lead (Health)	Audit Wales Performance Audit Lead (Health)	November 2025	Received at the November 2025 meeting - Closed
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	Received at the August 2025 meeting. Closed.
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	Received at the August 2025 meeting. Closed
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	Received at the August 2025 meeting. Closed
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	Received at the August 2025 meeting. Closed
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	Received at the August 2025 meeting. Closed
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	Received at the August 2025 meeting. Closed
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	Received at the August 2025 meeting. Closed

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	Received at the August 2025 meeting. Closed
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	Received at the August 2025 meeting. Closed



Agenda Item

8.2.2

Audit, Risk & Assurance Committee

ANNUAL REPORT TIMETABLE 2025-2026

Dyddiad y Cyfarfod / Date of Meeting	03/02/2026
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 / Forum Individuals	Date	Outcome
Executive Leadership Group	02/02/2026	APPROVED

Acronyms / Glossary of Terms	

1. Situation / Background

- 1.1 In recent weeks the final iteration of the Manual for Accounts has been received confirming the deadlines for submission of documents to Welsh Government and Audit Wales. The Annual Report encompassing the required reporting elements set out in the Manual for Accounts will be presented at the Health Board's Annual General Meeting on 31 July 2026. As in previous years, the suite of Annual Report documents will be presented electronically at the Annual General Meeting.

2. Specific Matters for Consideration

- 2.1 There is a timetable enclosed at **Appendix 1**, supporting the development of the Annual Report led by the Assistant Director of Governance & Risk and Head of Corporate Governance & Board Business. The timetable highlights the final deadline dates to deliver the Annual Report and Financial Statements for the year 2025/26.
- 2.2 Submissions are being sought from Executive Directors during February 2026 and the content is being worked through. Those which are outstanding will be followed up in order that we are able to complete the complex task of drafting the Annual Report element and these are being processed for the initial review by ELG.
- 2.3 Audit Wales and Internal Audit colleagues have received a copy of the timetable and concur that they will be able to meet the scheduled dates.

3. Key Risks / Matters for Escalation

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

4. Assessment

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



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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> 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 for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	



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

5. Recommendation

- 5.1 The Committee is asked to **NOTE** the final timescales in place in respect of the delivery of the Annual Report process for 2025-2026

Annual Report and Accounts Timetable – 2025-2026

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

Main Tasks	Executive Lead	February 2026	March 2026	April 2026	May 2026	June 2026	July 2026
Introductory Pages Foreword CEO and Chair About CTMUHB CTM2030 Issues of Particular Note Performance and Delivery Report (within Annual Report) - Performance Overview - Delivery and Performance Analysis - Wellbeing of Future Generations (Wales) Act 2015 - Welsh Language - Sustainability Report Accountability Report - Corporate Governance Report - Statement of Accountable Officer and Directors Responsibilities - Governance Statement - Remuneration and Staff Report - Modern Slavery Act 2015	Various – Please refer to content requirements spreadsheet	Drafting	Content / Narrative Submissions to Corporate Governance by 6th March 2026. 2ND March 2026 - Issue Governance Compliance Statement to NIAW for signing on the 31st March 2026.	Draft to Executive Leadership Group for comment 7th April 2026 at the latest. Draft to Independent Members for comment by the 1st May 2026. Joint Commissioning Committee will complete a full Governance Statement to provide assurance on the Chief Commissioner's Accountable Officer (AO) status for the propriety and regularity for public finances delegated to them by Welsh Government, Health Boards and the JCC. Draft AGS to JCC meeting in March 2026. Submit to CTM before 1 May 2026. NIAW Compliance Statement signed and received.	Annual Governance Statement JCC due in on the 1st May 2026. By the 4th May 2026 Internal Audit provide their draft opinion (but not full draft annual report) to allow inclusion in version being prepared for WG submission Draft to Welsh Government/ Audit Wales by 8th May 2026 (<i>request comments within a fortnight</i>). Following any necessary amendments draft prepared (with inclusion of complete internal audit draft annual report submission) for consideration at existing meeting of Audit, Risk & Assurance committee on 19 May 2026.	Final Draft to Extra-ordinary Audit, Risk & Assurance Committee to endorse for Board Approval 24th June 2026. Final Draft received at Extra-ordinary Public Board held in public 25th June 2026 for approval. Final version to Welsh Government via Auditor Wales by Close of play 26th June 2026. Auditor General Certification – 26th June 2026. Audit Wales to Submit to WG – noon 30th June 2026. Initiate Welsh Language Translation.	Welsh Language Translation. Annual General Meeting 30th July 2026.
Audited Financial Accounts and Statements Pooled Budgets and All FRs including FR6, (except FR10) MS A to C and F-H inclusive	Sally May, Executive Director of Finance	Drafting	Drafting	Drafting	Unaudited Accounts to be submitted by CTMUHB to Audit Wales & Welsh Government by 1st May 2026. Draft Accounts to the Audit, Risk & Assurance committee on 19th May 2026.	Audited Accounts Final Draft to Extra-ordinary Audit, Risk & Assurance Committee to endorse for Board Approval 24th June 2026. Final Draft received at Extra-ordinary Public Board held in public 25th June 2026 for approval. Final version (Signed and Unsigned) to be sent to Audit Wales by Close of play 26th June 2026. Auditor General Certification – 26th June 2026. Audit Wales to Submit to WG – noon 30th June 2026.	Annual General Meeting 30th July 2026.